



SALISH BHO

ADVISORY BOARD MEETING

DATE: Friday, January 27, 2017

TIME: 12:00 PM – 2:00 PM

LOCATION CHANGE: City of Sequim, Civic Center Chambers
152 W Cedar Street, Sequim WA 98382

AGENDA

<http://www.kitsapgov.com/hs/sbho/sbhoboard.htm>

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of October 28, 2016 Minutes (Attachment 5)
6. Action Item
 - a. Appointment of Nominating Committee for Board Officers
7. Informational Items
 - a. Background on Ombuds
 - b. BHO Integration Paper (Attachment 7.b)
 - c. 1115 Demonstration Grant Accountable Communities of Health Toolkit
 - d. Opioid Project
 - e. Substance Abuse Block Grant Funding (Attachment 7.e)
 - f. Potential Funding Changes July 1
 - g. Western State Hospital (Attachments 7.g.1, 7.g.2, and 7.g.3)
 - h. Quality Assurance (Attachment 7.h)
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Board Member Check-in
10. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHO	Behavioral Health Organization, replaced the Regional Support Network
CAP	Corrective Action Plan
CMHA	Community Mental Health Agency
CMS	Center for Medicaid & Medicare Services (federal)
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DDA	Developmental Disabilities Administration
DMHP	Designated Mental Health Professional
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FBG	Federal Block Grant (specifically MHBG and SABG)
FYSPRT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IS	Information Services
ITA	Involuntary Treatment Act
LOC	Level of Care
MAT	Medical Assisted Treatment
LRA	Least Restrictive Alternative
MCO	Managed Care Organization
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QA, QI	Quality Assurance, Quality Improvement
QUIC	Quality Improvement Committee
QRT	Quality Review Team
RCW	Revised Code Washington
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SAPT	Substance Abuse Prevention Treatment
SBHO	Salish Behavioral Health Organization
SUD	Substance Use Disorder
UM	Utilization Management
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Go to <http://www.kitsapgov.com/hs/sbho/sbhopolicies.htm> for a full listing of definitions and acronyms

SALISH BEHAVIORAL HEALTH ORGANIZATION

AGENDA BRIEFING

January 27, 2016

ACTION ITEMS

- a. Appointment of Nominating Committee for Board Officers

The Chair will appoint a nominating committee to develop a slate of candidates for Chair and Vice Chair positions, with the election to be conducted at the February meeting.

INFORMATIONAL ITEMS

- a. Background on Ombuds

Staff will provide background on the creation of the Ombuds function in Washington State, and the current Ombuds contractor will provide background on how they conduct their work.

- b. BHO Integration Paper

In 2014, the Washington Legislature passed SSB 6312, which called for the integration of mental health and substance use disorder services into a single managed care contract effective April 1, 2016; and, called for the integration of behavioral and physical healthcare by 2020. The actual legislation does not specify the legislative intention that all funding needed to be integrated, but that services need to be.

The executive branch, including the Health Care Authority and Governor's office, have adopted the position that full integration requires integrated funding, with all Medicaid funding used to purchase services through Managed Care Organizations (MCOs). They have implemented this in Southwest Washington, where all Medicaid funding goes through Molina or Community Health Plans of Washington, and Beacon Health for non-Medicaid services.

Behavioral Health Organizations believe that there is a benefit to the involvement of locally based Behavioral Health Organizations in the development and oversight of services to some of the most vulnerable populations in our state. In keeping with that belief, we have created the attached white paper which we will be utilizing during the upcoming legislative session to attempt to maintain a role for local input and oversight of public behavioral health services.

- c. 1115 Demonstration Grant Accountable Communities of Health Toolkit

The Health Care Authority has achieved approval of their 1115 Medicaid Demonstration Project, which includes three strategies. Strategy One is to transform the delivery of Medicaid services, and funding for this work will be through the Accountable Communities of Health (ACH). The Toolkit for this work that has been developed, and is out in DRAFT, identifies eight projects that ACHs can apply for funding to implement, with three of the eight mandatory projects. The toolkit is available here: <http://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation> under Updates.

- d. Opioid Project

Staff will provide an update on the Opioid project being headed by the Olympic Community of Health.

e. Substance Abuse Block Grant Funding

Following the allocation of funding through the request for proposal process, the SBHO had an unallocated balance of \$304,000 in Substance Abuse Block Grant (SABG) funding. Staff will discuss with the board a potential reallocation of these funds.

Staff is in the process of developing the RFP for the SABG funding for July 1 services and is seeking volunteers to participate in the process.

f. Potential Funding Changes July 1

At the last Board meeting, staff presented information on the potential for significant funding shifts with the exemption of the Alaskan Native/American Indian (AI/AN) population from the Medicaid waiver. We do not have an update on that issue for this meeting, but an additional funding issue has been identified that staff will present.

g. Western State Hospital

The Governor released a proposed budget in December which focused significantly on the mental health system in general, and the State Hospitals specifically. In the budget, no funds were earmarked for expansion of community services except in relation to the state hospital. Since the end of the 2016 legislative session, the state has engaged a number of consultants to assist in the "redesign" of the state hospital system, with the entire reports available here: <http://www.kitsapgov.com/hs/sbho/sbhoreports.htm> .

Attached are the summary sections of each report. One focus of the main report is to re-focus the state hospitals so they are mainly for forensic patients, shrinking the number of civil patients committed there. This shift would move potentially hundreds of civil patients back to their home communities, and the budget requests of the Governor did not seem to fund this level of community development.

h. Quality Assurance

Quality Assurance staff will present an update on performance measures.

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**12:00 p.m., Friday, October 28, 2016
City of Sequim Civic Center Meeting Room
152 W Cedar Street, Sequim WA 38382**

CALL TO ORDER – Russ Hartman, chair, called the meeting to order at 12:08 p.m.

INTRODUCTIONS – Self introductions.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS

Joe Roszak: Voiced concern with agenda packet Attachment 7.a.4 Impact of American Indian/Alaskan Native Exclusion from Managed Care spreadsheet; he felt there should be more discussion before the board votes to recommend spreading the funding loss to a 6% across the board cut to each agency's budget. The chair pointed out this is a discussion item not a proposal at this time.

APPROVAL OF THE AGENDA

Agenda was adjusted to move item 7.c Substance Use Disorder Agency Presentation to before Action Items to accommodate presenter Dr. Dave Beck; and to add item 7.g. Discussion of Board Schedule Survey.

Revised agenda was approved without motion.

APPROVAL OF OCTOBER 28, 2016 MINUTES

MOTION: John Freeburg moved to approve the minutes of the October 28, 2016 meeting as submitted. Lois Hoell seconded. Motion carried.

PRESENTATION

➤ Substance Use Disorder Agency Presentation

- Dr. Dave Beck, presented on substance use disorder treatments.
- Provided a brief background summary, he is a generalist and an addiction specialist, currently working for Evergreen Treatment Center.
- The Center for Disease Control, Department of Justice at the Federal level, White House Office of National Drug Control Policy and the National Institute of Health all agree that there is an official epidemic of opioid use disorders and opioid overdose deaths in this country.
- Dr. Beck spoke to the initial use of an opioid substance, the addiction, and the effects on the brain and body.
- Discussed the high re-use of opioids with abstinence-based therapies; Medication Assisted Treatment (MAT) is evidence-based practice when combined with use of pharmacotherapies, behavioral therapies, and supplementary core services.
- Medication is not the treatment, it allows treatment and recovery to occur.
- There was time for a question and answer period at end of presentation.

ACTION ITEMS

➤ Election of Vice Chair

- With the resignation of Anthonie Cullen, the Advisory Board discussed electing another vice chair.
- Lois nominated John Freeburg. There were no other nominations from the floor.

MOTION: Lois Hoell moved the board appoint John Freeburg as the vice chair, replacing Anthonie Cullen. Jennifer Kreidler-Moss seconded. Motion carried.

- On another issue of board members, the board member nominating committee was asked to consider the application from a Jefferson County resident to fill the position vacated by Anthonie Cullen. Two of the three committee members were present and agreed that the applicant, Freida Fenn, would be a good replacement. The Committee asked staff to reaffirm that Freida wasn't currently employed by any of the Salish BHO contracted providers. Staff will contact applicant and forward information to committee as requested. The information will be shared with the absent committee member also.

INFORMATION ITEM

➤ Funding Primer

- Staff provided information on how SBHO funding works.
- **Revenue:** Medicaid revenue is paid on a capitated per member per month payment for each Medicaid recipient in the region with the SBHO acting as an insurance agency for both the substance use disorder and chronic mental health Medicaid population. The rate is actuarially determined and varies by each BHO. State funding is distributed by each county's overall population. The two federal block grant funding streams, substance use disorder and mental health, are based largely on population.
- **Expenditures:** Medicaid funding for mental health services is paid to providers on a per member per month basis. State funding is distributed to providers determined by general population census information. Federal mental health block grant funding is distributed to providers based on its historical distribution.

Funding for substance use disorder providers is of three types—residential, withdrawal management, and outpatient services. Residential and withdrawal management services are paid on a bed day rate basis, with Medicaid or State funding used based on the individual's eligibility. Medicaid outpatient funding is paid on a case rate basis; State funding is distributed to providers based on historical distribution prior to being part of the SBHO. Federal block grant funds were distributed through a request for proposal process and will be paid on a cost reimbursement basis.

- By 2019, all Medicaid payments will be value based/outcome based--the SBHO currently meets this criteria.

- Impact of American Indian Exclusion from Behavioral Health Waiver: When the state submitted their new federal waiver without tribal involvement, the tribes began discussions directly with the Center for Medicaid and Medicare Services (CMS) requesting Medicaid covered individuals identified as American Indians or Alaskan Natives be exempt from the managed care system. This part of the waiver was approved and becomes effective in July 2017. This will have a substantial financial effect on some of our agencies, especially West End Outreach Services, which serves a higher ratio of designated Native Americans. Staff will develop and present to the board alternative funding models prior to the waiver becoming effective.
- Health Care Reform
 - 1115 grant: Washington's Health Care Authority has received an agreement in principle from the Centers for Medicare and Medicaid Services to provide funding for the 1115 Demonstration Project. The grant authorizes up to \$1.125 billion in total expenditures for the establishment and implementation of a five-year Delivery System Reform Incentive Payment (DSRIP) program. The grant has three main initiatives, most funds going to *Initiative 1-* through Communities of Health which will receive incentive payments for achievement of quality targets and for value-based purchasing milestones while adhering to the triple aim for better care with less cost for better health. *Initiative 2-* will create a new Medicaid Alternative Care (MAC) benefit package for individuals eligible for Medicaid but not currently receiving Medicaid-funded long term services and supports (LTSS). *Initiative 3-* will provide for supported services in supported housing, not housing costs, as well as supported employment.
 - There is going to be a redefinition of IMD (Institutes for Mental Disease) inpatient facilities with over 16 beds. Currently, Medicaid won't pay for services in facilities over 16 beds though Washington has a waiver in place; however, effective July 2017, they will cover stays of up to 15 days per month. Staff believes it will be a tracking nightmare.
- Western State Hospital (WSH)
 - The hospital continues to be under review, some of the information should be available prior to January 2017. SBHO has continued to be under census. The hospital has indicated in recent meetings that WSH going forward plans to look and act more like a regular hospital with people going in and coming out, and not warehousing folks that have no where else to go.
 - The SBHO generally has no one waiting to get into WSH.
- Quality Assurance
 - Richelle Jordan, discussed the graphs provided to the board and asked for feedback to better understand the board's needs. Board asked for a standing QA Meeting Update as an agenda item.
- Opioid Project
 - **Dr. Thomas**, spoke to the ongoing process for their Opioid Project. Staff are speaking to local physicians, SUD providers, first responders, hospitals, etc. to develop a data base to determine coverage and need. Also developing a resource list for all to use. The Olympic Communities of Health (OCH) summary report will be ready in January 2017.

- **Russ Hartman, Board Chair**, spoke to the Executive Board’s interest in the Nurse Care Manager Opioid project. More information to follow.
- Discussion of Board Schedule Survey
 - Item was tabled until next meeting due to lack of discussion time.

OPPORTUNITY FOR PUBLIC COMMENT

- None

FOR THE GOOD OF THE ORDER

- Board Member Check-In: John mentioned the successful NAMI state meeting in Port Angeles. Lois would like to add more information about SUD; Helen appreciated the presentation information.
- Staff Report: The next meeting is Friday, December 9, at Quimper Unitarian Universalist Fellowship.

ADJOURNMENT - The meeting adjourned at 2:05 pm.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<p><u>Present</u> Anne Dean John Freeburg Jolene George Russ Hartman Lois Hoell Jennifer Kreidler-Moss Barbara Maxwell Helen Morrison Janet Nickolaus Charles Pridgen Mike Stringer</p> <p><u>Absent/Excused</u> Roberta Charles Catharine Robinson Steve Schermerhorn Jon Stroup</p>	<p>Heather Lewis, Bridges Ombuds Vivian Mosey, Bridges Ombuds Lisa Rey Thomas, Olympic Community of Health Joe Roszak, Kitsap Mental Health Services Adam Marquis, Jefferson Mental Health Services Wendy Sisk, Peninsula Behavioral Health Pam Brown, West End Outreach Services Ford Kessler, Safe Harbor/Beacon of Hope Kathleen Kler, BOCC Jefferson Kim Yacklin, Clallam County Health & Human Services Doug Washburn, Kitsap Human Services</p>	<p>Anders Edgerton Linda Ward Richelle Jordan Ileea Nehus</p>

**“An Alternative Pathway to Full Behavioral Health/Health Care Integration:
Leveraging the capacity of Washington State’s Behavioral Health Organizations”**

Proposal:

- Allow for an alternative pathway to Full Behavioral Health/Primary Health Care integration that builds on the existing infrastructure and strengths of the BHOs and Apple Health MCOs and achieves improved outcomes and reduced costs.
- Regions/Counties would be given the option to develop, in partnership with the Health Care Authority, an integrated model of physical and behavioral health that achieves the goals of the Triple Aim and meets the needs of the local communities.
- Provide flexibility in 2020 procurement of Medicaid that provides for local regions to determine the best structure for integrated financing.

The Business Case for an Alternative Pathway:

1. The population of persons with Serious Mental Illness and Substance Use Disorders present complex challenges for treatment. Any model for the integration of behavioral health and physical health care needs to be designed specifically with their treatment needs in mind.
2. The institutional knowledge and expertise for treating persons in the community with Serious Mental Illness and/or Substance Use disorders resides primarily within the current BHO system and its contracted providers.
3. Care coordination to persons with Serious Mental Illness and/or Substance Use disorders is best provided by locally administered systems that rely primarily on face to face contact.
4. There has not yet been sufficient time to thoroughly evaluate the model for fully integrated financial integration currently being tested in Southwest Washington. Before expanding this model to other regions, there should be a thorough evaluation conducted by an independent organization. If the State is willing to allow an alternative model, then this too should be subject to a thorough evaluation.
5. Most states who are experimenting with models for full integration are using other approaches, many of which maintain a specialty network of services for the seriously mentally ill.
6. The publicly managed BHO structure is able to invest a greater share of its resources in provider and community capacity because BHOs are not required to provide a return to shareholders.
7. BHOs have developed extensive community networks to coordinate crisis services and treatment for persons with behavioral health disorders. These networks have been built up over years and include relationships with law enforcement agencies, jails, schools, hospitals, social service and housing agencies, and other local government organizations. Empowering the most critical components of this valuable local infrastructure should be a state priority.

An Alternate Pathway to Full Integration:

This alternate pathway would be made up of all organizations that share in the financial risk of health and behavioral health as well as providers and other community stakeholders, will:

An Alternative Pathway to Full Integration

1. Create an Interlocal governance structure in each Regional Services Area [RSA] with the BHO/County Authorities and the Apple Health MCOs serving that region. The structure will provide collective ownership of the integration model (clinical and financial) that places individuals at the center of focus;
2. Keep the state's current contracts with BHOs and MCOs in place;
3. Include voting representatives from the elected county officials of each county in the RSA as well as a voting representative of each Apple Health MCO serving that region. Advisory seats on the Interlocal Governing Body would also be set aside for a representative of the Behavioral Health Advisory Board, the Accountable Community of Health, and the Tribal Nations in that RSA.
4. Be encouraged to invest resources into a common funding pool to support and provide financial incentives to primary care clinics, hospitals, and behavioral health agencies to support bi-directional care coordination.
5. Align contracting and standardize practices, where appropriate, across providers (primary care and behavioral health);
6. Include a system of data share agreements that would allow the tracking of persons across systems, identify high utilizers, and eventually measure shared performance outcomes.
7. Ensure outcomes are achieved through value-based purchasing and set benchmarks and milestones to move more contracting to value-based purchasing;
8. Blend funding as needed to ensure a full continuum of care (required to achieve outcomes and support system capacity and infrastructure);
9. Develop investment priorities that support the system; and
10. Make mutual investments toward shared priorities including shared savings arrangements where appropriate.

An Alternative Pathway to Full Integration

SALISH BHO Substance Use Disorder BUDGET REPORT

Attachment 7.e

Line Item	12 Month Budget	Life to Date	Percent	Balance
Medicaid Outpatient	6,007,000.00	2,549,805.73	42%	3,457,194.27
Medicaid Residential	4,600,000.00	3,513,586.86	76%	1,086,413.14
Medicaid Detox Clallam ABHS	416,100.00	133,131.00	32%	282,969.00
Medicaid Detox KRC	500,000.00	283,105.08	57%	216,894.92
Medicaid Admin	453,250.00	427,197.00	94%	26,053.00
Med Special Proj/Unallocated	1,000,000.00	0.00	0%	1,000,000.00
State Outpatient	641,500.00	175,606.79	27%	465,893.21
State Residential	332,500.00	15,339.08	5%	317,160.92
State Detox Clallam ABHS	200,000.00	8,439.00	4%	191,561.00
State Detox KRC	300,000.00	27,494.92	9%	272,505.08
State Admin	151,000.00	21,399.00	14%	129,601.00
SAPT = Child svcs/PPW housing	189,540.00	47,852.46	25%	141,687.54
SAPT Outpatient	1,067,301.00	39,321.79	4%	1,027,979.21
SAPT Residential*	375,000.00	272,458.52	73%	102,541.48
SAPT Spec Proj/Unallocated	304,138.00	0.00	0%	304,138.00
CJTA Outpatient	452,000.00	26,555.56	6%	425,444.44
Expense total	16,989,329.00	7,541,292.79	44%	9,448,036.21

SALISH BHO Substance Use Disorder BUDGET REPORT				
Line Item	12 Month Budget	Life to Date	Percent	Balance
Medicaid Outpatient	6,007,000.00	2,549,805.73	42%	3,457,194.27
Medicaid Residential	4,600,000.00	3,513,586.86	76%	1,086,413.14
Medicaid Detox Clallam ABHS	416,100.00	133,131.00	32%	282,969.00
Medicaid Detox KRC	500,000.00	283,105.08	57%	216,894.92
Medicaid Admin	453,250.00	427,197.00	94%	26,053.00
Med Special Proj/Unallocated	1,000,000.00	0.00	0%	1,000,000.00
State Outpatient	641,500.00	175,606.79	27%	465,893.21
State Residential	332,500.00	15,339.08	5%	317,160.92
State Detox Clallam ABHS	200,000.00	8,439.00	4%	191,561.00
State Detox KRC	300,000.00	27,494.92	9%	272,505.08
State Admin	151,000.00	21,399.00	14%	129,601.00
SAPT = Child svcs/PPW housing	189,540.00	47,852.46	25%	141,687.54
SAPT Outpatient	1,067,301.00	39,321.79	4%	1,027,979.21
SAPT Residential*	375,000.00	272,458.52	73%	102,541.48
SAPT Spec Proj/Unallocated	304,138.00	0.00	0%	304,138.00
CJTA Outpatient	452,000.00	26,555.56	6%	425,444.44
Expense total	16,989,329.00	7,541,292.79	44%	9,448,036.21

Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	2016 Total
286,830.00	289,770.00	290,365.00	306,390.00	290,699.73	267,070.00	280,441.00	250,515.00	287,725.00	2,549,805.73
370,434.36	383,594.74	364,998.24	396,572.78	370,502.92	322,701.24	408,933.62	598,523.20	297,325.76	3,513,586.86
14,625.52	12,841.92	11,058.32	22,651.72	19,589.44	13,750.28	24,110.08	14,503.72	-	133,131.00
18,955.32	21,584.16	20,754.00	20,200.56	30,300.84	27,533.64	35,600.04	82,182.84	25,993.68	283,105.08
47,565.00	47,565.00	47,565.00	47,384.00	47,384.00	47,384.00	47,450.00	47,450.00	47,450.00	427,197.00
									0.00
21,716.15	15,986.62	24,738.24	17,217.24	18,172.80	27,126.85	14,765.43	17,013.55	18,869.91	175,606.79
29,996.28	29,498.28	29,216.40	31,171.92	31,585.32	26,155.08	30,962.40	38,607.04	(231,853.64)	15,339.08
954.48	838.08	721.68	1,478.28	1,210.56	849.72	1,489.92	896.28	-	8,439.00
1,594.68	1,815.84	1,746.00	1,699.44	2,549.16	2,316.36	2,199.96	4,567.16	9,005.32	27,494.92
2,355.00	2,355.00	2,355.00	2,403.00	2,403.00	2,403.00	2,375.00	2,375.00	2,375.00	21,399.00
4,917.00	4,647.00	5,182.95	4,728.67	6,253.92	5,588.66	5,315.12	5,762.14	5,457.00	47,852.46
			13,273.08	4,116.66		4,945.90	10,064.24	6,921.91	39,321.79
								272,458.52	272,458.52
									0.00
			2,169.00	1,912.20	3,450.79	5,774.24	4,847.97	8,401.36	26,555.56
799,943.79	810,496.64	798,700.83	867,339.69	826,680.55	746,329.62	864,362.71	1,077,308.14	750,130.82	7,541,292.79



Initial Findings Report

Washington Mental Health System Assessment

November 2016

PCG | *Health*

Public Focus. Proven Results.™

Table of Contents

1. Executive Summary	3
2. Introduction	8
2.1. Purpose of the Study	8
2.2. Purpose of this Report	8
2.3. Context of this Report	8
3. Approach	9
3.1. Summary of Approach	9
3.2. Limitations and Considerations	10
4. Current Mental Health System	11
4.1. Mental Health System Overview	11
4.2. Scope of Services	14
4.3. Determination of Need for Inpatient Care	16
4.4. Initiating Inpatient Care	19
4.5. State Hospital Utilization	23
4.6. Transition Planning and Challenges	39
4.7. Funding the System	50
4.8. Continuum of Care	57
4.9. Context from Other States	71
4.10. Key Findings	87
5. National Best Practices	89
5.1. Role of State Hospitals	89
5.2. Role of Community Mental Health	99
5.3. Funding the Mental Health System	105
5.4. Resources for Civil Commitment	109
5.5. Behavioral Health Integration	116
5.6. Key Findings	120
6. Washington State Perspective	121

6.1. Stakeholder Input.....	121
6.2. Staffing Model	123
6.3. Additional Efforts Underway.....	124
6.4. Key Findings.....	129
7. Major Findings Summary.....	131
Appendix A.....	132
Appendix B.....	134
Appendix C.....	138
Appendix D.....	159
Appendix E.....	164
Appendix F.....	167
Appendix G.....	174
Appendix H.....	182

1. Executive Summary

The state of Washington, Office of Financial Management, contracted Public Consulting Group (PCG) to examine the structure and financing of the of the mental health system, as required by Engrossed Substitute Senate Bill 6656. While state hospitals are a critical component of the state's current adult mental health system, this study addresses state hospital challenges as part of the broader continuum of care, accounting for community resources, transition planning and the funding streams that support that continuum.¹ Key findings presented here will provide the foundation for recommendations and implementation plans proposed in the "Final Alternative Options and Recommendations Report" and "Implementation and Communications Plans". These deliverables are scheduled for submission to the state on September 30 and November 15, 2016, respectively.

Our analysis is divided into three main sections as described below. First, a review of the current mental health system describes both the patient's journey through the system and how various funding streams reimburse services along the continuum. For context, the first section also includes a discussion of peer state trends and practices. Second, review of national best practices identifies significant trends in mental health system reform. Third, synthesis of stakeholder input identifies the key challenges faced in Washington today. Findings across these three areas of analysis were reviewed to identify commonly cited, significant challenges for the state, which will inform our recommendations moving forward.

The Current Mental Health System

Patients in need of mental health services may enter the continuum by a variety of means and engage in vastly different levels of care. The pathway followed by an individual is influenced by clinical need, acuity, geographic location, involvement in the criminal justice system, and other social and behavioral factors. Washington offers a wide array of treatment services for individuals with mental health conditions or symptoms. These services are largely distinguished by acute and non-acute services as well as institutional, residential and outpatient settings. Institutional services are further stratified by forensic service needs and civil services for individuals not engaged with the criminal justice system.

Navigating this continuum of services requires significant coordination and communication among the many parties involved. In reality, the full range of medical and non-medical care for people with mental health conditions in Washington state is disparate and difficult to conceptualize. This challenge reflects the breadth and complexity of the mental health infrastructure by payer type, provider type, multiple home and community based waivers, facility type and regional variation in the availability of privately administered services.

Most adult patients requiring inpatient treatment may be remanded to one of the state's two adult state psychiatric hospitals, a community hospital or an evaluation and treatment center. Lengths of stay and occupancy rates for the state psychiatric hospitals are higher than that of the other inpatient facilities. Broadly, these statistics reflect both the higher acuity and complexity of patients referred to the state hospitals and the difficulty in placing state hospital patients in safe and appropriate community-based settings on discharge.

At each stage of treatment, different payers and funding sources provide financial reimbursement for provider services. Thus, funding plays a key role in determining how successfully a patient can navigate through the

¹ Note that services and facilities specific to children and adolescents are not included in the scope of this analysis.

system. Spending on mental health services grew substantially from 2007 to present, increasing 75 percent overall. The fastest growing portion is federal funds, which grew from \$253 million to \$613 million over the decade, an increase of 142 percent. State general funds also increased 35 percent over the same ten-year period.

Our review of data supporting the care continuum and associated funding described above resulted in the following key findings.

Key Findings

- Community resources across the continuum of care operate in disparate systems, which may complicate both a patient or provider's ability to navigate the system and the successful placement of patients in the appropriate setting.
- Hospital discharge planning faces a number of specific barriers, including lack of residential placements that fit patient needs, lack of uniform discharge protocols across hospital units and limitations in use of electronic medical records to inform post-discharge care. Other states face similar challenges in placing patients in the appropriate treatment setting. While many states moved forward with deinstitutionalization, similar challenges in appropriately funding community resources were experienced. Minnesota represents a best practice example of efficient, system-wide focus on community-based care.
- Some geographic areas of the state lack specialized community resources that offer individuals services and supports targeted to their unique needs. This is particularly true for individuals with co-morbid conditions such as significant behavioral health needs together with complex medical needs.
- Quantifying unmet need and availability of services by geographic area requires further study. Lack of a uniform and comprehensive assessment across all provider types by geographic location and their relative ability to accept new patients hinders the study of appropriate utilization.
- Unit staffing at the state hospitals is lean in comparison to the states selected for this review. Although reporting differences confound a more detailed comparison, total direct care staff to patient ratios in many of the states reviewed were 10 to 50 percent higher than Washington, meaning more staff members are available per patient in other states.

Best Practices

PCG conducted a literature review to identify best practices in several key areas, covering the revolving roles of state hospitals and community resources and various funding issues related to mental health services. Our research found that states are increasingly limiting state hospital admissions to forensic patients and a smaller portion of civil patients, mainly those with psychotic disorders and bipolar diagnoses classified as high acuity due to behavioral or complex medical conditions. States share a common challenge of identifying the optimal number of beds per capita due to a lack of consistent reporting and identification of available beds across systems as well as issues quantifying population need as individuals face hurdles entering the system.

Facility treatment is moving toward recovery-oriented principles including the use of peer support programs and substance use treatment in state hospital settings. This trend reflects broader goals of person-centered care that permeate throughout physical and behavioral health guidelines. Best practices also document the

national trend toward community-based treatment, with significant focus on crisis intervention, integrated substance use disorder and identification and management of social and environmental issues that may significantly impact patient recovery.

Broadly, states are seeking system modernization and information technology (IT) interoperability to effectively transition mental health patients through the system and integrate with physical health. Mental health providers who have moved toward electronic health record adoption cite enhanced quality assurance, improved data reporting, improved productivity, reduced billing errors and the generation of client outcome measures among key advantages.

Finally, funding mechanisms are evolving to further incentivize community care. Federal funding for institutional care continues to decline in favor of alternative, community-based models. The relationship between reduced disproportionate share funding and significant support for innovative models, such as delivery system reform incentive pools, exemplifies this trend.

Washington Perspective

To document the first-hand perspective of individuals directly involved in Washington's mental health system, PCG conducted a series of stakeholder interviews in August 2016. Stakeholders were identified by the state and included mental health providers and provider organizations, Behavioral Health Organizations (BHOs), community hospitals, advocacy organizations, criminal justice system representatives, labor unions, legislative staff, state administrators, state hospital staff and Managed Care Organizations (MCOs) operating in the full integration early adopter region. Workgroups and other consultants in the state were also consulted to identify findings to date in their area of expertise. Synthesis of input from these sources resulted in the following key findings.

Key Findings

- Community resources, both availability and accessibility, present significant challenges. Specific and significant shortfalls in affordable housing, substance use disorder services, peer support, crisis stabilization and appropriate residential facilities for individuals with co-morbid or complex conditions, represent the greatest concern. In areas where services are available, accessing those services is hindered by awareness, the ability to make appropriate connections and lack of willingness of private providers to accept high need, low income patients.
- There is perceived ambiguity and lack of standardization throughout the current system. The processes for admission to and particularly discharge from the state hospitals are not well understood among those impacted by such determinations. Compounding this issue, discharge and related evaluation protocols differ from facility to facility, creating confusion and distrust in the system.
- The state hospital system faces a number of operational challenges. For both state hospitals, continuity across units, multiple staffing issues and a lack of recovery-oriented practices (such as peer support and substance use disorder services) were cited among these challenges. Many of these issues are exacerbated for Western State Hospital, where a significantly larger portion of this population is currently served.

- Stakeholders stressed that placing BHOs at risk for state hospital beds will also require significant changes in the level of control that BHOs may exercise over the populations under the risk arrangement to effectuate real bed day utilization changes.

Major Findings

Through analysis of quantitative data, peer state comparisons, national best practices and stakeholder input, four common findings persisted. These major findings encompass issues identified through multiple data streams and represent the most significant and persistent challenges facing Washington faces.

State hospital utilization and operations face a number of challenges. High occupancy rates and a lack of alternative settings for complex patients are compounded by lean staffing models, organizational silos and a lack of recovery-oriented programming. The hospitals currently serve a broad mix of civil and forensic patients. However, best practices and current national trends suggest that state hospitals are moving toward a model that serves an increasingly limited patient demographic, mainly focused on the forensic population. Thus while capacity is strained, systemic issues may be more appropriately addressed by expanding access to alternative settings rather than increasing state hospital beds. Available utilization data from BHOs indicates significant variation in utilization of the state hospital system. However, lack of uniform allocation methodologies across regions and available acuity data confounds further analysis as to the appropriateness of such utilization.

Community based resources exist in a complex, disparate set of systems that does not effectively support complex patient needs. The challenges here are two-fold. First, there are insufficient community resources to support patients who, while having complex medical, social and behavioral needs, do not require state hospitalization. Second, services that are available may not be fully utilized as their availability is not reported or organized on a system-wide basis. Thus patients, providers and care managers alike struggle to identify available resources for patients in need. These issues are further compounded by a lack of interoperability and standardization in the systems that support these services.

Ambiguity and a lack of system-wide standardization weakens the ability of providers, BHOs and patients alike to effectively use the system. Transition into and out of state hospital settings is managed through admission waitlists and discharge readiness assessments that vary significantly across the system and within facilities. Ambiguity regarding the reasons for admission and discharge has created skepticism among stakeholders regarding the appropriateness of patient care and ultimately contributes to delays in patient placement.

National best practices for mental health funding incentivize community treatment for civil patients and emphasize the use of state hospitals for the forensic population. Reductions in federal funding for state hospitals concurrent with increased funding for delivery system reform and value-based purchasing exemplify this trend. However, effective transition toward this model requires significant focus on improving the availability and accessibility of community mental health services.

PCG acknowledges and appreciates the assistance of state staff and stakeholders in providing us with data and qualitative information necessary to complete this initial findings report. We will continue to invite and welcome feedback and suggested additions to these findings to further sharpen the view of the current system and better inform recommendations as we move forward into the next phase of our work.



Final Alternative Options and Recommendations Report

Washington Mental Health System Assessment

November 28, 2016

Table of Contents

1. Executive Summary	3
2. Introduction	7
3. Strengths and Opportunities in the Current System.....	8
4. Approach for Phase II.....	10
4.1. Visioning Sessions and Stakeholder Interviews.....	10
4.2. Definition of Evaluation Criteria.....	15
4.3. Recommendations Development and Selection	16
5. Recommendations	17
5.1. Financing Recommendations.....	18
5.1.1. Financing Behavioral Health Organizations.....	18
5.1.2. Maximizing Federal Financial Participation.....	22
5.2. Strategic Recommendations	24
5.2.1. Community Services and Supports	25
5.2.2. Inpatient Care Outside of the Existing State Hospital System	30
5.2.3. State Hospital Care	33
5.2.4. Barriers to Discharge and Community Residential Placements.....	35
5.2.5. Supporting Continuity of Care and Transitional Care	42
Appendix A: Stakeholder Visioning Session Feedback.....	50

1. Executive Summary

The Washington Office of Financial Management contracted Public Consulting Group (PCG) to examine the structure and financing of the adult mental health system, as required by Engrossed Substitute Senate Bill 6656. This report, “Final Alternative Options and Recommendations,” is the second in a series of three reports aimed at identifying key challenges in the state’s existing mental health system and recommending potential solutions. This report builds from the “Initial Findings Report” as well as subsequent discussions with Washington stakeholders to pose recommendations that address critical challenges to effective behavioral health treatment and prepare the state for a 2020 transition to full integration of physical and behavioral health.

For this phase of the study, options for consideration were developed and vetted working with several key stakeholders. This visioning process confirmed the following key areas of opportunity that the recommendations aim to support:

1. Refine the role of state hospitals to serve the right patients in the right environment.
2. Improve early identification and treatment of behavioral health needs.
3. Increase collaboration and redesign system to achieve patient centered care.
4. Support workforce development efforts and use of best practices to attract and retain staff.
5. Increase focus on outcomes to ensure the system delivers desired results and continuous improvement.
6. Establish a robust continuum of care and support for transitions.

Stakeholder consultation additionally supported the development of five criteria by which all potential recommendations would be judged:

1. Improve efficiency and efficacy of the behavioral health system.
2. Facilitate community supports and refine use of the state hospitals.
3. Focus on patient centered, recovery oriented care.
4. Consider ease of implementation.
5. Consider potential to realize savings to offset cost.

This process culminated in development of the nine recommendations identified below. These recommendations require financial and strategic investments in community-based outpatient and residential care for the civil population to reduce bottlenecks to discharge and prevent hospital admissions and readmissions. They establish that the primary, but not exclusive, focus of Western and Eastern State Hospitals should be forensic care. The recommendations also focus on building the foundations for full integration of physical and behavioral health services in managed care by 2020.

Recommendation 1: Require the Director of the Health Care Authority (HCA) to submit a state psychiatric hospital managed care risk model to the Governor and the Legislature by December 31, 2017 to support putting Medicaid managed care organizations at risk for this benefit effective January 1, 2020. The risk model must address the proper role of commercial managed care for forensic as well as civil populations and the legal role of a business entity’s duties in managing a civil commitment. It should establish Managed Care Organization (MCO) contract and provider participation requirements, shared risk arrangements, quality and performance metrics and capacity of the state-hospital business model to adapt to commercial funding streams, including any impacts to labor agreements.

Key Features:

- Aligns with Washington's broad goal for full physical and behavioral health integration.
- Addresses the absence of an existing risk model for this unique class of providers.
- Addresses the need for accountability and risk management for hospital bed use by non-Medicaid populations and Medicaid enrollees not enrolled in managed care.

Recommendation 2: Establish a new unit within the Office of Financial Management (OFM) that integrates and coordinates fiscal analysis of all behavioral health services across agencies and units of government.

Key Features:

- Does not replace agency-based fiscal oversight by OFM.
- Complements agency-based fiscal oversight by adding an integrated analytical framework to enhance synergies between and among agency initiatives that have a behavioral health impact.

Recommendation 3: Enhance community support by strengthening acute care episode management and community services to reduce admissions to state psychiatric hospitals. Specifically, this will be done by funding three new mobile crisis teams, two new crisis walk in centers, a 15 percent increase in the number of peer support specialists and the commencement of a grant program to enhance substance use disorder treatment more broadly into mental health care.

Key Features:

- Supports integration of substance use disorder treatment across community outpatient settings.
- Requires capital investment to develop new facilities for walk-in crisis patients.

Recommendation 4: Establish six new 16-bed community hospitals for civil commitments and transitional acute psychiatric care needs to promote regional care and the potential for an emphasis in specialty care for co-morbid conditions. These conditions may include developmental disabilities, dementia and certain categories of co-occurring substance use disorders.

Key Features:

- Establishes four 16-bed facilities to serve civilly committed patients in the western region of the state and two in the eastern region of the state.
- Keeps patients closer to their communities of residence, thereby easing the transition to outpatient placement.
- Permits establishment of these facilities for exclusive focus on civil populations with comorbid conditions that are manageable in a smaller and potentially less intensive setting.

Recommendation 5: Reform state hospital programming to integrate substance use disorder treatment and add inpatient peer support.

Key Features:

- Redesigns treatment protocols to address substance use disorder in the context of mental health conditions for comorbid patients.
- Adds peer specialists to the inpatient treatment team for forensic patients.

Recommendation 6: Align community mental health placements with identified civil placement discharge needs by (1) establishing a transitional, statewide supportive housing benefit administrator; (2) creating a temporary Office of Behavioral Health Housing Initiatives, charged with facilitating the collaboration of capacity building investment pools, and (3) establishing expanded responsibility for selected state hospital transitions and management practices to Aging and Long-Term Support Administration (ALTSA) and Developmental Disabilities Administration (DDA).

Key Features:

- Builds capacity to assure new supportive housing benefit will be effective for behavioral health.
- Creates a coordinating entity to align disparate capacity investment efforts.
- Transfers responsibilities for transition management for individuals who are aging or have physical disabilities to the ALTSA.
- Transfers responsibility for management for individuals with developmental disabilities to the DDA.

Recommendation 7: Develop regional care coordination models to follow rising and high risk patients throughout the care continuum, including those with significant mental health and substance use disorder needs.

Key Features:

- Establishes a new regional model of comprehensive care and case management across the care continuum that helps better organize and focus existing services delivery and management efforts around the whole person.
- Builds on existing care and case management requirements for Behavioral Health Organizations (BHOs) and MCOs, including augmentation of existing health home services and potential utilization of delivery system reform incentive payments under the Medicaid Transformation demonstration.

Recommendation 8: Invest in transitional care reform initiatives to add step-up, step-down and Housing and Recovery through Peer Services (HARPS) resources. Specifically, add two new, 10-bed step down facilities in Western Washington and one new 10-bed step down facility in Eastern Washington.

Key Features:

- Develops step-down facilities following the Enhanced Services Facilities model implemented in Vancouver and Spokane and augments HARPS teams to connect discharged patients to available housing.
- Develops step-up facilities that allow for both patient walk-in appointments and short term admissions initiated by the patient or caregiver.

Recommendation 9: Create an integrative technology infrastructure to support behavioral health service delivery and transition to integrated care.

Key Features:

- Develops a learning health system to support patient-centered care and monitoring.
- Supports transition to full integration while providing unique functionality for behavioral health.

Many of the above recommendations expand on promising initiatives underway in Washington while addressing challenges posed by the current financial structure and other policy and operational impediments.

Although Washington has made significant progress in behavioral health redesign in recent years, the recommended areas of improvement aim to further align Washington with national best practices and improve both financial efficiency and health outcomes as the state moves toward full care integration.



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Attachment 7.h

* Regional Performance Measure ** Core Performance Measure

Definition of Indicator and Measurement Standard	Measurement																
<p>1. Crisis Response Timeliness*</p> <p>The percentage of crisis event face to face responses that occurred within 2 hours of request.</p> <p>Formula:</p> $\frac{\text{Number of crisis events where face to face response time was } \leq 2 \text{ hours from request during time period}}{\text{Number of crisis events for time period}}$ <p style="text-align: center;">Percentage of Crisis Responses within 2 hours of Request 1Q 2016 - 1Q 2017</p> <table border="1"> <caption>Percentage of Crisis Responses within 2 hours of Request</caption> <thead> <tr> <th>Agency</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Region</td> <td>97%</td> </tr> <tr> <td>DBH</td> <td>97%</td> </tr> <tr> <td>KMHS</td> <td>96%</td> </tr> <tr> <td>PBH</td> <td>98%</td> </tr> <tr> <td>WEOS</td> <td>100%</td> </tr> </tbody> </table>	Agency	Percentage	Region	97%	DBH	97%	KMHS	96%	PBH	98%	WEOS	100%	REGION	DBH	KMHS	PBH	WEOS
	Agency	Percentage															
	Region	97%															
	DBH	97%															
	KMHS	96%															
	PBH	98%															
WEOS	100%																
FY	98.2%	94.3%	98.6%	98.2%	100.0%												
1Q 2016	587/598	33/35	281/285	268/273	5/5												
2Q 2016	95.8%	93.3%	94.6%	97.4%	100.0%												
	644/672	42/45	295/312	299/307	8/8												
3Q 2016	97.3%	96.4%	97.1%	97.8%	100.0%												
	691/710	53/55	367/378	268/274	3/3												
4Q 2016	98.2%	98.9%	97.7%	98.5%	100.0%												
	658/670	88/89	301/308	265/269	4/4												
1Q 2017	95.5%	100.0%	93.9%	96.5%	100.0%												
	515/539	55/55	263/280	195/202	2/2												
	<p>Target: 95% or above Source: PIHP Contract</p> <p>Data Source: ProFiler Report - Crisis Response Time by Agency Data Notes: Numerator does not include crisis events that were non-emergent and/or pre-arranged. Data Valid as of 12/29/16</p>																



Definition of Indicator and Measurement Standard	Measurement						
<p>2. Child and Family (C&F) Team Meetings*</p> <p>Rate of Child & Family team meetings encountered using the HT modifier</p> <p>Formula:</p> $\frac{\text{Number of C\&F team meetings (using HT modifier) that are recorded for children and youth under the age of 21 during time period}}{\text{Number of children and youth services encountered in time period}}$	REGION DBH KMHS PBH WEOS						
	TARGET	0.67%	1.12%	0.68%	0.033%	0.77%	
	FY15 AVG	0.61%	1.02%	0.62%	0.03%	0.70%	
	FY16 AVG	0.79% 382/48425	0.76% 14/1845	0.94% 349/37321	0.10% 8/7881	0.80% 11/1378	
	1Q 2016	0.48% 51/10548	0.58% 3/520	0.57% 46/8035	0.12% 2/1726	0.00% 0/267	
	2Q 2016	1.01% 118/11667	1.22% 6/490	1.18% 105/8866	0.19% 4/2079	1.24% 3/242	
	3Q 2016	1.05% 138/13106	0.92% 3/325	1.26% 129/10199	0.09% 2/2177	0.99% 4/405	
	4Q 2016	0.57% 75/13067	0.41% 2/483	0.68% 69/10221	0.00% 0/1899	0.86% 4/464	
	1Q 2017	0.64% 68/10636	0.37% 2/539	0.80% 65/8149	0.00% 0/1639	0.32% 1/309	
	<p style="color: red;">Target: 10% increase over previous FY average Source: QUIC designated target</p> <p>Data Source: ProFiler Report - RSN Encounter Data Validation Data Notes: HT Modifier indicates Multi-disciplinary team and is recorded by meeting lead only Parameters: Encounters for children and youth under the age of 21 Data Valid as of 12/29/16</p>						

Child & Family Team Meetings FY 2016 Average





Definition of Indicator and Measurement Standard

3. Inpatient Utilization (Readmission Rate)**

Percent of clients who were discharged from inpatient psychiatric care and were readmitted to inpatient psychiatric care within 30 days of discharge

Formula:

$$\frac{\text{Number of clients readmitted to inpatient psychiatric care within 30 days of discharge within time period}}{\text{Number of clients discharged from inpatient psychiatric care during time period}}$$

Target: Within 2 points of the State's average for previous year
Source: Minimum performance standard

Measurement

	REGION	DBH	KMHS	PBH	WEOS
CY 15 TOTAL	9.1% 84/924	7.7% 5/65	9.0% 55/611	10.4% 23/222	3.8% 1/26
CY 16					
JAN	7.4% 6/81	0.0% 0/6	8.0% 4/50	8.3% 2/24	0.0% 0/1
FEB	8.3% 6/72	50.0% 1/2	6.0% 3/50	10.5% 2/19	0.0% 0/1
MAR	14.6% 14/96	30.0% 3/10	15.0% 9/60	8.3% 2/24	0.0% 0/2
APR	10.9% 10/92	20.0% 1/5	7.7% 5/65	20.0% 4/20	0.0% 0/2
MAY	10.3% 9/87	18.2% 2/11	14.0% 7/50	0.0% 0/23	0.0% 0/3
JUN	3.5% 3/85	0.0% 0/11	1.9% 1/54	11.8% 2/17	0.0% 0/3
JUL	18.0% 11/61	25.0% 1/4	19.0% 8/42	7.1% 1/14	100% 1/1
AUG	6.5% 5/77	0.0% 0/8	7.3% 4/55	8.3% 1/12	0.0% 0/2
SEP	7.8% 5/64	0.0% 0/4	9.3% 4/43	6.3% 1/16	0.0% 0/1
OCT	13.5% 12/89	15.4% 2/13	16.1% 9/56	5.9% 1/17	0.0% 0/3
NOV	8.4% 7/83	16.7% 1/6	8.8% 5/57	6.3% 1/16	0.0% 0/4

Data Notes: Time period is calculated based on month of discharge from psychiatric inpatient facility. Region CY16 calculated through November. Potential issues regarding data source - further review pending

Data Source: CommCare SBHO MH Readmissions Report, CommCare SBHO MH LOS Report, SCOPE. *Data Valid as of 12/2016*



Definition of Indicator and Measurement Standard

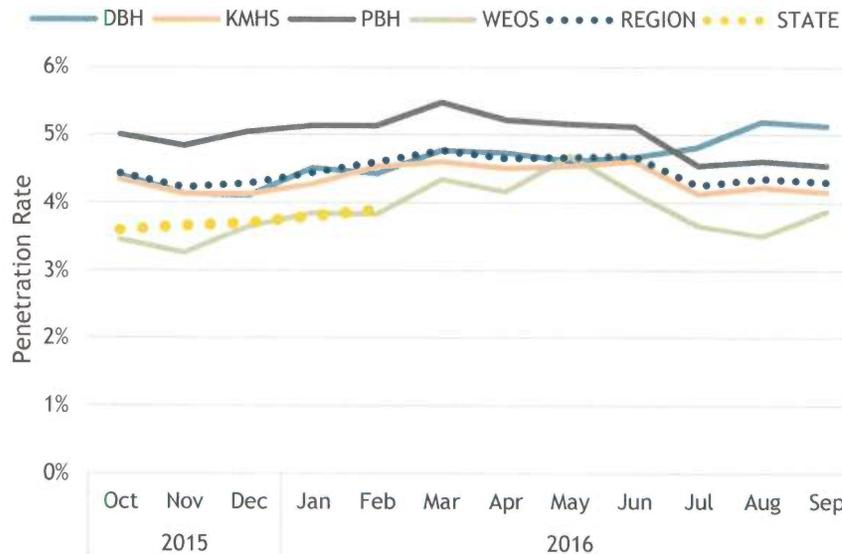
4. Access (Outpatient Penetration Rates)**

The proportion of Medicaid enrollees who received non-crisis outpatient MH services

Formula:

$$\frac{\text{Number of Medicaid clients receiving non-crisis outpatient MH services during time period}}{\text{Number of Medicaid eligible individuals during time period}}$$

Outpatient MH Penetration by Provider



Data Source: Profiler DW - RSNEncounterValid_2, Medicaid Eligible Population, SCOPE
 Data Notes: Regional count unduplicates clients completely.
 Data Valid as of 1/3/2017

Target: Not yet available from the State - anticipated Spring 2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
JAN STD	5.0% 2436/49073	5.0%	4.9%	5.4%	4.3%
JAN MAGI	3.5% 1015/28641	3.9%	3.2%	4.6%	2.9%
FEB STD	5.1% 2510/49309	4.8%	5.1%	5.5%	4.5%
FEB MAGI	3.8% 1105/29227	4.0%	3.6%	4.5%	2.5%
MAR STD	5.2% 2576/49097	5.2%	5.1%	5.7%	4.8%
MAR MAGI	4.0% 1169/29396	4.2%	3.7%	5.0%	3.3%
APR STD	5.1% 2516/49195	5.1%	5.1%	5.4%	4.5%
APR MAGI	3.9% 1146/29541	4.3%	3.5%	4.9%	3.5%
MAY STD	5.2% 2552/49260	5.2%	5.1%	5.5%	4.9%
MAY MAGI	3.8% 1131/29634	4.0%	3.5%	4.5%	4.2%
JUN STD	5.1% 2533/49215	5.1%	5.2%	5.3%	4.2%
JUN MAGI	3.9% 1164/29699	4.2%	3.6%	4.8%	3.9%
JUL STD	4.6% 2246/49085	5.6%	4.5%	4.6%	3.7%
JUL MAGI	3.7% 1102/29737	3.9%	3.4%	4.4%	3.5%
AUG STD	4.7% 2303/49080	5.8%	4.6%	4.7%	3.7%
AUG MAGI	3.8% 1130/29779	4.4%	3.5%	4.5%	3.1%
SEP STD	4.7% 2293/49183	5.8%	4.6%	4.7%	3.7%
SEP MAGI	3.7% 1105/29815	4.3%	3.4%	4.3%	4.3%



Definition of Indicator and Measurement Standard	Measurement																																																				
<p>5. Missing Demographics*</p> <p>Count of all SBHO clients with a mandatory demographic field missing.</p> <p>Formula:</p> <p>Count of all SBHO clients with mandatory demographic field missing in the Electronic Health Record</p> <div style="text-align: center;"> </div>	<table border="1"> <thead> <tr> <th></th> <th>REGION</th> <th>DBH</th> <th>KMHS</th> <th>PBH</th> <th>WEOS</th> </tr> </thead> <tbody> <tr> <td>Jul-15</td> <td>122</td> <td>91</td> <td>27</td> <td>1</td> <td>3</td> </tr> <tr> <td>Oct-15</td> <td>176</td> <td>111</td> <td>49</td> <td>6</td> <td>10</td> </tr> <tr> <td>Dec-15</td> <td>87</td> <td>8</td> <td>72</td> <td>0</td> <td>7</td> </tr> <tr> <td>Apr-16</td> <td>103</td> <td>13</td> <td>81</td> <td>5</td> <td>4</td> </tr> <tr> <td>Oct-16</td> <td>13</td> <td>3</td> <td>4</td> <td>4</td> <td>2</td> </tr> <tr> <td>Nov-16</td> <td>12</td> <td>0</td> <td>2</td> <td>9</td> <td>1</td> </tr> <tr> <td>Dec-16</td> <td>22</td> <td>6</td> <td>13</td> <td>3</td> <td>0</td> </tr> </tbody> </table> <p>Target: None</p> <p>Data Source: ProFiler Report - RSN Missing Demo Data Notes: This report is a snap-shot based on data run date. Report historically was pulled on quarterly basis. Now being run monthly on same date to obtain general picture of quantity. Data Valid as of 12/12/2016</p> <p>Parameters: includes clients with an RSN payor in the agency outpatient cost center if a mandatory field is missing such as ethnicity, sexual orientation, race, living situation, language, employment and education</p>						REGION	DBH	KMHS	PBH	WEOS	Jul-15	122	91	27	1	3	Oct-15	176	111	49	6	10	Dec-15	87	8	72	0	7	Apr-16	103	13	81	5	4	Oct-16	13	3	4	4	2	Nov-16	12	0	2	9	1	Dec-16	22	6	13	3	0
	REGION	DBH	KMHS	PBH	WEOS																																																
Jul-15	122	91	27	1	3																																																
Oct-15	176	111	49	6	10																																																
Dec-15	87	8	72	0	7																																																
Apr-16	103	13	81	5	4																																																
Oct-16	13	3	4	4	2																																																
Nov-16	12	0	2	9	1																																																
Dec-16	22	6	13	3	0																																																



SALISH BHO

ADVISORY BOARD MEETING

DATE: Friday, March 10, 2017
TIME: 10:00 AM – 12:00 PM
LOCATION: City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382

AGENDA

<http://www.kitsapgov.com/hs/sbho/sbhoboard.htm>

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of January 27, 2017 Minutes (Attachment 5)
6. Action Item
 - a. Election of Board Officers
7. Informational Items
 - a. Funding Issues
 - 1) Actuarial Rates (Attachment A.1.a, A.1.b)
 - 2) American Indian/Alaskan Native Exemption (Attachment A.2)
 - 3) IMD Issue (Attachment A.3.a,b,c)
 - 4) SUD Budget Update (Attachment A.4)
 - b. SUD Practices
 - 1) Executive Board Action on Opioid Issue (Attachment B.1.)
 - c. Integration
 - 1) 1115 Demonstration Grant Announcement
 - 2) Provider Integration Efforts (Attachment C.2.)
 - d. Quality Assurance (Attachment D.1., D.2.)
 - e. County Sales Tax Efforts
 - f. Board Priorities

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHO	Behavioral Health Organization, replaced the Regional Support Network
CAP	Corrective Action Plan
CMHA	Community Mental Health Agency
CMS	Center for Medicaid & Medicare Services (federal)
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DDA	Developmental Disabilities Administration
DMHP	Designated Mental Health Professional
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FBG	Federal Block Grant (specifically MHBG and SABG)
FYSPRT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IS	Information Services
ITA	Involuntary Treatment Act
LOC	Level of Care
MAT	Medical Assisted Treatment
LRA	Least Restrictive Alternative
MCO	Managed Care Organization
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QA, QI	Quality Assurance, Quality Improvement
QUIC	Quality Improvement Committee
QRT	Quality Review Team
RCW	Revised Code Washington
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SAPT	Substance Abuse Prevention Treatment
SBHO	Salish Behavioral Health Organization
SUD	Substance Use Disorder
UM	Utilization Management
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Go to <http://www.kitsapgov.com/hs/sbho/sbhopolicies.htm> for a full listing of definitions and acronyms

SALISH BEHAVIORAL HEALTH ORGANIZATION
AGENDA BRIEFING
March 10, 2017

ACTION ITEMS

a. Election of Board Officers

A nominating committee was appointed at the December Advisory Board meeting to develop a slate of candidates for Chair and Vice Chair positions, with the election to be conducted at the following meeting. The Nominating Committee will provide their slate of candidates at the March meeting.

INFORMATIONAL ITEMS

a. Funding Issues

1) Actuarial Rates

The current Medicaid Actuarial rates expire on June 30th, and the State has been working with Mercer (the actuarial firm engaged by the state) for the last year on a new rate setting process. The preliminary rates (Attachment A.1.a) that were presented to BHOs in February have the majority of BHOs losing ground in their rates, with the Salish BHO being the only BHO with significantly higher rates. When the rates are broken down into Mental Health and Substance Use Disorder separately, our rates for MH increase substantially, while we lose ground on the SUD side of the rates (Attachment A.1.b.). Some of this loss is a result of the IMD rule change discussed elsewhere, and staff has asked for clarification on a number of issues.

2) American Indian/Alaskan Native Exemption

Under the current waiver, any individual who claimed American Indian or Alaskan Native ancestry when they registered for Medicaid will no longer be required to be part of the managed care program as they have been for the last 25 years. As additional rate information has become available, we are better able to estimate the effects of this exemption, and new tables depicting this impact are included in this packet (Attachment A.2.).

3) IMD Issue

IMDs, or Institutions for the Mentally Diseased, were originally defined in the law enacting Medicaid in 1965 as a way to prevent the Federal Government from having to subsidize large institution like settings for individuals with Developmental Disabilities and Psychiatric disorders as state operated institutions downsized. July of 2017 brings a change in Federal regulation which will have a huge impact on the behavioral health system. The Federal government instituted a new regulation in July of 2016 that will become effective in July of 2017 in Washington changing the way community services in facilities larger than 16 beds can be paid. A series of papers describing the IMD (Institution for Mental Diseases) rules and changes is attached. (Attachment A.3.a, b, c)

4) SUD Budget Update

An update of SUD expenditures is attached (A.4.) for the Board's review.

b. SUD Practices

1) Executive Board Action on Opioid Issue

At its February 17 meeting, the SBHO Executive Board took three actions stemming from the Opioid Planning Grant and Summit which the Olympic Community of Health (OCH) coordinated. The Board voted to release a Request For Proposals for an Opiate Substitution Treatment Program, with a site in Kitsap County as well as Clallam County (Attachment B.1). Additionally, the Board voted to enter into a two year agreement with the North Olympic Health Network (NOHN) in Port Angeles to replicate the Harborview Nurse Care Manager project. Finally, the OCH requested bridge funding for Opioid Planning, and the Board voted to provide up to \$10,000 per month if the agency could not find other bridge funding. The funding will hopefully fill the gap until funds from the 1115 Demonstration Project become available to fund these activities.

c. Integration

1) 1115 Demonstration Project Announcement

The 1115 Demonstration Project is a five year agreement with the Federal government which provides the state with funds up-front to develop new Medicaid funded programs which are assumed to result in savings in later years. The grant includes three "strategies", including funding transformation demonstration activities through Accountable Communities of Health in Strategy One, funding for broader Medicaid eligibility for individuals who qualify for long term care in Strategy Two, and funding for Residential supports and Supported Employment for a limited number of individuals through Strategy Three.

Two new developments came to light during the last month regarding the 1115 Grant. First, Accountable Communities of Health will receive bonus payments if their geographic region agrees to become an adopter of Fully Integrated Managed Care prior to 2020. Secondly, Strategy Three money, which in the grant was to flow through Managed Care and Behavioral Health Organizations (MCOs and BHOs) will now flow through a Third Party Administrator, and BHOs which in July of 2016 received new funding to coordinate supported housing will lose that funding.

2) Provider Integration Efforts

Attached to the mailing (Attachment C.2.) is a description of the integrated healthcare efforts currently underway through the efforts of our contracted mental health centers.

d. Quality Assurance

Attached (Attachment D.1 and 2) are state and local data reports which Quality Assurance staff will present.

e. County Sales Tax Efforts

The Board is asked to discuss how it wants to continue to try to integrate efforts between the SBHO and County 1/10th efforts.

f. Board Priorities

It has been a year since the Board established its initial priorities, and a discussion of those priorities and their current relevance has been requested.

MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD

12:00 p.m., Friday, January 27, 2017
City of Sequim Civic Center Chambers
152 W Cedar Street, Sequim WA 38382

CALL TO ORDER – John Freeburg, vice chair, called the meeting to order at 12:00 p.m. Russ Hartman, chair, assumed the role of chair upon his arrival.

INTRODUCTIONS – Self introductions.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS - None

APPROVAL OF THE AGENDA

Add under Action Items: 6.b Discussion of board survey regarding meeting dates.

Revised agenda was accepted without motion.

APPROVAL OF OCTOBER 28, 2016 MINUTES

MOTION: Helen Morrison moved to approve the minutes of the October 28, 2016 meeting as submitted. Lois Hoell seconded. Motion carried.

ACTION ITEMS

- Appointment of Nominating Committee for Board Officers
 - The following board members volunteered to participate in the Nominating Committee: Helen Morrison, Jennifer Kreidler-Moss, and Charles Pridgen. They will present their slate of officers at the March 3 meeting for a vote by the membership.
- Discussion of Board Schedule Survey
 - After much discussion and by majority vote, the board agreed to change the advisory board meeting dates to the first Friday of each month, beginning March 3 from 10 a.m. to 12 noon.
 - Meeting location will be determined once availability for the year is secured. *(Update: the SBHO Advisory Board is scheduled to meet in the City of Sequim Transit Center through the end of 2017)*

INFORMATION ITEM

- Background on Ombuds
 - Vivian Morey, Bridges Ombuds staff, provided the board with a brief overview of the services the Ombuds office provides, including serving as a liaison between consumers, their family members and network provider agencies, responding to and reporting grievances and, when possible, resolving issues at the lowest level possible. They provide education and referral to anyone calling into their office.

- Our region's Ombuds program has been in place for more than 20 years. The original contract was with the Dispute Resolution Center of Kitsap County to advocate for our clients and work independent of the region--that relationship continues today.
- It's been highly successful program and for many years was used by the state Ombuds Office as a shining example of how an Ombuds program should be run. Originally, the program served the region's mental health clients and providers; since April 2016, it serves the behavioral health program for both mental health and substance use disorder clients.
- They bridge the gap between the client and the provider. Staff supports clients through the grievance process, trying to resolve issues at the lowest level possible.
- Their reporting process is mandated by federal Medicaid law.

➤ BHO Integration Paper

- In 2014 the state legislature passed bill SSB 6312, which provides a framework for integrated healthcare (both physical and behavioral) in Washington State by 2020. The state executive branch, including the Health Care Authority and the Governor's office believes that also means integrating the funding streams. The Medicaid funding would be used to purchase services through Managed Care Organizations (MCOs).
- The state's BHOs developed the attached white paper to present to the state legislature in November 2016, believing there is a benefit to the involvement of locally based BHOs in the development and oversight of services to some of the most vulnerable populations in our state; if current legislation passes, the nine statewide BHOs will be eliminated by 2020.
- HB1388 proposes to move the Division of Behavioral Health and Recovery (DBHR) under the Healthcare Authority (HCA).
- The regional BHOs are advocating that DBHR doesn't get transferred to HCA and that the BHOs not be eliminated. If this legislation goes through, DBHR will lose its ability to advocate and require standards for mental health and substance use disorder services at the local level.

➤ 1115 Demonstration Grant Accountable Communities of Health Toolkit

- Elya Moore distributed some background information on Olympic Community of Health (OCH).
- Discussed the Medicaid Demonstration Transformation Project. In addition to the three required projects in Domain 1 (Value Based Payment, Workforce Development, and Population Health Management); there is one required project in each of Domains 2 and 3; and six optional projects.
- The state signed Special Terms and Conditions that stated if financing is not fully integrated by 2020, then funding for the transformation grants will cease.

➤ Opioid Project

- Funding for the project came through the Olympic Community of Health (OCH), which let a Request for Ideas to improve healthcare in our region. The SBHO submitted an Opioid Project and was awarded funding.
- Project funding was re-contracted back to OCH to hire Dr. Lisa Rey Thomas to oversee the project, who for the last seven months has been surveying community stakeholders, and collecting data to determine the scope of the problem in our region and options. The results of this information is being compiled into a final report which will be available in the near future.

➤ Substance Abuse Block Grant Funding

- Following the allocation of funding through the Request for Proposal process, the SBHO had an unallocated balance of \$304,000 in Substance Abuse Block Grant (SABG) funding.
- Staff reported that unallocated Block Grant funds cannot be carried over, like state funds, Because of the late issuance of contracts, contractors won't be able to spend all money available to them. To save funding, the SBHO will be extending SABG contracts for agencies with viable projects. Money not spent returns to the state.
- Staff was asked about integrated funding and programs for providers. Integrating mental health and substance use disorder programs is difficult at this point because the state has not rewritten the WACs and RCW to allow integration of funding and programs.

➤ Potential Funding Changes July 1

- In July, the Native American Exemption will cause an estimated 6% drop in BHO funding. There will be more discussion on this issue prior to the next budget development as this funding cut is unevenly distributed across the regional providers.
- IMDs (institutes for the mentally diseased) exemption will end June 30, 2017. Federal money can no longer be used for these services, which will need to be paid for with state funds.

➤ Western State Hospital (WSH)

- Psychiatric inpatient care will be changing as WSH will only be serving forensic inpatient services under the current plan put forth by the Executive Branch. Other patients will be forced into the community with no additional money to fund their care.
- In anticipation of this happening, large national corporations are building facilities to fill the need. BHOs will be on the hook for the costs associated with expensive inpatient care.

➤ Quality Assurance (QA)

- QA Staff reviewed the mental health quality indicators reports and answered questions from the board.

OPPORTUNITY FOR PUBLIC COMMENT - None

FOR THE GOOD OF THE ORDER

- Board Member Check-In: Russ thanked Linda for the updated pages for the board's member manuals; Jon asked about the board writing a letter to contact legislatives regarding some of the current issues discussed at today's meeting (staff suggested waiting to see what direction things would take); Russ asked that we discuss this issue with the executive board; Anne thanked Jon for always bringing the discussion back to the people we serve; Jennifer suggested that our BHO join with other BHOs, if we are going to approach the legislature; Board members thanked Linda for her work for the BHO and with the advisory board.
- Staff Report: The next meeting is Friday, March 3, at the City of Sequim Transit Center.

ADJOURNMENT - The meeting adjourned at 2:00 pm.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<p><u>Present</u> Roberta Charles Anne Dean John Freeburg Jolene George Russ Hartman Lois Hoell Jennifer Kreidler-Moss Helen Morrison Janet Nickolaus Charles Pridgen Steve Schermerhorn Mike Stringer Jon Stroup</p> <p><u>Absent/Excused</u> Barbara Maxwell Catharine Robinson</p>	<p>Vivian Morey, Bridges Ombuds Ellen Epstein, RMH Services Ru Kirk, Discovery Behavioral Health Rebekah Miller, Peninsula Behavioral Health Tammey Newton, Jefferson County Public Health Andy Brastad, Clallam County HHS Kim Yacklin, Clallam County Health & Human Services Pam Brown, West End Outreach Services Joe Roszak, Kitsap Mental Health Services Elya Moore, Olympic Community of Health</p>	<p>Anders Edgerton Linda Ward Richelle Jordan Ileea Nehus</p>

Behavioral Health Rate Ranges - SFY 17/18 Lower Bound and Upper Bound Rates and FY 16/17 Contract Rates

BHO	Disabled Adult			Non-Disabled Adult			Disabled Child			Non-Disabled Child			Newly Eligible			All Rating Groups		
	SFY 17/18 Lower Bound	FY 16/17 Contract Rate**	SFY 17/18 Upper Bound	SFY 17/18 Lower Bound	FY 16/17 Contract Rate**	SFY 17/18 Upper Bound	SFY 17/18 Lower Bound	FY 16/17 Contract Rate**	SFY 17/18 Upper Bound	SFY 17/18 Lower Bound	FY 16/17 Contract Rate**	SFY 17/18 Upper Bound	SFY 17/18 Lower Bound	FY 16/17 Contract Rate**	SFY 17/18 Upper Bound	SFY 17/18 Lower Bound	FY 16/17 Contract Rate**	SFY 17/18 Upper Bound
Great Rivers	\$121.31	\$113.92	\$130.42	\$44.82	\$38.20	\$48.29	\$56.81	\$81.61	\$60.96	\$17.20	\$17.30	\$18.43	\$55.16	\$67.22	\$60.99	\$40.69	\$43.14	\$44.18
Greater Columbia	\$120.85	\$109.11	\$129.90	\$29.87	\$32.65	\$32.12	\$57.75	\$86.38	\$62.00	\$8.64	\$10.64	\$9.29	\$36.77	\$49.96	\$40.95	\$27.33	\$32.41	\$29.79
King	\$175.91	\$199.83	\$189.43	\$32.93	\$37.50	\$35.64	\$94.15	\$104.27	\$100.69	\$13.79	\$15.43	\$14.79	\$40.10	\$51.20	\$44.38	\$39.65	\$47.11	\$43.15
North Central	\$98.54	\$108.27	\$107.59	\$22.21	\$18.72	\$24.53	\$61.95	\$61.18	\$67.24	\$8.94	\$8.25	\$9.79	\$30.97	\$48.42	\$34.65	\$22.63	\$27.27	\$24.98
North Sound	\$148.48	\$140.49	\$158.91	\$32.48	\$31.36	\$34.85	\$63.23	\$73.88	\$67.78	\$11.85	\$12.65	\$12.69	\$45.34	\$57.47	\$50.26	\$37.48	\$41.63	\$40.75
Pierce	\$162.64	\$156.75	\$174.93	\$29.50	\$30.38	\$31.72	\$50.95	\$66.65	\$54.74	\$10.85	\$8.96	\$11.66	\$42.36	\$55.83	\$47.12	\$38.05	\$41.67	\$41.44
Salish	\$155.31	\$123.87	\$167.42	\$34.97	\$32.77	\$38.15	\$89.32	\$93.48	\$96.18	\$18.87	\$15.96	\$20.37	\$47.20	\$57.82	\$51.74	\$47.40	\$47.10	\$51.50
Spokane	\$114.32	\$116.58	\$123.27	\$34.61	\$34.02	\$37.57	\$90.61	\$111.69	\$97.15	\$18.27	\$14.95	\$19.66	\$48.37	\$62.58	\$52.98	\$41.37	\$46.61	\$44.91
Thurston Mason	\$116.28	\$151.34	\$124.94	\$31.06	\$38.30	\$33.35	\$44.49	\$77.47	\$47.80	\$12.09	\$15.83	\$12.98	\$47.65	\$54.52	\$52.40	\$37.91	\$46.87	\$41.16
Total*	\$144.83	\$147.50	\$155.81	\$32.16	\$33.55	\$34.72	\$70.36	\$87.10	\$75.49	\$12.74	\$13.00	\$13.70	\$42.76	\$54.98	\$47.31	\$37.04	\$42.09	\$40.31

*Total rate effective from July 1, 2017 - June 30, 2018 is weighted on Projected SFY 17/18 membership. Excludes the Southwest BHO from weighted-average calculations as their rates are not impacted by the SFY 17/18 rate development.

**Actual FY 16/17 contract rates for the Non-AIAN population only, excluding Local Match. Highlighted cells fall outside the projected SFY 17/18 Rate Ranges.

Statewide SFY 17/18 WISE Case Rate Payment	\$2,721
--	---------

Projected SFY 17/18 Member Months***

BHO	Disabled Adult	Non-Disabled Adult	Disabled Child	Non-Disabled Child	Newly Eligible	Total
Great Rivers	79,952	89,166	17,835	446,362	233,831	867,146
Greater Columbia	174,061	332,931	57,413	1,429,825	831,296	2,825,526
King	363,713	687,345	71,922	1,923,450	1,929,015	4,975,446
North Central	49,756	99,927	15,513	466,208	244,025	875,428
North Sound	226,847	393,673	57,721	1,302,786	1,105,803	3,086,831
Pierce	225,725	345,520	66,870	1,086,582	651,143	2,565,839
Salish	93,494	117,580	22,294	332,527	356,935	922,830
Spokane	204,933	273,626	53,517	915,671	775,544	2,223,290
Thurston Mason	88,524	122,733	23,382	371,649	343,256	949,545
Total	1,507,004	2,462,501	376,468	8,275,060	6,670,847	19,291,880

***Projected SFY 17/18 Member Months based on November 2016 forecast

Monthly Revenue Based on New Rates and AI/AN Exemption			
	Total	MH	SUD
Current Monthly Revenue	\$ 3,647,755	\$ 2,511,025	\$ 1,136,731
Revenue with New Rates	\$ 3,793,922	\$ 2,925,053	\$ 786,720
New Rates Excluding AI/AN	\$ 3,582,494	\$ 2,762,092	\$ 743,137

Impact of American Indian/Alaskan Native Exclusion from Managed Care								
Provider	February 2017 Monthly billing	February at new rates w/AI/AN Pop	New Rates, no AI/AN	Change	Percent	Redistribution Opion	Change from February	Change from Straight Sub- Cap
West End Outreach	\$ 101,843	\$ 131,491	\$ 85,497	\$ (16,346)	-16.1%	\$ 110,000	\$ 8,157	\$ 24,503
Peninsula Behavioral Health	\$ 474,857	\$ 609,456	\$ 565,535	\$ 90,678	19.1%	\$ 561,042	\$ 86,185	\$ (4,493)
Discovery Behavioral Health	\$ 203,290	\$ 254,134	\$ 251,611	\$ 48,321	23.8%	\$ 249,217	\$ 45,927	\$ (2,394)
Kitsap Mental Health Services	\$ 1,474,565	\$ 1,897,571	\$ 1,830,094	\$ 355,529	24.1%	\$ 1,812,478	\$ 337,913	\$ (17,616)
	\$ 2,254,555	\$ 2,892,652	\$ 2,732,737	\$ 478,182	21.2%	\$ 2,732,737	\$ 478,182	

Institutions for Mental Diseases

- Federal law has barred “Federal Financial Participation” (FFP) for individuals living in IMDs since 1965
 - IMDs include Substance Use Disorder Residential programs, as well as psychiatric hospitals and residential programs
- Washington secured a waiver of Federal rules around 2013
 - Was allowed to use Federal funds for IMDs because it was shown to save money
- In April 2016, Washington’s waiver was applied to Substance Use Disorder residential services
 - A majority of SUD residential care is in IMDs
- New Federal rule in July of 2017
 - Allows FFP in IMDs for up to 15 days per month
 - No waivers
 - If over 15 days, all care going back to the 1st of the month is no longer eligible for Medicaid
 - Accounting nightmare
- Legislature needs to fill the loss of funds with State dollars
- Future:
 - Many new large (100+ bed) psychiatric facilities being built
 - These will, invariably, be utilized
 - No new state funds for care in these new IMD facilities
 - State closing state hospitals and pushing care back to community

Institution for Mental Disease (IMD) as an “in lieu of” service



Mat DeLillo

Summary

This paper has been updated from the original version to clarify a discrepancy in the effective date of compliance with the IMD provisions. It has also been updated to reflect additional sub-regulatory guidance issued by CMS through an addendum to the 2016 Medicaid Managed Care Rate Development Guide.

Federal financial participation (FFP) is not available for Medicaid services for individuals between the ages of 21 and 64 who are patients in an Institution for Mental Disease (IMD). This IMD exclusion is a long-standing component of Title XIX (Grants to States for Medical Assistance Programs) of the Social Security Act (Title XIX), which has recently come under scrutiny because of the combination of inpatient psychiatric capacity constraints and rapid enrollment growth of the Medicaid population. The final Medicaid managed care regulations (final rule) clarify the use of IMDs as an “in lieu of” service. In the near term, states will need to carefully weigh their options based on their specific needs for inpatient psychiatric and subacute psychiatric capacity. The risk is that adding too much inpatient capacity could induce utilization and drive members away from community-based alternatives. The managed care rule also contains some rate-setting differences for IMDs as an “in lieu of” service. Beyond the impact of the final rule, IMDs will continue to be a topic of interest to state policy makers as they bolster the continuum of behavioral health and substance use disorder services.

Introduction

The Centers for Medicare and Medicaid Services (CMS) has had a policy in place since Medicaid began that does not provide FFP for any services for a member between the ages of 21 and 64 either inside or outside an IMD while that member is a patient in an IMD. This law, generally termed the “IMD exclusion,” has evolved over time but has largely remained unchanged. Outside of this age band, full FFP is provided as long as the service is included in the state plan for the over-65 population. The under-21 population is covered as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service at the state’s regular match rate. The IMD exclusion applies to fee-for-service and managed care delivery systems.

This setting exclusion is defined in the Medicaid statute under 1905(a)(29). When Title XIX was passed by Congress in 1965,

the treatment of mental illness was primarily performed in an institutional setting. States built and operated large mental institutions to house and feed people with mental illness. The IMD exclusion was included to ensure states would continue to be responsible for the costs of those large hospitals.¹ Over time, a few limited mechanisms have been developed to pull down FFP for IMD utilization within the exclusion age corridor of 21 to 64 years of age. In some cases, states may have already utilized IMDs as an “in lieu of” service.²

Timeline: Major changes to the IMD exclusion³

- The original definition included a state option to cover enrollees 65 and older in an IMD (1965)
- State option to receive FFP at an IMD for enrollees under age 21 (1972)
- Facilities with fewer than 16 beds were excluded from the IMD exclusion (1988)
- FFP was made available for facilities other than hospitals for enrollees under 21 (1990)
- The definition of psychiatric residential treatment facilities (PRTF) was completed, allowing FFP for enrollees under age 21 based on the 1990 change (2001)

What is an IMD?

An IMD is defined in federal statute as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.⁴ CMS has published sub-regulatory

- 1 MACPAC (March 31, 2016). Proceedings of Public Meeting, p. 98. Retrieved May 18, 2016, from <https://www.macpac.gov/wp-content/uploads/2015/05/March-April-2016-Public-Meeting.pdf>.
- 2 MACPAC (March 31, 2016). The Medicaid Institution for Mental Diseases (IMD) Exclusion, slides 6 and 7. Retrieved May 18, 2016, from <https://www.macpac.gov/wp-content/uploads/2016/03/The-Medicaid-Institution-for-Mental-Diseases-IMD-Exclusion.pdf>.
- 3 Ibid.
- 4 Legal Information Institute (July 12, 2006). 42 CFR 435.1009 - Institutionalized individuals. Cornell University Law School. Retrieved May 18, 2016, from <https://www.law.cornell.edu/cfr/text/42/435.1009>.

guidance on the definition of an IMD, in the state Medicaid manual in section 4390.⁵ These additional guidelines speak to distinct components of larger organizations and whether a psychiatric “wing” is an IMD or simply a component of the larger organization. The Medicaid manual adds specificity on whether the “overall character of a facility is that of an IMD,” stating that “a facility’s IMD status depends on whether the evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.” To the extent any of the following guidelines are met, the manual states, “a thorough IMD assessment must be made:”

- The facility is licensed as a psychiatric facility.
- The facility is accredited as a psychiatric facility.
- The facility is under the jurisdiction of the state’s mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.)
- The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients’ records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients is receiving psychopharmacological drugs.
- The current need for institutionalization for more than 50% of all the patients in the facility results from mental diseases.

Most states publish lists of IMDs, as the IMD designation is made by the state.

Current methods for drawing down FFP on IMDs within the exclusion:

- Section 1115 waivers
- Medicaid Emergency Psychiatric Demonstration
- The new Medicaid managed care rule
- Disproportionate share (DSH) hospital payments

Existing usage of IMDs

The final rule should be considered a clarification of CMS’s policy on Medicaid funds covering IMD, rather than a significant shift in policy. As CMS notes in its fiscal estimate in the final rule, 17 states have claims experience in the IMD exclusion age corridor. Many states have already considered IMDs as an “in lieu of” service or they have other pilot programs or 1115 waivers to utilize this setting. As states

continue to review their entire continuums of behavioral health services, additional 1115 waivers may be proposed to CMS to include the use of IMDs to alleviate capacity issues. In July 2015, CMS issued a State Medicaid Director letter regarding “New Service Delivery Opportunities for Individuals with a Substance Use Disorder.”⁶ In this letter, CMS includes the use of IMDs if certain criteria are met.

Summary of the regulatory requirements

Section 438.6(e) of the final rule clarifies that states can receive FFP and make a capitation payment on behalf of an enrollee that spends part of the month as a patient in an IMD if the following conditions are met:

- The provision of this service must meet the four following conditions for “in lieu of” services, as stated in Section 438.3(e)(2).
 1. The state determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan.
 2. The enrollee is not required by the managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) to use the alternative service or setting.
 3. The services are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP.
 4. The utilization and actual cost of “in lieu of” services is taken into account in developing the component of the capitation rates that represents the covered state plan services.
- The facility must be a hospital providing psychiatric or substance use disorder inpatient care or a subacute facility providing psychiatric or substance use disorder crisis residential services.
- The length of stay cannot exceed 15 days during a given month (capitation payment period).
- IMD utilization may be included in the development of a managed care capitation rate, *but utilization must be priced at the cost of same services included under the state plan* (note: further discussion is provided in the next section of this paper).

While FFP is being introduced for short-term IMD stays for adults of ages 21 to 64, changes in the usage of IMD is highly discretionary for both states and managed care entities (MCEs), given that the services must meet the conditions of an “in lieu of” service.

5 CMS.gov. The State Medicaid Manual, Section 4390. Retrieved May 18, 2016, from <https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

6 CMS (July 27, 2015). New Service Delivery Opportunities for Individuals With a Substance Use Disorder. Letter to State Medicaid Director. Retrieved May 18, 2016, from <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>.

In the comments section of the final rule, CMS provides an explanation for granting FFP for adult IMD stays and limiting it to 15 days in a month:

- **Ensuring access to and availability of short-term stay inpatient psychiatric services.** With additional demand for mental health services brought about by Medicaid expansion and insurance marketplace coverage, and a corresponding need by MCEs to ensure access to services under their contracts, CMS believes it appropriate for MCEs to use alternative settings “to provide appropriate medical services in lieu of Medicaid-covered settings.”
- **Limitation of 15 days.** CMS indicates that the 15-day parameter is supported by IMD length of stay evidence from the Medicaid Emergency Psychiatric Demonstration, which indicated an average length of stay of 8.2 days, with the 15-day definition accounting for variability in length of stay for acute inpatient psychiatric services. CMS also notes the 15-day limitation is consistent with existing federal statute that prohibits FFP for non-elderly adult IMD services.

The utilization of IMDs as an “in lieu of” service is optional at many levels:

- States have the option to authorize it through their managed care contracts.
- MCEs have the option to offer it to their enrollees.
- Enrollees have the option of accepting it in lieu of state plan services.

The administration of the adult IMD provision in the final rule is also addressed in the comments section of the final rule:

- The MCE must determine if the enrollee has an inpatient level of care need that necessitates treatment for no more than 15 days.
- While the final rule limits coverage of adult IMD stays to no more than 15 days, CMS indicates it is possible that an MCE could receive two capitation payments for consecutive months if the length of stay exceeded 15 days, with no more than 15 days occurring in each month.
- CMS reiterates that it is the state’s responsibility to design contract terms with MCEs to prevent managed care capitation payments from being made for beneficiaries enrolled in an IMD more than 15 days in a given month.

This rule stipulates that this regulation is effective 60 days from publication, however CMS issued sub-regulatory guidance on compliance on July 1, 2016.⁷ The guidance was issued through an addendum to the 2016 Medicaid Managed Care Rate Development Guide.

The bulletin describes how CMS will handle compliance for provisions of the mega reg that are effective July 5, 2016. In short, there are three time spans described in the letter that will dictate how CMS will review rates relative to the new provisions. The IMD provisions fall under this guidance.

- CMS does not intend to review rates already approved for the requirements effective July 5, 2016.
- For states that have already developed their Medicaid managed care rates for rating periods starting before October 1, 2016, CMS does not intend to require states to redevelop their rates solely to comply with the new requirements. If a state does not comply with the July 5 provisions, they will be placed on a corrective action plan until the next rate-setting period.
- States with rate periods beginning on or after October 1, 2016, that have not yet had contracts and rates for that period reviewed and approved by CMS, will be expected to fully comply with the new July 5 requirements.

State policy implications

The final rule provides a state Medicaid program with a potential additional avenue to provide inpatient psychiatric and substance use disorder services. In order to determine if policy changes are warranted, states and other payers, including Medicaid MCEs, will need to understand the current supply and demand for inpatient psychiatric and substance use disorder services. Based on this capacity analysis, decisions can be made whether to offer IMDs as an “in lieu of” service. Any material increase in provider capacity should be done carefully to avoid utilization that is not medically appropriate.

EXISTING SERVICE CAPACITY SUFFICIENT

If a state does not face capacity issues for inpatient services, it may not be inclined to include IMD as an “in lieu of” service in its managed care contracts. States may already provide inpatient psychiatric and substance use disorder services through the mechanisms previously discussed. If the state has been effective at alleviating capacity constraints, it may decide not to offer this service for fear of shifting the balance of enrollees served in the home and community-based setting to the institutional setting.

EXISTING SERVICE CAPACITY CONSTRAINED

If capacity in a region is constrained, calculations for pent-up demand may be needed for the geographic region to accurately estimate the utilization of newly available IMD services. Pent-up demand may be estimated by evaluating existing utilization of short-term acute behavioral health services in other states, or geographies within a state that do not have capacity constraints. A reliance on local jails or emergency rooms for “boarding” individuals with mental health or substance use disorder conditions may also be an indication of

7 CMS (July 1, 2016) Addendum to 2016 Medicaid Managed Care Rate Setting Guide.

the need for additional service capacity.⁸ An analysis done by the Bureau of Justice Statistics indicated that more than 60% of local jail inmates had a mental health problem. Substance use disorders were reported to occur in 76% of local inmates with a mental health problem (relative to 53% of inmates without a mental health problem).⁹

Rate-setting guidance in final rule for “in lieu of” services

Previous rate-setting guidance for “in lieu of” services published by CMS¹⁰ allowed actuaries to use the expected utilization and unit cost of “in lieu of” services as a proxy for the state plan services being replaced. While the final rule maintains this provision of other “in lieu of” services, it makes an exception for IMD services. For purposes of rate setting, the state’s actuary may use service utilization from an IMD stay, but the unit cost may not reflect that of the IMD. Rather, IMD utilization “must be priced consistent with the cost of the same services through providers included in the state plan.” This exception was made to preserve the intent of the law, which, in part, was not to shift costs from the state to the federal government. There is the possibility that an IMD’s unit could be lower than a benchmark that the state’s actuary might use. This is an area of the final rule that may require additional sub-regulatory guidance.

Actuaries are not required to use only IMD utilization and may also review other inpatient psychiatric stays on which to base their IMD utilization estimates. The utilization reflected in the rate development process may not include IMD stays that exceed 15 days per month (including the portion of the stay prior to the 15-day limitation). Possible unit cost data points to reflect “state plan unit cost” include per diem rates for members outside the IMD exclusion age band, rates for facilities with fewer than 16 beds, and commercial rates.

As required under Section 438.7(b), the incorporation of IMD utilization in the rate development process should be documented in a transparent fashion. A requirement of “in lieu of” services is that they be cost-effective relative to the substituted service. Because the service being substituted is simply the same service

in a different setting, if the unit cost is at or lower than inpatient psychiatric in a non-IMD, this would be cost-effective. If possible, cost-effectiveness could also make assumptions about emergency room and acute inpatient bed avoidance. The state’s actuary may be called upon to demonstrate this cost-effectiveness as part of the rate review process.

Where does the IMD exclusion go from here?

Over the last few years there has been a groundswell of activity around the IMD exclusion. Most of the large state-run institutions that permeated the mental health treatment landscape have closed and the network of providers is very different from 1965. This rule was written in direct response to access concerns over inpatient and subacute psychiatric and substance use disorder services. These access concerns have increased significantly with Medicaid expansion and insurance coverage expansion through the marketplace. This rule is likely only the beginning of other changes to the IMD exclusion. It is important to remember that the rule is only applicable to managed care. The disabled population is most likely to use IMDs as an “in lieu of” service, and this group typically has the lowest managed care penetration. It is also important to note that behavioral health services are frequently carved out of managed care or are sometimes offered in a separate delivery system, such as a PIHP or PAHP.

In summary, allowing Medicaid MCEs to utilize IMDs as an “in lieu of” service is one component of a state’s overall efforts to bolster its continuum of behavioral health and substance use disorder treatment in the face of rapid enrollment increases and demand. There are likely some near-term analytical challenges in estimating demand and finding suitable unit cost proxies. The level of effort required to set rates is likely to vary by region, based on a state’s service delivery design.

FOR MORE ON MILLIMAN’S PERSPECTIVE ON THE MEDICAID MANAGED CARE RULE:

Visit milliman.com/medicaidmanagedcare
Visit our blog at healthcaretownhall.com
Or follow us on Twitter at twitter.com/millimanhealth

CONTACT

Mat DeLillo
mat.delillo@milliman.com

-
- 8 Evans, M. (February 13, 2016). Behind Medicaid’s move to pay psychiatric hospitals. *Modern Healthcare*. Retrieved May 18, 2016, from <http://www.modernhealthcare.com/article/20160213/MAGAZINE/302139980>.
- 9 U.S. Department of Justice (December 14, 2006). *Mental Health Problems of Prison and Jail Inmates*. Bureau of Justice Statistics Special Report. Retrieved May 18, 2016, from <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.
- 10 CMS (December 2009). *Providing Long-Term Services and Supports in a Managed Care Delivery System: Enrollment Authorities and Rate Setting Techniques*. Retrieved May 18, 2016, from <http://www.pasrassist.org/sites/default/files/attachments/10-07-23/ManagedLTSS.pdf>.

LEGAL ACTION CENTER

The Medicaid IMD Exclusion: An Overview and Opportunities for Reform

The Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. The exclusion is one of the very few examples of Medicaid law prohibiting the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services. The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21, and has long been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services.

What is in the law?

The IMD exclusion is found in section [1905\(a\)\(B\)](#) of the Social Security Act, which prohibits “payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases” except for “inpatient psychiatric hospital services for individuals under age 21.” The law goes on to define “institutions for mental diseases” as any “hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.” The IMD exclusion was intended to ensure that states, rather than the federal government, would have principal responsibility for funding inpatient psychiatric services.

The IMD exclusion has been part of the Medicaid program since Medicaid’s enactment in 1965, and while Congress has had the opportunity on numerous occasions to amend or repeal the exclusion, it has remained largely intact. In addition, the regulations governing the IMD exclusion have not been updated since 1988.

What makes a facility an IMD?

In the [State Medicaid Manual](#), the federal Department of Health and Human Services (HHS) interprets the IMD exclusion to include any institution that, by its *overall character* is a facility established and maintained primarily for the care and treatment of individuals with mental diseases. The guidelines used to evaluate if the overall character of a facility is that of an IMD are based on whether the facility:

- Is licensed or accredited as a psychiatric facility;
- Is under the jurisdiction of the state’s mental health authority;

- Specializes in providing psychiatric/psychological care and treatment, which may be ascertained if indicated by a review of patients' records, if an unusually large proportion of the staff has specialized psychiatric/psychological training, or if a facility is established and/or maintained primarily for the care and treatment of individuals with mental diseases; or
- Has more than 50 percent of all its patients admitted based on a current need for institutionalization as a result of mental diseases.

If any of these criteria is met, a thorough IMD assessment will be made. Therefore, a facility is determined to be an IMD based on the character of the institution, including its governance, staffing, and patient population.

How do the regulations define "mental disease?"

In interpreting whether an individual's admission to an institution is a result of a "mental disease" for the purpose of applying the "50 percent test," reviewers will consult the International Classification of Diseases (ICD-9-CM), of which the Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subclass. Because the ICD-9-CM system classifies substance use disorders (SUD) as mental disorders, facilities providing inpatient SUD treatment may be considered IMDs under the law. In its discussion of SUD treatment facilities, the State Medicaid Manual says:

There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

The State Medicaid Manual also clarifies that facilities that rely on peer counseling and meetings to promote group support and encouragement, and primarily use lay persons as counselors, are not considered IMDs and the services they provide are not eligible for Medicaid reimbursement because they do not provide medical assistance.

What options might be available to improve the IMD exclusion?

The IMD exclusion is included in federal Medicaid statute so significant changes to the IMD exclusion would require an act of Congress, and while Congress has had opportunities to change the IMD exclusion it has largely not done so. There are also certain limited administrative options available to HHS to make it easier for facilities to use Medicaid to finance inpatient mental health and/or SUD services. Specifically, the following options are among those that are frequently discussed:

- Congress could fully repeal the IMD exclusion,
- Congress could raise the bed limit above 16 to a number that would allow larger facilities to fall outside of the scope of the IMD exclusion,
- HHS could exclude SUD from the definition of mental disease for the purposes of determining if a treatment facility is an IMD, or
- HHS could allow states to use section 1115 waivers to drawdown FFP for services provided in IMDs.

There are potential downsides to each approach that would need to be considered by policymakers. For example, potential risks associated with a full or partial repeal by Congress could be to encourage inpatient treatment when outpatient treatment is preferable. Repeal would also be quite expensive for the federal government.

If HHS were to exclude SUD from the definition of mental disease for the purpose of determining if a facility was an IMD, states could draw down federal funds for SUD treatment provided in inpatient settings with more than 16 beds if less than 50 percent of patients had co-occurring mental illnesses that required an inpatient level of care. However, this approach could promote a separate service delivery system and financing limitations for patients with co-occurring mental health and SUD conditions.

HHS could also allow states to use waivers to cover services provided in IMDs in some circumstances, which would improve access to inpatient behavioral health services for Medicaid beneficiaries. Waivers must be cost-neutral to the federal government and are time-limited. In addition, waivers are state specific, which would limit the impact of increasing access to residential treatment services using this approach.

Other considerations

Finally, while the IMD exclusion has remained essentially stagnant for decades, the health care system and disability law in the United States has changed dramatically in that time. These changes must be considered as context for the IMD exclusion and its continued role in the Medicaid program.

For example, the Affordable Care Act significantly expands Medicaid coverage to low-income adults, and while states have flexibility to determine the benefits that are available to the expansion population, it is likely that beneficiaries in many states will have coverage for inpatient behavioral health services that they will be unable to access because they are only available in IMDs. In addition, as states have continued to move to managed care delivery systems for their Medicaid programs beneficiaries often are covered by the same provider networks as individuals enrolled in commercial coverage that includes facilities that Medicaid considers IMDs, leaving Medicaid enrollees unable to access certain services and leading to disparities.

The IMD exclusion also raises parity issues after the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, since for no other conditions are Medicaid services in certain medical institutions excluded. The requirements of MHPAEA apply to Medicaid managed care coverage and will apply to fee-for-service and managed care coverage provided to those adults gaining Medicaid eligibility under the Affordable Care Act.

Finally, federal law and several key court decisions since the implementation of the IMD exclusion have afforded individuals with disabilities the right to community-based care when appropriate. The expansion of protections to individuals with disabilities may potentially mitigate some of the concerns Congress had when it established the IMD exclusion.

SALISH BHO Substance Use Disorder BUDGET REPORT

Line Item	Budget	Life to Date	Percent	Balance	Apr-16	May-16	Jun-16
Medicaid Outpatient	6,007,000.00	3,214,277.83	54%	2,792,722.17	295,410.00	303,300.00	300,070.00
Medicaid Residential	4,600,000.00	3,948,133.48	86%	651,866.52	378,111.96	384,577.14	368,884.32
Medicaid Detox	416,100.00	199,774.12	48%	216,325.88	14,625.52	19,793.04	14,849.84
Medicaid Detox KRC	500,000.00	316,068.08	63%	183,931.92	18,955.32	21,584.16	20,754.00
Medicaid Admin	453,250.00	462,096.00	102%	(8,846.00)	47,565.00	47,565.00	47,565.00
Med Special Proj/Unallocated	1,000,000.00	0.00	0%	1,000,000.00			
State Outpatient	641,500.00	188,029.90	29%	453,470.10	21,716.15	15,986.62	24,738.24
State Residential	332,500.00	46,662.94	14%	285,837.06	30,644.28	36,478.86	29,864.40
State Detox	200,000.00	11,721.48	6%	188,278.52	954.48	1,094.16	861.36
State Detox KRC	300,000.00	9,639.16	3%	290,360.84	-	-	-
State Admin	151,000.00	34,164.00	23%	116,836.00	2,355.00	2,355.00	2,355.00
SAPT = Child svcs/PPW housing	189,540.00	48,101.94	25%	141,438.06	4,917.00	4,647.00	5,182.95
SAPT Outpatient	1,067,301.00	138,457.74	13%	928,843.26			
SAPT Residential*	375,000.00	272,458.52	73%	102,541.48			
SAPT Spec Proj/Unallocated	304,138.00	0.00	0%	304,138.00			
CJTA Outpatient	452,000.00	262,729.56	58%	189,270.44	529.48	802.76	768.60
Expense total	16,989,329.00	9,152,314.75	54%	7,837,014.25	815,784.19	838,183.74	815,893.71

SUD Budget update

Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	2016 Total	Jan-17	Feb-17
314,730.00	297,344.73	278,410.00	290,491.00	259,952.60	305,514.50	2,645,222.83	283,179.05	285,875.95
395,940.86	367,659.28	346,911.58	421,729.36	584,494.50	365,503.80	3,613,812.80	302,198.94	32,121.74
23,283.64	22,433.08	14,382.20	26,953.72	19,559.08	20,239.60	176,119.72	23,654.40	-
20,200.56	30,300.84	27,533.64	35,600.04	82,182.84	25,993.68	283,105.08	32,963.00	-
47,384.00	47,384.00	47,384.00	59,083.00	59,083.00	59,083.00	462,096.00		
						0.00		
17,217.24	18,172.80	27,126.85	14,765.43	17,013.55	20,973.01	177,709.89	10,320.01	-
31,171.92	31,585.32	32,889.24	32,409.60	35,042.76	(239,473.76)	20,612.62	24,281.04	1,769.28
1,501.56	1,315.32	873.00	1,594.68	1,082.52	1,164.00	10,441.08	1,280.40	-
-	-	-	-	2,600.00	7,039.16	9,639.16		-
2,403.00	2,403.00	2,403.00	6,630.00	6,630.00	6,630.00	34,164.00		
4,728.67	6,253.92	5,588.66	5,315.12	5,762.14	5,706.48	48,101.94	5,668.71	2,667.00
13,473.08	4,230.66	5,455.77	13,321.12	16,868.39	85,108.72	138,457.74	63,245.16	-
					272,458.52	272,458.52		
						0.00		
2,766.80	2,510.00	3,997.35	6,286.64	5,548.25	239,519.68	262,729.56	3,137.86	-
874,801.33	831,592.95	792,955.29	914,179.71	1,095,819.63	1,175,460.39	8,154,670.94		

SALISH BEHAVIORAL HEALTH ORGANIZATION

REQUEST FOR PROPOSAL

RFP#

Opiate Substitution Treatment

DRAFT

Issued:

Submission Deadline:

3:00 PM

SALISH BHO REQUEST FOR PROPOSAL
2016-148

Opiate Substitution Treatment

TABLE OF CONTENTS

I.	INTRODUCTION	3
II.	PLANNING SCHEDULE.....	3
III.	APPLICANT ELIGIBILITY	4
IV.	AVAILABLE FUNDING.....	4
V.	PERIOD OF PERFORMANCE.....	4
VI.	TARGET POPULATION AND PROGRAM ELEMENTS.....	4
VII.	PROPOSAL SUBMISSION.....	5
VII.	PROGRAM/CONTRACT BUDGETING	7
IX.	REVIEW AND SELECTION CRITERIA	8
X.	GENERAL PROPOSAL REQUIREMENTS.....	8
XI.	ATTACHMENTS.....	11
	ATTACHMENT A: PROPOSAL COVER SHEET	11
	ATTACHMENT B: PROPOSAL ABSTRACT.....	12
	ATTACHMENT C-1: SALISH BEHAVIORAL HEALTH ORGANIZATION STANDARD CONTRACT.....	13
	Attachment C-2 – Special Terms and Conditions.....	22
	ATTACHMENT D: STATEMENT OF WORK, Opiate Substitution Treatment	30
	ATTACHMENT E-1: BUDGET.....	32
	ATTACHMENT E-2: BUDGET NARRATIVE	33
	ATTACHMENT E-3: STAFF SALARY AND BENEFITS NARRATIVE	34
	ATTACHMENT F: BUSINESS ASSOCIATE AGREEMENT Error! Bookmark not defined.	
	ATTACHMENT G: DATA SECURITY REQUIREMENTS ... Error! Bookmark not defined.	
	ATTACHMENT H: CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND	47
	OTHER RESPONSIBILITY MATTERS	47
	ATTACHMENT I: CERTIFICATION REGARDING LOBBYING.....	48

**SALISH BHO
REQUEST FOR PROPOSAL SUMMARY**

Opiate Substitution Treatment

I. INTRODUCTION

The Salish Behavioral Health Organization (SBHO) is requesting proposals for Enhanced Substance Use Disorder Treatment: Primary Outpatient and Opiate Substitution Treatment & Medication-Assisted Treatment services within Kitsap, Clallam, and Jefferson Counties.

Proposal Deadline:

This Request For Proposal (RFP) is available on the Internet at <http://www.kitsapgov.com/purchasing/bids.htm> or by contacting Colby Wattling at: Kitsap County Department of Administrative Services, 614 Division Street, MS-07, Port Orchard, Washington 98366; 360.337.7036; or email: cwattling@co.kitsap.wa.us. SBHO reserves the right to make unilateral modifications to this RFP to address changes on the state and/or local level. Questions about the program content of the Request for Proposal contact Anders Edgerton at aedgertn@co.kitsap.wa.us

The purpose of this RFP is to seek applications from interested and qualified parties to provide Enhanced Substance Use Disorder Treatment Services, specifically Opiate Substitution Treatment (moderate to severe use or dependence on heroin, oxycodone, hydrocodone, morphine, oxymorphone, fentanyl or other opioids). These services will be provided to individuals residing in Kitsap, Clallam or Jefferson Counties within the SBHO Regional Service Area.

II. PLANNING SCHEDULE

<u>DATE</u>	<u>ACTIVITY</u>
RFP Post Date	
Application Due	
Application Evaluation Period	
Award Decision Made	
Contract Negotiations	
Contract to SBHO Board	SBHO Advisory Board meets to Review and Approve of Contract Award Recommendations
Contract Start Date	

	SBHO Advisory Board meets to Review and Approve of Contract Award Recommendations

III. APPLICANT ELIGIBILITY

SBHO intends to contract with for-profit or non-profit entities to provide Substance Use Disorder treatment that includes Opiate Substitution Treatment services to individuals with opiate use disorders at one location in Clallam County and one location in Kitsap County. Prospective individuals may be experiencing or receiving treatment for mild to severe mental illness and shall not be excluded from participation in services as a result. It is expected that the proposal to provide these services will comply with all applicable State and Federal standards and guidelines.

IV. AVAILABLE FUNDING

This RFP is aimed at promoting and supporting an efficient and effective system of care for Medicaid individuals with substance use disorders referred for Substance Use Disorder treatment including, but not limited to Opiate Substitution Treatment (OST) Services who are eligible for Federal or State government programs.

V. PERIOD OF PERFORMANCE

Funding for program is on-going on a fee for service basis.

VI. TARGET POPULATION AND PROGRAM ELEMENTS

The target population is Medicaid eligible adults in Clallam, Jefferson, and Kitsap Counties meeting criteria for Opiate Substitution Treatment.

The goals are to:

- Reduce deaths related to opiate use/abuse
- Reduce unnecessary ED visits/EMS contact
- Reduce utilization of county jails
- Enhance community health
- Reward positive life changes while maintaining accountability for personal decisions
- Reduce travel outside of region
- Improve care coordination
- Provide a path to recovery for individual with opiate use disorders

Service Delivery System Expectations

- Community-based Substance Use Disorder treatment which includes outpatient, opiate substitution treatment services; Buprenorphine track (within 6 months of contract award); case management services, and other ancillary and care coordination services.
- Provide access to all 4 opiate substitution treatment options. (buprenorphine, Vivitrol, suboxone, and methadone)
- Enhanced Care Coordination with social service providers.
- Accept referrals and coordinate care with local jails.

VIII. PROPOSAL SUBMISSION

All responses to this Request for Proposals (RFP) must be complete. All proposals shall be on plain white bond paper (8.5 x 11 inches) and stapled once in the upper left corner. No binding or folders will be accepted. Binder clips may be used to keep pages together. The original response and five (5) additional copies with one electronic form (CD/disk), including all supporting material, must be sealed in an envelope or box and submitted to:

Please submit by mail to:

Colby Wattling, Buyer
Kitsap County Purchasing Office
614 Division Street, MS-7
Port Orchard, WA 98366

OR

For hand delivery, express, or courier:

Colby Wattling, Buyer
Kitsap County Administration Building
Purchasing Office – Fourth Floor
619 Division Street
Port Orchard, WA 98366

Please ensure that the box or envelope has this address clearly marked on it.

Applications must be received BY 3:00 P.M.

A. Proposal Format

In order to be considered, proposers must supply all the information requested. The proposal **must** contain the following sections in order:

1. Proposal Cover Sheet. (Attachment A)
2. Proposal Abstract (Attachment B - limited to one page).
3. Program Activities and Services Narrative (limited to 2 typed pages using 12-point font).
4. Organizational Capability Narrative (limited to 2 typed pages using 12-point font - not including resumes and organizational chart).
5. Budgets (Attachments E-1, E-2, E-3)
6. Debarment/Suspension Certificate (Attachment H).
7. Certification Regarding Lobbying (Attachment I).
8. Bonding and Insurance Certificates/Assurances.

B. Proposal Contents

All responses must contain sufficient information necessary to thoroughly describe the program design and operation.

1. Proposal Cover Sheet (Attachment A)
Check the boxes that represent the areas you propose to service.
2. Proposal Abstract (Attachment B)
Provide summary of services to be provided, limited to one page.

3. Program Activities and Services Narrative (Limited to 6 pages)

The program narrative should include a thorough description of proposed activities and services.

- a. Describe the population you intend to serve. Include specific information regarding projected number of PPW and IUID.
- b. Describe how you coordinate services in other counties within SBHO region.
- c. Please describe the location and set up of the clinic. Include explanation of transportation access (must be on accessible bus line).
- d. Describe the estimated initial patient population. Describe projected ability to increase patient population at chosen location.
- e. Describe staffing requirements and plan. (Proposed organizational chart)
- f. Describe expected outcomes, methods of measurement to be utilized, and expected timelines.
- g. Identify any evidence based, research based, and promising practices you plan to utilize with this program.
- h. Describe public process to garner community support.
- i. Describe other program information you would like considered during the evaluation process?

4. Organizational Capability: (Limited to 2 pages)

- a. Describe your basic managerial and fiscal structure including program management, accounting, internal controls, program monitoring and evaluation, and any outside contractors to be utilized in the administration of the program. Provide an organizational chart and explain the relationship of your agency to any parent or sponsoring agency.
- b. Briefly describe your agency's past experience in the delivery of opiate substitution treatment.
- c. Summarize the results of your Agency's last audit. Include description of any disallowed costs, questioned costs and administrative findings. SBHO may request a complete copy of the Audit Report prior to contract award.
- d. Attach copies of documents that demonstrate your agency can meet the insurance and bonding requirements outlined below. If self-insured, a letter from an authorized agency official so stating will substitute for the following:

The County is named as an additional insured as respects this contract and such insurance as is carried by Contractor is primary over any insurance carried by the County. Evidence of said liability insurance shall be presented to the County at least 10 days prior to execution of this contract.

The Contractor's insurance policies contain a "Cross Liability" endorsement substantially as follows:

The Contractor shall have Commercial General Liability Insurance with limits of not less than Combined Bodily Injury/Property Damage Liability of \$1,000,000 each occurrence and \$2,000,000 aggregate.

The amount of bonding coverage shall be equal to the highest monthly total advancement received during the past twelve months not to exceed \$100,000. For new Contractors, the bonding amount will be set at the highest advance through check or draw down planned for the present grant year.

- d. Submit these documents:
 1. Copies of the insurance policies and/or bonding instruments.
 2. Certificates of insurance and/or bonding.
 3. Certificates of insurability and/or bonding, from a Washington State banker or insurance company, stating that the proposing agency may obtain the required insurance and bonding prior to the contract start date.
 - e. Summarize the qualifications of key staff members who will implement this proposal. Describe how the staffing level is related to participant service levels.
5. Budget: (Attachments E-1, E-2, E-3)
Provide a Budget for the program
 6. Debarment/Suspension Certificate: (Attachment H)
Sign and date in the appropriate places on the form.
 7. Certification Regarding Lobbying: (Attachment I)
Sign and date in the appropriate places on the form.
 8. Bonding and Insurance Certificates/Assurances:
Provide certificates/assurances described above.

IX. PROGRAM/CONTRACT BUDGETING

A. Cost Reimbursable Contracts/Budgets:

Contractors will receive reimbursement for actual allowable costs of operating the program. The Contractor will bill only for actual and accrued costs to meet immediate cash needs. All costs associated with contract payments will be supported by original documentation charged to appropriate cost classifications and subject to audit.

B. Budget Form Instructions:

Each bidder will complete the proposed Budget form (Attachment E-1), Budget Narrative form (Attachment E-2), and Staff Salary and Benefits Narrative form for the Program Year (7/1/16 – 6/30/17) for each project being proposed. Instructions on how to fill out the forms follow:

1. Proposer - Type in the name of the agency submitting the proposal.
2. County - Type in the name of the county - Clallam, Jefferson, or Kitsap

3. Quarters 1-4 - For each applicable budget line item, fill in the budget amount for each quarter. **Each quarter is cumulative.** If there are any other miscellaneous account titles, enter the account name and quarterly amounts.
4. Budget Narrative – Complete a set of corresponding budget narrative pages (Attachment E-2). For each account title used on the budget, there must be a narrative that describes how the budget total was arrived at.
5. Staff Salary and Benefits Narrative (Attachment E-3) - provide information on all staff assigned to the program.

X. REVIEW AND SELECTION CRITERIA

A. Basic Minimum Criteria: The absolute minimum requirements of 2 and 3 below must be met before further consideration is given to a proposal.

1. Proposals will be evaluated according to the information contained within the written proposal.
2. Each proposal must meet the submittal requirements of Section VIII. A. to be considered for funding.
3. Each proposal meeting the submittal requirements must meet the following minimum requirements:

B. Program Design Elements:

Proposals meeting the above minimum technical requirements will be further reviewed for program design elements. Each of the following criteria has equal weight:

1. Potential effectiveness of the overall plan.
2. The plan has clear performance measures and outcome expectations.
3. The agency has demonstrated experience indicating likelihood to meet and exceed the performance goals, cost factors, quality of services and characteristics of participants identified in these instructions.
4. The proposed staffing level for the planned services is adequate.

C. Cost/Price Reasonableness:

Proposals will be evaluated for cost/price reasonableness. The price will be judged based on a comparison of prices among competing proposals. Price will also be compared to past prices offered by similar services, if applicable. Cost reasonableness will be judged by means of line item budget analysis. Line items will be reviewed for necessary and reasonable costs. This criteria has equal weight among those listed in B. above.

XI. GENERAL PROPOSAL REQUIREMENTS

A. Authorship

Proposals developed with the assistance of organizations or individuals outside the bidder's own organization should be identified. No contingent fees for such assistance will be allowed to be paid under any contract or grant resulting from this RFP. All proposals submitted become the property of the SBHO, and it is understood and agreed that the bidder claims no proprietary rights to the ideas contained therein.

B. Independent Price Determination

The proposer guarantees that in connection with this proposal the prices and/or cost data have been arrived at independently, without consultation, communication or agreement for the purpose of restricting competition. This section does not preclude or impede the formation of a consortium of agencies which intend to respond to this RFP.

C. Subcontracting

Proposers must include any plans for subcontracting of services or activities of the program. It is understood that the contractor(s) is held responsible for the satisfactory accomplishment of the service or activities included in such subcontract. The SBHO reserves the right to approve all subcontractors.

D. Rejection of Proposal

No applications (Proposals) submitted under this Request for Proposals (RFP) will be returned for correction or clarification. If the application is incomplete, it will be rejected. Verbal, alternative, and late proposals will not be considered for selection. The SBHO reserves the right to accept or reject any or all proposals received as a result of this RFP, to negotiate with all qualified sources, or to cancel in part, or in its entirety, this RFP if it is in the best interest of the SBHO to do so.

E. Appeal Process

Any agency may appeal the selection of proposals by filing a complaint under the SBHO's Complaint & Grievance System. System procedures may be obtained from the SBHO upon request.

F. Cancellation of Award

The SBHO reserves the right to cancel an award immediately if new State or Federal regulations or Department of Social and Health Services determinations make it necessary to substantially change the project purpose or content, or prohibit such a project.

G. Price Warranty

The proposer warrants that the rates quoted for services in response to this RFP are not unreasonably greater than the rates for the same services performed by the same individuals under any other existing contracts or grants.

H. Waivers

The right is reserved by the SBHO to waive specific terms and conditions contained in this Request for Proposals. It shall be understood that any proposal is predicated upon the acceptance of all terms and conditions in the RFP unless the proposer has obtained such a waiver.

I. Addenda to the Request for Proposals

In the event it becomes necessary to revise any part of this RFP, addenda will be provided to all proposers who received the RFP.

J. Publicity

No informational pamphlets, notices, press releases, research reports, or similar public notices concerning this proposal will be released by the proposer without obtaining prior written approval of the SBHO.

K. Limitation

This Request for Proposals does not commit the SBHO to award a contract, to pay any costs incurred in the preparation of a proposal to this request, or to procure or contract for services or supplies.

L. Signature

The proposal shall be signed by an official authorized to bind the bidder and shall provide the following information: name, title, address, and telephone number of individual(s) with authority to negotiate and contractually bind the bidder, and who may be contacted during the period of proposal evaluation.

M. Contract Award

The SBHO may award a contract based on proposals received; therefore, each proposal should be submitted in the most favorable terms from a budgetary, technical, and programmatic standpoint. The SBHO reserves the right to request additional data, discussion or presentation in support of written proposals.

DRAFT

XII. ATTACHMENTS

ATTACHMENT A: PROPOSAL COVER SHEET

SALISH BHO Opiate Substitution Treatment

Proposal for

Legal name of Company/Agency:

Doing Business as:

Street Address:

City, State, Zip Code:

Authorized Representative:

Title

Phone/Fax:

Program Address, if different than above:

Email Address:

Tax ID#:

DRAFT

ATTACHMENT B: PROPOSAL ABSTRACT

Responding Organization:

Contact Person:

Title:

Address:

Telephone:

Program Name/Summary of Major Features:

DRAFT

ATTACHMENT C-1: SALISH BEHAVIORAL HEALTH ORGANIZATION STANDARD CONTRACT

Contract Number: **KC-XXX-17**

Contractor:

Amount:

Contract Term:

Purpose: This contract is entered into for the purpose of ensuring Enhanced Substance Use Disorder Treatment Services: Primary Outpatient and Opiate Substitution Treatment & Medication-Assisted Treatment services in Kitsap, Clallam, and Jefferson Counties.

This contract is made between Contractor Name (hereinafter "Contractor") and the Salish Behavioral Health Organization (hereinafter "SBHO"). This notification of contract, including all material incorporated by reference, contains all terms and conditions agreed to by the parties hereto. No other understandings, oral or otherwise, regarding the subject matter of this agreement shall be deemed to exist or to bind any of the parties hereto. The Kitsap County Department of Human Services shall act as administrator of this contract on behalf of the SBHO.

The rights and obligations of the parties shall be subject to, and governed by, the terms and conditions contained herein and by the Statement of Work, General Agreement, Special Terms and Conditions, Business Associate Agreement, Data Security Requirements and the Budget. In the event of any inconsistency in this notification of contract, including the items incorporated herein by reference, the inconsistency shall be resolved by giving precedence in the following order: (1) General Agreement; (2) Special Terms and Conditions; (3) Statement of Work; (4) Budget.

As evidenced by signatures hereon, the parties accept the terms and conditions of this contract.

SALISH BEHAVIORAL HEALTH ORGANIZATION, By KITSAP COUNTY BOARD OF COMMISSIONERS, Its Administrative Entity

CONTRACTOR:

Name:

Title:

I attest that I have the authority to sign this contract on behalf of:

Karen Goon, County Administrator

DATE:

SECTION I. CONTRACTOR REQUIREMENTS

Contractor agrees to perform the services as set forth in the Statement of Work Attachment D, as attached herein.

A. Authority

Contractor possesses legal authority to apply for the funds covered under this contract.

B. Assignment/ Subcontract

1. Contractor shall not assign its rights and/or duties under this contract without the prior written consent of the SBHO.
2. Contractor shall obtain written approval for assignment from the SBHO Administrator prior to entering into any subcontract for the performance of any services contemplated by this contract; provided, however, that approval shall not be unreasonably withheld.
 - a. In the event that the Contractor enters into any subcontract agreement funded with money from this contract, the Contractor is responsible for subcontractor:
 - o Compliance with applicable terms and conditions of this contract;
 - o Compliance with all applicable law; and
 - o Provision of insurance coverage for its activities.

C. Limitations on Payments

1. Contractor shall pay no wages in excess of the usual and accustomed wages for personnel of similar background, qualifications and experience.
2. Contractor shall pay no more than reasonable market value for equipment and/or supplies.
3. Any cost incurred by Contractor over and above the year-end sums set out in the budgets shall be at Contractor's sole risk and expense.

D. Compliance with Laws

1. Contractor shall comply with all applicable provisions of the Americans with Disabilities Act and all regulations interpreting or enforcing such act.
2. Contractor shall comply with all applicable federal, state and local statutes, regulations, rules and ordinances.

3. Contractor shall comply with applicable federal, state, local and SBHO policies, procedures and practices.
4. Contractor will not discriminate against any employee or applicant for employment because of race, color, creed, marital status, religion, sex, sexual orientation, national origin, Vietnam era or disabled veteran's status, age, the presence of any sensory, mental or physical disability; provided, that the prohibition against discrimination in employment because of disability shall not apply if the particular disability prevents the individual from performing the essential functions of his or her employment position, even with reasonable accommodation. Such action shall include, but not be limited to, the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; lay-off or termination, rates of pay or other forms of compensations, and selection for training, including apprenticeship.

E. Indemnification

To the fullest extent permitted by law, Contractor shall indemnify, defend and hold harmless the Salish Behavioral Health Organization, Kitsap County, Jefferson County and Clallam County, and the elected and appointed officials, officers, employees and agents of each of them, from and against all claims resulting from or arising out of the performance of this contract, whether such claims arise from the acts, errors or omissions of Contractor, its subcontractors, third parties, the Salish Behavioral Health Organization, Kitsap County, Jefferson County or Clallam County, or anyone directly or indirectly employed by any of them or anyone for whose acts, errors or omissions any of them may be liable. "Claim" means any loss, claim, suit, action, liability, damage or expense of any kind or nature whatsoever, including but not limited to attorneys' fees and costs, attributable to personal or bodily injury, sickness, disease or death, or to injury to or destruction of property, including the loss of use resulting therefrom.

Contractor's duty to indemnify, defend and hold harmless includes but is not limited to claims by Contractor's or any subcontractor's officers, employees or agents. Contractor's duty, however, does not extend to claims arising from the sole negligence or willful misconduct of the Salish Behavioral Health Organization, Kitsap County, Jefferson County or Clallam County, or the elected and appointed officials, officers, employees and agents of any of them. For the purposes of this indemnification provision, Contractor expressly waives its immunity under Title 51 of the Revised Code of Washington and acknowledges that this waiver was mutually negotiated by the parties. This provision shall survive the expiration or termination of this contract.

F. Insurance

1. For the duration of the contract and until all work specified in the contract is completed, Contractor shall maintain in effect all insurance as required herein. Work under this contract shall not commence until evidence of all required insurance and bonding is provided to the SBHO. Evidence of such insurance shall consist of a completed copy of the Certificate of Insurance, signed by the insurance agent for the Contractor and returned to
Program Lead, Salish Behavioral Health Organization
Kitsap County Department of Human Services
614 Division Street, MS-23 Port Orchard, WA
98366.
2. The Contractor's insurer shall have a minimum A.M. Best's Rating of A-VII.
3. Coverage shall include the following terms and conditions:
 - a. The policy shall be endorsed and certificate shall reflect that the SBHO and Clallam, Jefferson and Kitsap Counties are named as an additional insureds on the Contractor's General Liability Policy with respect to the activities under this Contract.
 - b. The policy shall provide and the certificate shall reflect that the insurance afforded applies separately to each insured against which a claim is made or a suit is brought except with respect to the limits of the Contractor's liability.
 - c. The policy shall be endorsed and the certificate shall reflect that the insurance afforded therein shall be primary insurance and any insurance or self-insurance carried by Kitsap County on behalf of the SBHO shall be excess and not contributory insurance to that provided by the Contractor.
 - d. If for any reason, any material change occurs in the coverage during the course of this contract, such changes shall not become effective until forty-five (45) days after Kitsap County Risk Management has received written notice of changes.
 - e. SBHO and Clallam, Jefferson and Kitsap Counties have no obligation to report occurrences unless a claim is filed with the SBHO; and SBHO or Clallam, Jefferson or Kitsap Counties have no obligation to pay premiums.
4. The Contractor shall insure that every officer, director, or employee who is authorized to act on behalf of the Contractor for the purpose of receiving

or depositing funds into program accounts or issuing financial documents, checks or other instruments of payment for program costs shall be bonded to provide protection against loss.

- a. Fidelity bonding secured pursuant to this contract must have coverage of \$100,000 or the highest planned advance or reimbursement for the program year, whichever is greater.
- b. If requested, the Contractor will provide a copy of the bonding instrument or a certification of the same from the bond issuing agency.

5. **Workers' Compensation and Employer Liability.** The Contractor will maintain workers' compensation insurance as required by Title 51, Revised Code of Washington, and will provide evidence of coverage to the Kitsap County Risk Management Division. If the contract is for over \$50,000, then the Contractor will also maintain employer liability coverage with a limit of not less than \$1 million.

6. The Contractor shall have insurance coverage and limits as follows:

a. Comprehensive Liability

Comprehensive General Liability Insurance and Comprehensive Automobile Liability Insurance with limits of not less than:

COVERAGE	LIMITS OF LIABILITY
-----------------	----------------------------

Comprehensive General Liability Insurance

- a. Bodily Injury Liability \$1,000,000 each occurrence
- b. Property Damage Liability \$1,000,000 each occurrence

OR

- c. Combined Bodily Injury/Property Damage Liability \$2,000,000 aggregate

Comprehensive Automobile Liability Insurance

- a. Bodily Injury Liability \$1,000,000 each person \$1,000,000 each occurrence

- b. Property Damage Liability \$1,000,000 each occurrence

OR

- c. Combined Single Limit Coverage of \$2,000,000

b. Professional Liability Insurance with limits of not less than:

Professional Liability Insurance \$1,000,000 each occurrence

G. Conflict of Interest

Contractor agrees to avoid organizational conflict of interest and the Contractor's employees will avoid personal conflict of interest and the appearance of conflict of interest in disbursing contract funds for any purpose and in the conduct of procurement activities.

H. Documentation

1. Contractor shall maintain readily accessible records and documents sufficient to provide an audit trail needed by the SBHO to identify the receipt and expenditure of funds under this contract, and to keep on record all source documents such as time and payroll records, mileage reports, supplies and material receipts, purchased equipment receipts, and other receipts for goods and services.
2. The Contractor is required to maintain property record cards and property identification tabs as may be directed by SBHO codes and changes thereto. This applies only to property purchased from funds under this contract specifically designated for such purchases. Ownership of equipment purchased with funds under this contract so designated for purchase shall rest in the SBHO and such equipment shall be so identified.
3. The Contractor shall provide a detailed record of all sources of income for any programs it operates pursuant to this contract, including state grants, fees, donations, federal funds and others for funds outlined in appropriate addenda. Expenditure of all funds payable under this contract must be in accordance with the approved Statement of Work.
4. The SBHO shall have the right to review the financial and service components of the program as established by the Contractor by whatever means are deemed expedient by the SBHO, or their respective delegates. Such review may include, but is not limited to, with reasonable notice, onsite inspection by SBHO agents or employees, inspection of all records or other materials which the SBHO deems pertinent to this contract and its performance, except those deemed confidential by law.
5. All property and patent rights, including publication rights, and other documentation, including machine-readable media, produced by the Contractor in connection with the work provided for under this contract shall vest in the SBHO. The Contractor shall not publish any of the results of this contract work without the advance written permission of the SBHO. Such material will be delivered to the SBHO upon request.

SECTION II. RELATIONSHIP OF THE PARTIES

The parties intend that an independent contractor relationship will be created by this contract, and the conduct and control of the services will lie solely with the Contractor. No official, officer, agent, employee, or servant of the Contractor shall be, or deemed to be, an official, officer, employee, servant, or otherwise of the SBHO for any purpose; and the employees of the Contractor are not entitled to any of the benefits the SBHO provides for SBHO employees. It is understood that the SBHO does not agree to use Contractor exclusively. Contractor will be solely and entirely responsible for its acts and for the acts of its officials, officers, agents, employees, servants, subcontractors, or otherwise during the performance of this agreement.

In the performance of the services herein contemplated, Contractor is an independent contractor with the authority to control and direct the performance of the details of the work, SBHO being interested only in the results obtained. However, the work contemplated herein must meet the approval of the SBHO and shall be subject to SBHO's general right of inspection and supervision to secure the satisfactory completion thereof.

In the event that any of the Contractor's officials, officers, employees, agents, servants or otherwise, carry on activities or conduct themselves in any manner which may either jeopardize the funding of this agreement or indicate said officials, officers, employees, agents or servants are unfit to provide those services as set forth within, the Contractor shall be responsible for taking adequate measures to prevent said official, officer, employee, agent or servant from performing or providing any of the services as called for within.

SECTION III. MODIFICATION

No change, addition or erasure of any portion of this agreement shall be valid or binding upon either party. There shall be no modification of this agreement, except in writing, executed with the same formalities as this present instrument. Either party may request that the contract terms be renegotiated when circumstances, which were neither foreseen nor reasonably foreseeable by the parties at the time of contracting, arise during the period of performance of this contract. Such circumstances must have a substantial and material impact upon the performance projected under this contract and must be outside of the control of either party.

SECTION IV. TERMINATION

A. Failure to Perform

This contract may be terminated, in whole, or in part, without limiting remedies, by either party to this contract if the other party materially fails to perform in

accordance with the terms of this contract. In this event, the aggrieved party shall deliver ten (10) working days advance written notification to the other party specifying the performance failure and the intent to terminate.

B. Without Cause

Either party to this contract may elect to terminate this contract without cause by delivering a thirty (30) day written notice of intent to terminate to the other party.

C. Funding

The SBHO may unilaterally terminate or negotiate modification of this contract at any time if its federal, or state grants are suspended, reduced, or terminated before or during this contract period, or if federal or state grant terms and regulations change significantly.

In the event of early contract termination initiated by either party for whatever reason, the Contractor is only entitled to costs incurred prior to the time of contract termination.

SECTION V. LEGAL REMEDIES

Nothing in this contract shall be construed to limit either party's legal remedies including, but not limited to, the right to sue for damages or specific performance should either party materially violate any of the terms of this contract. Failure to act on any default shall not constitute waiver of rights on such default or on any subsequent default.

SECTION VI. VENUE AND CHOICE OF LAW

Any action at law, suit in equity, or other judicial proceeding for the enforcement of this contract or any provision thereof shall be instituted only in the courts of the State of Washington, County of Kitsap. It is mutually understood and agreed that this contract shall be governed by the laws of the State of Washington, both as to its interpretation and performance.

SECTION VII. WAIVER

No official, officer, employee, or agent of SBHO has the power, right, or authority to waive any of the conditions or provisions of this contract. No waiver of any breach of this agreement shall be held to be a waiver of any other or subsequent breach. All remedies afforded in this agreement or at law shall be taken and construed as cumulative, that is, in addition to every other remedy provided herein or by law. The

failure of the SBHO to enforce at any time any of the provisions of this contract, or to require at any time performance by Contractor of any provisions hereof, shall in no way be construed to be a waiver of such provisions, or in any way affect the validity of this contract or any part, hereof, or the right of SBHO to thereafter enforce each and every provision.

SECTION VIII. NOTICES

All notices called for or provided for in this contract shall be in writing and must be served on the party either personally or by certified mail and shall be deemed served when deposited in the United States mail. Such notice shall be made to:

Point of Contact
Contractor
Address
City, State Zip

Anders Edgerton, SBHO Regional
Administrator
Contract Administrator
Kitsap County
614 Division St., MS-23
Port Orchard, WA 98366-4676

SECTION IX. PAYMENTS

- A. All payments to be made by Kitsap County, on behalf of the SBHO, under this agreement shall be made to: Contractor, City of , County of , State of Washington.
- B. This contract shall not exceed the amount set forth in the contract budget, Attachment C. Contractor agrees to participate in and be bound by determinations arising out of the SBHO's disallowed cost resolution process.

SECTION X. DURATION

The Contractor is authorized to commence providing services pursuant to this contract.

SECTION XI. WHOLE AGREEMENT

This instrument embodies the whole agreement of the parties. There are no promises, terms, conditions, or obligations other than those contained herein; and this contract shall supersede all previous communications, representations, or agreements, either verbal or written, between parties.

SECTION XII. SEVERABILITY

It is understood and agreed by the parties that if any part, term, or provision of this contract is held by the courts to be illegal or in conflict with any law of the state where made, the validity of the remaining portions or provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if this contract did not contain the particular part, term, or provision held to be invalid.

SECTION XIII. ATTACHMENTS.

The parties acknowledge that the following attachments, which are attached to this Contract, are expressly incorporated by this reference:

Attachment C-2 – Special Terms and Conditions
Attachment D – Statement of Work
Attachments E-1, E-2, E-3 – Budget Summary/Estimated Expenditures
Attachment F – Business Associate Agreement
Attachment G – Data Security Requirements
Attachment H – Certification Regarding Debarment, Suspension, and Other Responsibility Matters
Attachment I – Certification Regarding Lobbying

The rights and obligations of the parties shall be subject to, and governed by, the terms and conditions contained herein and by the Statement of Work, General Agreement, Special Terms and Conditions, Business Associate Agreement, Data Security Requirements and the Budget. In the event of any inconsistency in this notification of contract, including the items incorporated herein by reference, the inconsistency shall be resolved by giving precedence in the following order: (1) General Agreement; (2) Special Terms and Conditions; (3) Statement of Work; (4) Budget.

ATTACHMENT C-2: SPECIAL TERMS AND CONDITIONS

A. Program Requirements

1. Client Service

- a. The Contractor's performance during each calendar quarter, in terms of clients served, client outcomes, client service hours, clinical services, and contract expenditures, will be reviewed.
- b. A deviation below the standards established in the SBHOs policies and procedures and Quality Improvement Plan will initiate the corrective action process as outlined below, Corrective Action Process.
- c. The Contractor will be out of compliance with this contract if such deviation exists at the end of this contract period.

2. Public Record

All records required to be maintained by this contract or by state law, except medical, treatment and personnel records, shall be considered to be public records and maintained in accordance with applicable laws. Medical and treatment records shall be confidential and shall not be published or open to public inspection except that such records may be inspected by the Director of the Department of Social and Health Services, or his delegate; and Contract Administrator for the purpose of program review, evaluation and comparative cost studies.

All medical and/or treatment information, records, and data collected in connection with this contract shall be protected from unauthorized disclosure in accordance with 45 CFR 431.300 through 431.307, 42 CFR Part 2, and RCW 70.02, 71.24 and 71.34.

3. Records Retention

Records Retention during the term of this Agreement is for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records is started before expiration of the six year period, the records shall be retained until completion and resolution of all issues arising there from or until the end of the six year period, whichever is later.

- a. The Contractor shall maintain records sufficient to:

- (1) Maintain the content of all medical records in a manner consistent with utilization control requirements of 42 CFR §456.
- (2) Document performance of all acts required by law, regulation, or this Agreement.
- (3) Substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance.
- (4) Demonstrate the accounting procedures, practices, and records that sufficiently and properly document the Contractor's invoices to SBHO and all expenditures made by the Contractor to perform as required by this Agreement.

4. Equal Opportunity Notices

a. Posting

The Contractor agrees to post in conspicuous places available to employees and applicants for employment, notices to be provided by the Department of Social and Health Services setting forth the provision of the Equal Opportunity Clause.

b. Collective Bargaining Agreements

The Contractor will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding a notice to be provided by the Department of Social and Health Services, advising the labor union or workers' representative of the Contractor's commitments under this Equal Opportunity Clause, and shall post notice in conspicuous places available to employees and applicants for employment.

5. Non-discrimination

a. Department of Social and Health Services Plan

The Contractor shall comply with all pertinent sections of the Department of Social and Health Services' Non Discrimination Plan, or develop a time line for accomplishing full compliance.

b. Notices

The Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, national origin, creed, marital status, age Vietnam era or disabled veteran status, or the presence of any sensory, mental, or physical disability.

6. Executive Order No. 11246

a. Compliance

The Contractor will comply with all provisions of Executive Order No. 11246 of September 24, 1965, as amended by Executive Order No. 11375 (State Equal Opportunity Orders) and of the rules, regulations, and relevant orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the Department of Social and Health Services and by the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations and orders.

b. Non-compliance

In the event of Contractor non-compliance with the Equal Opportunity Clause of this contract or with any of the said rules, regulations, or orders, this contract may be canceled, terminated or suspended in whole or in part, and the Contractor may be declared ineligible for further government contracts in accordance with procedures authorized in the above Executive Order, and such other sanctions may be imposed and remedies invoked as provided in said Executive Order, or by rules, regulations, or order of the Secretary of Labor, or as otherwise provided in law.

7. Compliance with Laws

The Contractor shall comply with RCW Chapter 71, as well as with all applicable Federal and State Statutes, administrative codes, and SBHO policies.

B. Fiscal Requirements

1. Withhold Payment

Failure of the Contractor to comply with the terms of this contract shall give the SBHO the right to withhold payment of any further funds under this contract.

2. Reimbursement

In the event that it is determined that any funds were disbursed under color of this contract, which violate the terms and conditions herein, such sums shall be reimbursed to the SBHO upon written demand. Neither payment of any funds under color of this contract, nor any other action of the SBHO or its officials, officers, agents or employees, prior to the discovery of the violation, shall constitute a waiver thereof.

3. Distribution by Kitsap County Treasurer

In the event of dissolution of the private non-profit corporation or arm thereof named herein as Contractor for services, or termination of contractual agreement for any reason named herein, or elimination of program elements by the SBHO Executive Board, or transference of program elements, then in that event any monies and/or funds and fees generated by Contractor by virtue of the existence of the services outlined herein, shall, after all legal and accountable liabilities have been duly satisfied, revert to the Kitsap County Treasurer for distribution by the SBHO Executive Board for community mental health services.

4. Modify Funding

Change of funding base in this contract may be made by the SBHO upon ten (10) days written notice to the Contractor, provided that such changes are necessitated by reduced funding or loss of program.

5. Termination by Default

In the event that this contract is terminated by default, no notice of termination shall be required.

6. Right to Hearing

All notices shall be given in writing specifying the reasons for such demands, reimbursement, termination, or amendment or such other actions contemplated in this contract and the Contractor shall have the right to a hearing within ten (10) days from such determination before the SBHO Executive Board for determination of the action and prior to commencement of any civil litigation, by the Contractor.

7. Evaluation

- a. The Contractor will cooperate with the SBHO in the evaluation of the Contractor's program and to make available all information required by any such evaluation process.
- b. The SBHO will give reasonable notice prior to such an evaluation and take into consideration the time required to provide data not routinely collected.
- c. The evaluation will be based on goals and objectives and performance standards as established by the State, SBHO, reporting requirements and operating budget under this contract.

8. Audit Requirements

- a. Nothing in this section shall preclude audits by other duly authorized representatives of the SBHO, Department of Social and Health Services or state government, nor shall it preclude the recoupment of overpayments identified through those audit procedures.
- b. Independent Audits will be submitted annually to the Kitsap County Department of Human Services in the following manner:

The Contractor shall acquire a financial audit by an independent auditing firm to determine, at a minimum, the fiscal integrity of the financial transaction and reports of the Contractor. Copies of the audit and management letter shall be submitted to Kitsap County Department of Human Services within 9 months of the end of the Contractor's fiscal year.

The Contractor shall provide an independent audit of the entire organization which:

- (1) Is performed by an independent Certified Public Accountant, the Washington State Auditor's Office, or another entity, which the County and Contractor mutually agree will produce an audit which meets the requirements described in items 2 and 3 below.
- (2) Provides statements consistent with the guidelines of AICPA SOP 78-10, Reporting for Other Non-Profit Organizations.
- (3) Is performed in accordance with generally accepted auditing standards and with Federal Standards for Audit

of Governmental Organizations, Programs, Activities and Functions, and meeting all requirements of OMB Circular A-133, as applicable for agencies receiving federal funding in the amount of \$750,000 or more during their fiscal year.

- (4) The Contractor shall submit a copy of the audit and the management letter directly to the SBHO Administrator immediately upon completion.

9. Suspension, Debarment, and Lobbying

The Contractor shall certify, on a separate form (Attachment H), that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency. Contractor shall actively monitor its employees for excluded status in accordance with the SBHOs Policies and Procedures. Also, the Contractor, on a separate form (Attachment I), will certify that it does not use Federal funds for lobbying purposes. Both forms are attached to this Contract.

C. Corrective Action Process

The SBHO conducts a variety of reviews of Contractors, including but not limited to clinical reviews, administrative reviews, fiscal reviews, and encounter data validation. During the course of any review conducted, if a significant deviation from expected performance is noted, the SBHO will request the agency to provide a Corrective Action Plan. SBHO staff will work with agency staff in creating Corrective Action Plans when requested.

If the Contract Administrator finds indications of ongoing potential non-compliance during the contract monitoring processes or learns that the Contractor, or its subcontractors, are out of compliance with any of the terms or conditions of this contract, the following process will be pursued:

1. Informal Meeting

Informal process wherein the Regional Administrator alerts the appropriate Contractor's staff of the potential non-compliance and an agreeable solution is reached.

2. Official Verbal Notification

If the informal meeting does not result in resolution, the SBHO will contact the Contractor for the purpose of official verbal notification of possible noncompliance

to establish a date when representatives of the SBHO and the Contractor shall meet and discuss areas of contention and attempt to resolve the issues.

3. Written Summary

Within five (5) working days of such verbal notification, the SBHO will provide the Contractor representative a written summary of the areas of non-compliance or potential non-compliance by certified mail. Notice shall be sent to the individual identified in the General Agreement.

4. Discussion

Within twenty (20) days of the date of the written notification, a discussion between SBHO and Contractor staff shall be conducted to address areas of noncompliance or potential non-compliance.

5. Withhold Payments

If the SBHO and the Contractor cannot agree upon a resolution within ten (10) working days of the discussion described in the previous paragraph, the SBHO shall withhold contract payments related to the area(s) of non-compliance or potential non-compliance, unless a written, time-limited extension of the period to agree upon corrective action is issued by the SBHO.

D. Reporting Requirements

All reports shall be submitted to the Contract Administrator. Meet all requirements and State and Federal requirements.

E. Billing Procedures

1. Contractor shall bill on a free for service basis.

ATTACHMENT D: STATEMENT OF WORK, Opiate Substitution Treatment

Special Requirements Pursuant to Request for Proposals Primary Outpatient and Opiate Substitution Treatment Provider

1. Assessments

The activities conducted to evaluate an individual to determine if the individual has a substance use disorder and determine placement in accordance with the American Society of Addiction Medicine (ASAM) criteria.

2. Opiate Substitution Treatment

Services include prescribing and dispensing of an approved medication, as specified in 21 CFR Part 291, for opiate substitution services in accordance with WAC 388-877B. Both withdrawal management and maintenance are included, as well as physical exams, clinical evaluations, individual or group therapy for the primary patient and their family or significant others. Additional services include guidance counseling, family planning and educational and vocational information. The service as described satisfies the level of intensity in ASAM Level 1.

3. Buprenorphine Track:

Medically assisted treatment (MAT) can significantly improve outcomes for addicted individuals.

Washington State has relied on methadone as the primary intervention of MAT for participants. However, the program is identifying young adults and other participants with a relatively short (1 to 3 year) opiate addiction that might benefit from a less restrictive and potentially shorter-term opiate replacement model such as buprenorphine. A more structured model, dispensing buprenorphine based on length of program compliance and stability and requiring demonstrated abstinence, and treatment stability to earn carries, would allow more liberal and effective use of buprenorphine in the SBHO BHO Regional Service Area. The Applicant is expected to work toward providing buprenorphine via a structured model within the first 6 months following the award of the contract.

4. Weekly Individual and Group Treatment

Outcomes are significantly better in programs that require participants to meet with a treatment provider or clinical case manager for at least one individual session per week when for the first 90 days. Group sessions may not provide sufficient time and opportunities to address each participant's clinical and social service needs.

Individual sessions reduce the likelihood that individuals will fall through the cracks during the early stages of treatment when they are most vulnerable to cravings, withdrawal symptoms, and relapse. The Applicant will be required to provide weekly one on one's during the initial phases of treatment or until the client is stabilized.

5. Case management

Case management services are services provided by a Chemical Dependency Professional (CDP), CDP Trainee, or person under the clinical supervision of a CDP who will assist clients

in gaining access to needed medical, social, education, and other services. Does not include direct treatment services in this sub element. This covers case planning, case consultation and referral services, and other support services for the purpose of engaging and retaining clients in treatment or maintaining clients in treatment. This does not include treatment planning activities required in WAC 388-877B.

6. Cognitive-Behavioral Interventions

A substantial body of research spanning several decades reveals that outcomes are significantly better when:

- individuals receive behavioral or cognitive-behavioral interventions,
- the interventions are carefully documented in the treatment record,
- treatment providers are trained to deliver the interventions, and
- quality treatment is maintained through continuous supervision of the treatment providers.

The Applicant will be required to create individual services plans with cognitive-behavioral interventions.

7. Gender Specific Treatment:

Substantial evidence shows that women, particularly those with histories of trauma, perform significantly better in gender-specific substance abuse treatment groups. The Applicant will be required to provide women's groups if the population being served demonstrates the need.

8. Random UA's

The Applicant will be required to obtain random UAs as clinically indicated and medically necessary in accordance with WAC-877B-0400.

9. Relapse Prevention

SBHO will require Applicant to provide relapse prevention as part of the Applicant's continuum of care.

10. Access to Mental Health Services

Behavioral health screening and assessments are imperative in identifying potential barriers to success and developing the appropriate treatment intervention tailored to the needs of the individual. SBHO is committed to serving and succeeding with the co-occurring population. In order to accomplish this goal, SBHO will require a behavioral health screening at intake and a follow up assessment for individuals identified as having significant mental health symptoms. Participants with co-occurring disorders will require access to mental health counseling and medications as needed. This may be satisfied through referral and care coordination.

11. Coordination with Primary Care

The Applicant will be required to coordinate care with the individuals Primary Care Provider (medical). If the individual does not have a primary care provider, the Applicant will facilitate a referral and work to ensure the individual is engaged.

The Applicant will coordinate and provide on-going consultation support for all Primary Care Providers providing Medication Assisted Treatment (MAT) within the service area.

12. Transportation

The facility sites must be located on an accessible bus line. Facilities will be required to provide transportation coordination for services.

ATTACHMENT E-1: BUDGET

Program:

Proposer:

Account Title	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Staff Wages				
Staff Benefits				
Supplies				
Communications				
Staff Travel				
Equipment Rent				
Equipment Expense				
Equipment Purchase				
Premises Rent				
Premises Expenses				
Insurance & Bonding				
Other Miscellaneous - Specify				
Total Budget				

ATTACHMENT E-2: BUDGET NARRATIVE

Proposer:

Briefly describe how you arrived at the line item totals which are contained in your budget.

Account Title	Narrative/Computations
Staff Salaries	
Staff Benefits	
Supplies	
Communications	
Staff Travel	
Equipment Rent	
Equipment Expense	
Equipment Purchase	
Premises Rent	
Premises Expense	
Insurance & Bonding	
Other Miscellaneous – Specify	

ATTACHMENT E-3: STAFF SALARY AND BENEFITS NARRATIVE

Proposer:

County:

Position Title/Name of Staff Person	# of Positions	Position Wages	Positions Benefits	Total Wages	Total Benefits Amount	Total Salary Amount
TOTALS						

Attachment F: Business Associates Agreement

1. HIPAA Compliance.

1.1. Definitions.

- 1.1.1. "Business Associate," as used in this Contract, means the "Contractor" and generally has the same meaning as the term "business associate" at 45 CFR 160.103. Any reference to Business Associate in this Contract includes Business Associate's employees, agents, officers, Subcontractors, third party contractors, volunteers, or directors.
- 1.1.2. "Business Associate Agreement" means this HIPAA Compliance section of the Contract and includes the Business Associate provisions required by the U.S. Department of Health and Human Services, Office for Civil Rights.
- 1.1.3. "Breach" means the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the Protected Health Information, with the exclusions and exceptions listed in 45 CFR 164.402.
- 1.1.4. "Covered Entity" means THE SBHO, a Covered Entity as defined at 45 CFR 160.103, in its conduct of covered functions by its health care components.
- 1.1.5. "Designated Record Set" means a group of records maintained by or for a Covered Entity, that is: the medical and billing records about Individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or Used in whole or part by or for the Covered Entity to make decisions about Individuals.
- 1.1.6. Electronic Protected Health Information (EPHI)" means Protected Health Information that is transmitted by electronic media or maintained in any medium described in the definition of electronic media at 45 CFR 160.103.
- 1.1.7. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104- 191, as modified by the American Recovery and Reinvestment Act of 2009 ("ARRA"), Sec. 13400 – 13424, H.R. 1 (2009) (HITECH Act).
- 1.1.8. "HIPAA Rules" means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Parts 160 and Part 164.
- 1.1.9. "Individual(s)" means the person(s) who is the subject of PHI and includes a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
- 1.1.10. "Minimum Necessary" means the least amount of PHI necessary to accomplish the purpose for which the PHI is needed.
- 1.1.11. "Protected Health Information (PHI)" means individually identifiable health information created, received, maintained or transmitted by Business

Associate on behalf of a health care component of the Covered Entity that relates to the provision of health care to an Individual; the past, present, or future physical or mental health or condition of an Individual; or the past, present, or future payment for provision of health care to an Individual. 45 CFR 160.103. PHI includes demographic information that identifies the Individual or about which there is reasonable basis to believe can be used to identify the Individual. 45 CFR 160.103. PHI is information transmitted or held in any form or medium and includes EPHI. 45 CFR 160.103. PHI does not include education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USCA 1232g(a)(4)(B)(iv) or employment records held by a Covered Entity in its role as employer.

- 1.1.12. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.
- 1.1.13. "Subcontractor" as used in this HIPAA Compliance section of the Contract (in addition to its definition in the General Terms and Conditions) means a Business Associate that creates, receives, maintains, or transmits Protected Health Information on behalf of another Business Associate.
- 1.1.14. "Use" includes the sharing, employment, application, utilization, examination, or analysis, of PHI within an entity that maintains such information.

1.2. Compliance.

Business Associate shall perform all Contract duties, activities and tasks in compliance with HIPAA, the HIPAA Rules, and all attendant regulations as promulgated by the U.S. Department of Health and Human Services, Office of Civil Rights.

1.3. Use and Disclosure of PHI.

Business Associate is limited to the following permitted and required uses or disclosures of PHI:

- 1.3.1. Duty to Protect PHI. Business Associate shall protect PHI from, and shall use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 (Security Standards for the Protection of Electronic Protected Health Information) with respect to EPHI, to prevent the unauthorized Use or disclosure of PHI other than as provided for in this Contract or as required by law, for as long as the PHI is within its possession and control, even after the termination or expiration of this Contract.
- 1.3.2. Minimum Necessary Standard. Business Associate shall apply the HIPAA Minimum Necessary standard to any Use or disclosure of PHI necessary to achieve the purposes of this Contract. See 45 CFR 164.514 (d)(2) through (d)(5).
- 1.3.3. Disclosure as Part of the Provision of Services. Business Associate shall

only Use or disclose PHI as necessary to perform the services specified in this Contract or as required by law, and shall not Use or disclose such PHI in any manner that would violate Subpart E of 45 CFR Part 164 (Privacy of Individually Identifiable Health Information) if done by Covered Entity, except for the specific uses and disclosures set forth below.

- 1.3.4. Use for Proper Management and Administration. Business Associate may Use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- 1.3.5. Disclosure for Proper Management and Administration. Business Associate may disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been Breached.
- 1.3.6. Impermissible Use or Disclosure of PHI. Business Associate shall report to the SBHO in writing all Uses or disclosures of PHI not provided for by this Contract within five (5) business days of becoming aware of the unauthorized Use or disclosure of PHI, including Breaches of unsecured PHI as required at 45 CFR 164.410 (Notification by a Business Associate), as well as any Security Incident of which it becomes aware. Upon request by the SBHO, Business Associate shall mitigate, to the extent practicable, any harmful effect resulting from the impermissible Use or disclosure.
- 1.3.7. Failure to Cure. If the SBHO learns of a pattern or practice of the Business Associate that constitutes a violation of the Business Associate's obligations under the terms of this Contract and reasonable steps by the SBHO do not end the violation, the SBHO shall terminate this Contract, if feasible. In addition, If Business Associate learns of a pattern or practice of its Subcontractors that constitutes a violation of the Business Associate's obligations under the terms of the ir contract and reasonable steps by the Business Associate do not end the violation, Business Associate shall terminate the Subcontract, if feasible.
- 1.3.8. Termination for Cause. Business Associate authorizes immediate termination of this Contract by the SBHO, if the SBHO determines that Business Associate has violated a material term of this Business Associate Agreement. SBHO may, at its sole option, offer Business Associate an opportunity to cure a violation of this Business Associate Agreement before exercising a termination for cause.
- 1.3.9. Consent to Audit. Business Associate shall give reasonable access to PHI, its internal practices, records, books, documents, electronic data and/or all other business information received from, or created or

received by Business Associate on behalf of the SBHO, to the SBHO, Secretary of DHHS and/or to the SBHO for use in determining compliance with HIPAA privacy requirements.

- 1.3.10. Obligations of Business Associate Upon Expiration or Termination. Upon expiration or termination of this Contract for any reason, with respect to PHI received from the SBHO or THE SBHO, or created, maintained, or received by Business Associate, or any Subcontractors, on behalf of THE SBHO or the SBHO, Business Associate shall:
 - 1.3.10.1. Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
 - 1.3.10.2. Return to the SBHO or destroy the remaining PHI that the Business Associate or any Subcontractors still maintain in any form;
 - 1.3.10.3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 (Security Standards for the Protection of Electronic Protected Health Information) with respect to Electronic Protected Health Information to prevent Use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate or any Subcontractors retain the PHI;
 - 1.3.10.4. Not Use or disclose the PHI retained by Business Associate or any Subcontractors other than for the purposes for which such PHI was retained and subject to the same conditions set out in the "Use and Disclosure of PHI" section of this Contract which applied prior to termination; and
 - 1.3.10.5. Return to the SBHO or destroy the PHI retained by Business Associate, or any Subcontractors, when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.
- 1.3.11. Survival. The obligations of the Business Associate under this section shall survive the termination or expiration of this Contract.
- 1.4. Individual Rights.
 - 1.4.1. Accounting of Disclosures.
 - 1.4.1.1. Business Associate shall document all disclosures, except those disclosures that are exempt under 45 CFR 164.528, of PHI and information related to such disclosures.
 - 1.4.1.2. Within ten (10) business days of a request from the SBHO, Business Associate shall make available to the SBHO the information in Business Associate's possession that is necessary for the SBHO to respond in a timely manner to a request for an accounting of

disclosures of PHI by the Business Associate. See 45 CFR 164.504(e)(2)(ii)(G) and 164.528(b)(1).

1.4.1.3. At the request of the SBHO or in response to a request made directly to the Business Associate by an Individual, Business Associate shall respond, in a timely manner and in accordance with HIPAA and the HIPAA Rules, to requests by Individuals for an accounting of disclosures of PHI.

1.4.1.4. Business Associate record keeping procedures shall be sufficient to respond to a request for an accounting under this section for the six (6) years prior to the date on which the accounting was requested.

1.4.2. Access

1.4.2.1. Business Associate shall make available PHI that it holds that is part of a Designated Record Set when requested by the SBHO or the Individual as necessary to satisfy the SBHO's obligations under 45 CFR 164.524 (Access of Individuals to Protected Health Information).

1.4.2.2. When the request is made by the Individual to the Business Associate or if the SBHO asks the Business Associate to respond to a request, the Business Associate shall comply with requirements in 45 CFR 164.524 (Access of Individuals to Protected Health Information) on form, time and manner of access. When the request is made by the SBHO, the Business Associate shall provide the records to the SBHO within ten (10) business days.

1.4.3. Amendment.

1.4.3.1. If the SBHO amends, in whole or in part, a record or PHI contained in an Individual's Designated Record Set and the SBHO has previously provided the PHI or record that is the subject of the amendment to Business Associate, then the SBHO will inform Business Associate of the amendment pursuant to 45 CFR 164.526(c)(3) (Amendment of Protected Health Information).

1.4.3.2. Business Associate shall make any amendments to PHI in a Designated Record Set as directed by the SBHO or as necessary to satisfy the SBHO's obligations under 45 CFR 164.526 (Amendment of Protected Health Information).

1.5. Subcontracts and other Third Party Agreements.

In accordance with 45 CFR 164.502(e)(1)(ii), 164.504(e)(1)(i), and 164.308(b)(2), Business Associate shall ensure that any agents, Subcontractors, independent contractors or other third parties that create, receive, maintain, or transmit PHI on Business Associate's behalf, enter into a written contract that contains the same terms, restrictions, requirements, and conditions as the HIPAA compliance provisions in this Contract with respect to such PHI. The same provisions must

also be included in any contracts by a Business Associate's Subcontractor with its own business associates as required by 45 CFR 164.314(a)(2)(b) and 164.504(e)(5) .

1.6. Obligations.

To the extent the Business Associate is to carry out one or more of the SBHO's obligation(s) under Subpart E of 45 CFR Part 164 (Privacy of Individually Identifiable Health Information), Business Associate shall comply with all requirements that would apply to the SBHO in the performance of such obligation(s).

1.7. Liability.

Within ten (10) business days, Business Associate must notify the SBHO of any complaint, enforcement or compliance action initiated by the Office for Civil Rights based on an allegation of violation of the HIPAA Rules and must inform the SBHO of the outcome of that action. Business Associate bears all responsibility for any penalties, fines or sanctions imposed against the Business Associate for violations of the HIPAA Rules and for any imposed against its Subcontractors or agents for which it is found liable.

1.8. Breach Notification.

- 1.8.1. In the event of a Breach of unsecured PHI or disclosure that compromises the privacy or security of PHI obtained from the SBHO or involving SBHO clients, Business Associate will take all measures required by state or federal law.
- 1.8.2. Business Associate will notify the SBHO Incident Manager within three (3) business days by submitting an Incident Report in accordance with SBHO Policy, or by telephone, of any acquisition, access, Use or disclosure of PHI not allowed by the provisions of this Contract or not authorized by HIPAA Rules or required by law of which it becomes aware which potentially compromises the security or privacy of the Protected Health Information as defined in 45 CFR 164.402 (Definitions).
- 1.8.3. Business Associate will notify the SBHO Incident Manager within Three (3) business days by submitting an Incident Report in accordance with SBHO Policy, or by telephone, of any potential Breach of security or privacy of PHI by the Business Associate or its Subcontractors or agents. Business Associate will follow telephone or e-mail notification with a faxed or other written explanation of the Breach, to include the following: date and time of the Breach, date Breach was discovered, location and nature of the PHI, type of Breach, origination and destination of PHI, Business Associate unit and personnel associated with the Breach, detailed description of the Breach, anticipated mitigation steps, and the name, address, telephone number, fax number, and e-mail of the individual who is responsible as the primary point of contact. Business Associate will address communications to the SBHO Incident Manager. Business Associate will coordinate and cooperate with the SBHO to provide a copy of its investigation and other

information requested by the SBHO, including advance copies of any notifications required for the SBHO review before disseminating and verification of the dates notifications were sent.

1.8.4. If either the SBHO or the Contractor determines that Business Associate or its Subcontractor(s) or agent(s) is responsible for a Breach of unsecured PHI received from the SBHO or involving SBHO clients:

1.8.4.1. requiring notification of Individuals under 45 CFR § 164.404 (Notification to Individuals), Business Associate bears the responsibility and costs for notifying the affected Individuals and receiving and responding to those Individuals' questions or requests for additional information;

1.8.4.2. requiring notification of the media under 45 CFR § 164.406 (Notification to the media), Business Associate bears the responsibility and costs for notifying the media and receiving and responding to media questions or requests for additional information;

1.8.4.3. requiring notification of the U.S. Department of Health and Human Services Secretary under 45 CFR § 164.408 (Notification to the Secretary), Business Associate bears the responsibility and costs for notifying the Secretary and receiving and responding to the Secretary's questions or requests for additional information; and

1.8.4.4. The SBHO will take appropriate remedial measures up to termination of this Contract.

1.9. Miscellaneous Provisions.

1.9.1. Regulatory References. A reference in this Contract to a section in the HIPAA Rules means the section as in effect or amended.

1.9.2. Interpretation. Any ambiguity in this Contract shall be interpreted to permit compliance with the HIPAA Rules.

Attachment G: Data Security Requirements

1. **Definitions.** The words and phrases listed below, as used in this Exhibit, shall each have the following definitions:
 - a. "Authorized User(s)" means an individual or individuals with an authorized business requirement to access DSHS Confidential Information.
 - b. "Hardened Password" means a string of at least eight characters containing at least one alphabetic character, at least one number and at least one special character such as an asterisk, ampersand or exclamation point.
 - c. "Unique User ID" means a string of characters that identifies a specific user and which, in conjunction with a password, passphrase or other mechanism, authenticates a user to an information system.
2. **Data Transport.** When transporting DSHS Confidential Information electronically, including via email, the Data will be protected by:
 - a. Transporting the Data within the (State Governmental Network) SGN or Contractor's internal network, or;
 - b. Encrypting any Data that will be in transit outside the SGN or Contractor's internal network. This includes transit over the public Internet.
3. **Protection of Data.** The Contractor agrees to store Data on one or more of the following media and protect the Data as described:
 - a. **Hard disk drives.** Data stored on local workstation hard disks. Access to the Data will be restricted to Authorized User(s) by requiring logon to the local workstation using a Unique User ID and Hardened Password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards.
 - b. **Network server disks.** Data stored on hard disks mounted on network servers and made available through shared folders. Access to the Data will be restricted to Authorized Users through the use of access control lists which will grant access only after the Authorized User has authenticated to the network using a Unique User ID and Hardened Password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on disks mounted to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

For DSHS Confidential Information stored on these disks, deleting unneeded Data is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in the above paragraph. Destruction of the Data as outlined in Section 5. Data Disposition may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

- c. **Optical discs (CDs or DVDs) in local workstation optical disc drives.** Data provided by DSHS on optical discs which will be used in local workstation optical disc drives and which will not be transported out of a Secured Area. When not in use for the contracted purpose, such discs must be locked in a drawer, cabinet or other container to which only Authorized Users have the key, combination or mechanism required to access the contents of the container. Workstations which access DSHS Data on optical discs must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
- d. **Optical discs (CDs or DVDs) in drives or jukeboxes attached to servers.** Data provided by DSHS on optical discs which will be attached to network servers and which will not be transported out of a Secured Area. Access to Data on these discs will be restricted to Authorized Users through the use of access control lists which will grant access only after the Authorized User has authenticated to the network using a Unique User ID and Hardened Password or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Data on discs attached to such servers must be located in an area which is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.
- e. **Paper documents.** Any paper records must be protected by storing the records in a Secured Area which is only accessible to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.
- f. **Remote Access.** Access to and use of the Data over the State Governmental Network (SGN) or Secure Access Washington (SAW) will be controlled by DSHS staff who will issue authentication credentials (e.g. a Unique User ID and Hardened Password) to Authorized Users on Contractor staff. Contractor will notify DSHS staff immediately whenever an Authorized User in possession of such credentials is terminated or otherwise leaves the employ of the Contractor, and whenever an Authorized User's duties change such that the Authorized User no longer requires access to perform work for this Contract.
- g. **Data storage on portable devices or media.**
 - (1) Except where otherwise specified herein, DSHS Data shall not be stored by the Contractor on portable devices or media unless specifically authorized within the

terms and conditions of the Contract. If so authorized, the Data shall be given the following protections:

- (a) Encrypt the Data with a key length of at least 128 bits
- (b) Control access to devices with a Unique User ID and Hardened Password or stronger authentication method such as a physical token or biometrics.
- (c) Manually lock devices whenever they are left unattended and set devices to lock automatically after a period of inactivity, if this feature is available. Maximum period of inactivity is 20 minutes.

Physically Secure the portable device(s) and/or media by

- (d) Keeping them in locked storage when not in use
 - (e) Using check-in/check-out procedures when they are shared, and
 - (f) Taking frequent inventories
- (2) When being transported outside of a Secured Area, portable devices and media with DSHS Confidential Information must be under the physical control of Contractor staff with authorization to access the Data.
- (3) Portable devices include, but are not limited to; smart phones, tablets, flash memory devices (e.g. USB flash drives, personal media players), portable hard disks, and laptop/notebook/netbook computers if those computers may be transported outside of a Secured Area.
- (4) Portable media includes, but is not limited to; optical media (e.g. CDs, DVDs), magnetic media (e.g. floppy disks, tape), or flash media (e.g. CompactFlash, SD, MMC).

h. Data stored for backup purposes.

- (1) DSHS data may be stored on portable media as part of a Contractor's existing, documented backup process for business continuity or disaster recovery purposes. Such storage is authorized until such time as that media would be reused during the course of normal backup operations. If backup media is retired while DSHS Confidential Information still exists upon it, such media will be destroyed at that time in accordance with the disposition requirements in Section 5. Data Disposition
- (2) DSHS Data may be stored on non-portable media (e.g. Storage Area Network drives, virtual media, etc.) as part of a Contractor's existing, documented backup process for business continuity or disaster recovery purposes. If so, such media

will be protected as otherwise described in this exhibit. If this media is retired while DSHS Confidential Information still exists upon it, the data will be destroyed at that time in accordance with the disposition requirements in Section 5. Data Disposition.

4. Data Segregation.

- a. DSHS Data must be segregated or otherwise distinguishable from non-DSHS data. This is to ensure that when no longer needed by the Contractor, all DSHS Data can be identified for return or destruction. It also aids in determining whether DSHS Data has or may have been compromised in the event of a security breach. As such, one or more of the following methods will be used for data segregation.
- b. DSHS Data will be kept on media (e.g. hard disk, optical disc, tape, etc.) which will contain no non-DSHS data. And/or,
- c. DSHS Data will be stored in a logical container on electronic media, such as a partition or folder dedicated to DSHS Data. And/or,
- d. DSHS Data will be stored in a database which will contain no non-DSHS data. And/or,
- e. DSHS Data will be stored within a database and will be distinguishable from non-DSHS data by the value of a specific field or fields within database records.
- f. When stored as physical paper documents, DSHS Data will be physically segregated from non-DSHS data in a drawer, folder, or other container.
- g. When it is not feasible or practical to segregate DSHS Data from non-DSHS data, then both the DSHS Data and the non-DSHS data with which it is commingled must be protected as described in this exhibit.

- 5. Data Disposition.** When the contracted work has been completed or when no longer needed, except as noted in Section 3. Protection of Data b. Network Server Disks above, Data shall be returned to DSHS or destroyed. Media on which Data may be stored and associated acceptable methods of destruction are as follows:

Data stored on:	Will be destroyed by:
Server or workstation hard disks, or Removable media (e.g. floppies, USB flash drives, portable hard disks) excluding optical discs	Using a "wipe" utility which will overwrite the Data at least three (3) times using either random or single character data, or

	Degaussing sufficiently to ensure that the Data cannot be reconstructed, or Physically destroying the disk
Paper documents with sensitive or Confidential Information	Recycling through a contracted firm provided the contract with the recycler assures that the confidentiality of Data will be protected.
Paper documents containing Confidential Information requiring special handling (e.g. protected health information)	On-site shredding, pulping, or incineration
Optical discs (e.g. CDs or DVDs)	Incineration, shredding, or completely defacing the readable surface with a coarse abrasive
Magnetic tape	Degaussing, incinerating or crosscut shredding

6. **Notification of Compromise or Potential Compromise.** The compromise or potential compromise of DSHS shared Data must be reported to the DSHS Contact designated in the Contract within one (1) business day of discovery. If no DSHS Contact is designated in the Contract, then the notification must be reported to the DSHS Privacy Officer at dshsprivacyofficer@dshs.wa.gov. Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or DSHS.
7. **Data shared with Subcontractors.** If DSHS Data provided under this Contract is to be shared with a subcontractor, the Contract with the subcontractor must include all of the data security provisions within this Contract and within any amendments, attachments, or exhibits within this Contract. If the Contractor cannot protect the Data as articulated within this Contract, then the contract with the sub-Contractor must be submitted to the DSHS Contact specified for this contract for review and approval.

ATTACHMENT H: CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS

Primary Covered Transactions 45 CFR 76

1. The prospective primary participant certifies to the best of its knowledge and belief, that it and its principles:
 - a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;
 - b. Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connections with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement, or receiving stolen property;
 - c. **Are not presently indicted for or otherwise criminally or civilly charges by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph 1.b. of this certification; and**
 - d. **Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.**
2. Where the prospective primary participants are unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

This Certification is executed by the person(s) signing below who warrant they have authority to execute this Certification.

CONTRACTOR:

Name:
Title:

DATE:

ATTACHMENT I: CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and believe, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Contractor Organization

Signature of Certifying Official

Date

Local examples: clinical integration of primary care, substance use, and mental health treatment

KITSAP COUNTY

1. Kitsap Mental Health Services (KMHS)

INTEGRATION OF PRIMARY CARE / BEHAVIORAL HEALTH SERVICES: KMHS, due in part through a 3 year CMS CMMI Innovation Award completed in 2015, now offers full integration of mental health, co-occurring substance use disorders, primary care, and dental care, and also offers multiple supports to community partners for co-located behavioral health services. Services are based on the collaborative care model adapted for provision of care in the specialty behavioral health setting. Bi-directional care includes psychiatric consultation for all primary care providers and, in collaboration with Harrison Health Partners (HHP), placement of a Behavioral Health Professional or Licensed Social Worker in HHP clinics. For KMHS clients, in this bi-directional model, an HHP provider and a PCHS provider are "in clinic" weekly at KMHS to provide primary care services and medications management to KMHS patients best served in the community mental health setting. Partners also include Harrison Medical Center for emergency department data, the Kitsap Public Health District for epidemiology and evaluation, and multiple primary care provider offices for patient care coordination. The bi-directional care integration project is complex and a great deal of data is available. Other bi-directional care is accomplished through co-located behavioral health services with law and justice, courts, jail, nursing homes, community outreach sites, housing and other partners.

JEFFERSON COUNTY

1. Discovery Behavioral Healthcare (DBH, formerly Jefferson Mental Health Services)

INTEGRATION OF PRIMARY CARE / BEHAVIORAL HEALTH SERVICES: DBH has a joint business venture with Jefferson Healthcare (JHC), a local hospital with primary care clinics in East Jefferson County, to provide psychiatric services together through a 50/50 split with a MD/ Psychiatrist starting June 2015. A Psychiatrist works in Jefferson Healthcare primary care clinics in the morning and operates as part time Medical Director and Psychiatrist in the afternoons at DBH. In October 2016 we added a 50/50 PMHNP/Addiction Specialist working alongside our Psychiatrist/Medical Director. The 50/50 Psychiatric ARNP delivers psychiatric evaluations and medication management mornings and afternoons to support the Safety and Assessment beds project at the hospital in overseeing Single Bed Certifications. DBH is partnering with JHC with their Safety and Assessment beds to assist with crisis stabilization of clients awaiting a community hospital inpatient opening. DBH added Chemical Dependency Licensure in early 2016 and is building a Medication Assisted Treatment (MAT) program in conjunction with JHC to address the increased opioid usage and deaths in East Jefferson County. DBH operates two relapse prevention groups at Jefferson County Jail and added a full time case manager who does post-discharge initial case management to coordinate care and make referrals to DBH or other local providers to decrease recidivism and connect offenders with appropriate treatment providers. DBH has an ongoing referral and consultative relationships with medical providers and practices in our community through an RN Care Manager. RN Care Manager provides referral and psychiatric consultation for Jefferson Care PCPs and local independent Physician practices. Other bi-directional care is offered through participation in school based health clinics at all four (4) school districts in East Jefferson County providing an embedded Therapist alongside Jefferson County funded Nurse Practitioners. DBH provides some co-located care at a tribe through an embedded psychiatric provider who performs psychiatric evaluations and medication management.

CLALLAM COUNTY

1. Peninsula Behavioral Health (PBH)

INTEGRATED PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES: PBH contracts with Olympic Medical Center (OMC) to provide psychiatric rounding services five days a week to OMC patients, as well as consultation to their hospitalists, and psychiatric rounding to over 100 of OMC's patients in three area nursing homes. PBH also provides psychiatric evaluations and medication management in three Olympic Medical Physician Clinics (two in Port Angeles and one in Sequim) through a Behavioral Health Specialist (Advanced Registered Nurse Practitioner); Mental Health assessments and counseling and psychiatric consultation at the North Olympic Healthcare Network (NOHN) through a full-time Licensed Independent Clinical Social Worker. NOHN is a federally qualified healthcare clinic (FQHC) in Clallam County. Through a partnership with Behavioral Health Northwest, PBH provides care management services to OPTUM and Molina patients with chronic health conditions throughout Clallam and Jefferson Counties; and has ongoing referral and consultative relationships with medical providers and practices in our community. In the recently signed WA state budget, PBH received \$847,000 in capital grant funding to renovate the north side of a PBH building that also houses our crisis stabilization program, develop a Medical Clinic/Healthcare Home so patients can receive primary and behavioral health services under the same roof.

2. West End Outreach Services (WEOS)

West End Outreach Services has placed a behavioral health specialist in one of the Forks Community Hospital's primary care clinics. WEOS provides crisis and referral services for Bogachiel Clinic and the Emergency Room. Telepsych services have been offered at the Bogachiel Clinic in order to encourage increased communication between psychiatry and primary care providers. WEOS is currently exploring offering a small Suboxone clinic with one of the Bogachiel Clinic providers pending approval from Forks Community Hospital (FCH).



Cross-System Outcome Measures for Adults Enrolled in Medicaid

With the passage of Engrossed House Bill 1519 (Chapter 320, Laws of 2013) and Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013), the Washington State Legislature directed that contracts the Department of Social and Health Services and the Health Care Authority execute with service contracting entities (Behavioral Health Organizations, Area Agencies on Aging, and Medicaid Managed Care Organizations) include measures to address shared outcomes. Engrossed House Bill 1519 further directed the phased implementation of public reporting of outcome measures in a form that allows for comparison of measures and levels of improvement between geographic regions of Washington State. This site provides results for selected measures for each delivery system, by Regional Service Areas defined under the requirements of Second Substitute Senate Bill 6312 (Chapter

Glossary of Measure Definitions

See the public reporting website for detailed information about measure specifications, attribution and interpretation

<https://www-staging.dshs.wa.gov/node/28147><https://www-staging.dshs.wa.gov/node/28147>

Abbreviation	Name	Short Description
MH-B	Mental Health Treatment Penetration - Broad Definition	The percentage of members with a mental health service need who received mental health services in the measurement year, including RSN/BHO services, MCO services and Medicare-paid services for dual eligibles
PCR-P	Psychiatric Inpatient 30-Day Readmission	The proportion of acute inpatient psychiatric stays during the measurement year that were followed by an acute psychiatric readmission within 30 days.
HOME-B	Percent Homeless - Broad Definition	The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year. Includes "homeless with housing" ACES living arrangement code.
EMP	Percent Employed	The percentage of Medicaid enrollees with any earnings reported in Employment Security Department (ESD) employment data in the measurement year.
ARREST	Percent Arrested	The percentage of Medicaid enrollees who were arrested at least once in the measurement year.

Measure Attribution of Clients to Service Contracting Entities

December 27, 2016
Version 2.2

Context

This document provides definitions used to attribute Medicaid clients to specific service contracting entities for 5732/1519 cross-system outcome measure reporting. This information is intended to complement the technical specifications for each outcome measure.

Client Attribution to Service Contracting Entities

The criteria used to attribute patients to a service contracting entity in the reporting period depend on the measure type. Measures fall into three different types:

1. **Annual-experience measures**
 - a. Adults' Access to Preventative/Ambulatory Care (HEDIS)
 - b. Substance Use Disorder Treatment Penetration Rate
 - c. Mental Health Services Penetration Rate (Broad and Narrow)
 - d. Homelessness Rate (Broad and Narrow)
 - e. Employment Rate
 - f. Arrest Rate
2. **Index-event measures**
 - a. Plan All-Cause Readmission Rate (HEDIS)
 - b. Psychiatric Hospital Readmission Rate
 - c. Initiation and Engagement in Substance Use Disorder Treatment (Washington Circle Adaptation)
3. **Utilization measures**
 - a. Emergency Department (ED) Visits per 1000 Member Months
 - b. Home and Community-Based Service (HCBS) Use as a Proportion of All Long-term Supports and Services (LTSS) Use

Annual-experience measures generally examine a client's experience over the course of the reporting year to identify whether a specific qualifying event (e.g., an ambulatory care visit or receipt of mental health treatment) has occurred. The event may occur at any point in the year. NCQA-HEDIS measures of this type (such as Adults' Access to Preventative/Ambulatory Care) generally require near-continuous health plan enrollment for a member to be attributed to a health plan in the reporting year. We have adopted an analogous attribution approach that requires near-continuous affiliation of the client with the service contracting entity in the measurement year.

Index-event measures reflect the occurrence of a sentinel "index event" (e.g., a hospital discharge) at some time during the measurement year. For hospital readmission measures, we have adopted the HEDIS approach that requires near-continuous affiliation of the client with the

service contracting entity in the 12 months prior to the index discharge and in the 30-day follow-up window.

Utilization measures reflect the volume of measured services used, relative to the volume of qualifying months of service in the population. The ED utilization metric reflects the number of outpatient ED visits, relative to the number of qualifying medical coverage months in the population. For this metric, we have adopted a somewhat less restrictive continuous enrollment criterion (6 months of continuous enrollment up to and including the measurement month) for client attribution to a service contracting entity.

The HCBS/Institutional balance measure reflects HCBS service use relative to the volume of qualifying person-months receiving LTSS services. For this metric we attribute a client to a service contracting entity based on the client's residential location in the qualifying month of service.

For annual-experience measures – with the exception of the arrest, employment and housing measures – the following methods were used to attribute a client to a service contracting entity in the measurement year:

- Area Agencies on Aging
 - Assigned to the reported AAA (PSA) as recorded in the CARE “Clientassignhistory” table in at least 11 months in the measurement year AND
 - Received ALTSA-funded in-home personal care services in at least 11 months in the measurement year
- Medicaid enrollees with mental health service needs (Behavioral Health Organizations)
 - Resided in the BHO service area in at least 11 months in the measurement year AND
 - Presented an indication of a mental health service need in the 24 months leading up to the end of the measurement year¹
- Medicaid enrollees with substance use disorders (Behavioral Health Organizations)
 - Resided in the BHO service area in at least 11 months in the measurement year AND
 - Presented an indication of a substance use disorder treatment need in the 24 months leading up to the end of the measurement year²
- HCA Managed Care Organizations (MCOs)
 - Enrolled with the MCO in at least 11 months in the measurement year
 - Will include fully integrated managed care plans

For arrest, employment and housing measures, we perform attribution using a threshold of 7+ months of Medicaid enrollment and 7+ months of residential location or managed care enrollment affiliation. Less stringent inclusion criteria are used for arrest and housing stability measures because criminal justice involvement and homelessness are associated with increased risk of Medicaid enrollment disruption. Using this less restrictive approach for the employment metric extends the period of time during which clients who have earned their way off Medicaid count positively towards measured employment outcomes.

¹ See the Mental Health Service Penetration measure definition document for detailed information regarding the identification of mental health service needs.

² See the Substance Use Disorder (SUD) Treatment Penetration measure definition document for detailed information regarding the identification of SUD treatment needs.

For hospital readmission index event measures, the following methods were used to attribute a client to a service contracting entity in the measurement year:

- Area Agencies on Aging
 - Assigned to the reported AAA (PSA) as recorded in the CARE “Clientassignhistory” table in at least 11 of the 12 months up to/including the index discharge and in the month after discharge AND
 - Received ALTSA-funded in-home personal care services in at least 11 of the 12 months up to and including the index discharge and in the month after discharge
- Medicaid enrollees with mental health service needs (Behavioral Health Organizations)
 - Resided in the BHO service area in at least 11 of the 12 months up to/including the index discharge and in the month after discharge AND
 - Presented an indication of a mental health service need in the 24 months leading up to and including the index discharge and in the month after discharge
- Medicaid enrollees with substance use disorders (Behavioral Health Organizations)
 - Resided in the BHO service area in at least 11 of the 12 months up to/including the index discharge and in the month after discharge AND
 - Presented an indication of a substance use disorder treatment need in the 24 months leading up to and including the index discharge and in the month after discharge
- HCA Managed Care Organizations
 - Enrolled with the MCO in at least 11 of the 12 months up to/including the index discharge, and enrolled in the month after discharge

For the HCBS/Institutional balance measure, the following methods were used to attribute a client to a service contracting entity in the measurement year:

- Area Agencies on Aging
 - Assigned to the reported AAA (PSA) as recorded in the CARE “Clientassignhistory” table in the qualifying month of service
 - Received ALTSA-funded services in the qualifying month of service in one of the five modalities:
 - In-home personal care
 - Adult family home
 - Assisted living
 - Adult residential care
 - Nursing facility
- Medicaid enrollees with mental health service needs (Behavioral Health Organizations)
 - Resided in the BHO service area in the qualifying month of service
 - Presented an indication of a mental health service need in the 24 months leading up to and including the qualifying month of service
 - Received ALTSA-funded services in the qualifying month of service in one of the five modalities:
 - In-home personal care

- Adult family home
 - Assisted living
 - Adult residential care
 - Nursing facility
- Medicaid enrollees with substance use disorders (Behavioral Health Organizations)
 - Resided in the BHO service area in the qualifying month of service
 - Presented an indication of a substance use disorder treatment need in the 24 months leading up to and including the qualifying month of service
 - Received ALTSA-funded services in the qualifying month of service in one of the five modalities:
 - In-home personal care
 - Adult family home
 - Assisted living
 - Adult residential care
 - Nursing facility
 - HCA Managed Care Organizations
 - Enrolled with the MCO in the qualifying month of service
 - Received services from ALTSA in the qualifying month of service in one of the five modalities:
 - In-home personal care
 - Adult family home
 - Assisted living
 - Adult residential care
 - Nursing facility

For the ED utilization measure, the following methods were used to attribute a client to a service contracting entity in the measurement year:

- Area Agencies on Aging
 - Assigned to the reported AAA (PSA) as recorded in the CARE “Clientassignhistory” table continuously in the 6 months up to and including the qualifying service month AND
 - Received ALTSA-funded in-home personal care services continuously in the 6 months up to and including the qualifying service month
- Behavioral Health Organization Mental Health
 - Resided in the BHO service area continuously in the 6 months up to and including the qualifying service month AND
 - Presented an indication of a mental health service need in the 24 months leading up to and including the qualifying service month
- Behavioral Health Organization Substance Use Disorder
 - Resided in the BHO service area continuously in the 6 months up to and including the qualifying service month AND
 - Presented an indication of a substance use disorder treatment need in the 24 months leading up to and including the qualifying service month

Mental Health Service Penetration – Broad Measure Definition (MH-B)

December 27, 2016
Medicaid Version 1.5

Description

The percentage of members with a mental health service need who received mental health services in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 6 – 17, 18 – 64 and 65+
Continuous enrollment	The measurement year
Allowable gap	Member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year
Identification window	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months)
Benefit	Medicaid-only and dual eligibles excluding Part C enrollees Exclude persons with third-party liability (coverage)
Data sources	Medicaid MCO encounters and HCA-paid claims RSN/BHO encounter data and DBHR-paid behavioral health services CARE assessment diagnoses for identification of mental health service need Medicare Parts A and B claims and Medicare Part D encounters
Event/diagnosis	Members meeting the mental health service need criteria defined below
Claim status	Include only final paid claims or accepted encounters in measure calculation

Mental Health Service Need Definition

Mental health service need is identified by the occurrence of any of the following conditions:

1. Receipt of any mental health service meeting the numerator service criteria in the 24-month identification window
2. Any diagnosis of mental illness (not restricted to primary) in any of the categories listed in MH-Dx-value-set.xlsx in the 24-month identification window. These categories include:
 - a. Psychotic Diagnosis Set 101
 - b. Mania/Bipolar Diagnosis Set 102
 - c. Depression Diagnosis Set 103
 - d. Anxiety Diagnosis Set 104
 - e. ADHD Diagnosis Set 105
 - f. Disruptive/Impulse/Conduct Diagnosis Set 106
 - g. Adjustment Diagnosis Set 107
3. Receipt of any psychotropic medication listed in MH-Rx-value-set.xlsx in the 24-month identification window. These medications comprise the following drug therapy classes:
 - a. Antianxiety Rx
 - b. Antidepressants Rx
 - c. Antimania Rx
 - d. Antipsychotic Rx
 - e. ADHD Rx
4. Any claim with a service procedure code in the following set: 90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, H0004, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2035, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120
5. Any psychiatric inpatient stay in the following facility types: Community Psychiatric Hospital, Evaluation & Treatment Center, Child Long-Term Inpatient, Child Study Treatment Center, Eastern and Western State Hospital
6. A tribal mental health encounter paid through ProviderOne

Denominator

Include in the denominator all individuals in the eligible population with a mental health service need in the 24-month identification window.

Numerator

Include in the numerator all individuals receiving at least one mental health services meeting at least one of the following criteria in the 12-month measurement year:

TABLE 1.

Numerator Service Criteria

Criterion	Value Sets
Mental health service modality from RSN/BHO encounter data	crisis services, day support, engagement & outreach, family treatment, group treatment services, high intensity treatment, individual treatment services, intake evaluation, brief intervention treatment, medication management, medication monitoring, mental health clubhouse, peer support, psychological assessment, care coordination services, rehabilitation case management, special population evaluation, stabilization services, supported employment, therapeutic psychoeducation, case management, child family team meeting, co-occurring treatment, community transition, community based wraparound services, residential treatment services Note: Classification of outpatient or residential BHO services is based on procedure code and modifier field values defined in the applicable Service Encounter Reporting Instructions (SERI)
Tribal mental health encounter	A tribal mental health encounter paid through ProviderOne
Mental health provider taxonomy	Primary diagnosis code is a valid value in the MH-Dx-value-set.xlsx set AND Servicing provider taxonomy code is in the set: 101Y00000X, 101YM0800X, 101YP2500X, 103G00000X, 103T00000X, 103TB0200X, 103TC0700X, 103TC1900X, 103TC2200X, 103TF0000X, 103TH0100X, 103TP0016X, 103TP0814X, 103TP2700X, 103TP2701X, 103TR0400X, 104100000X, 1041C0700X, 106H00000X, 163WP0809X, 2080P0006X, 2084A0401X, 2084F0202X, 2084N0400X, 2084N0402X, 2084N0600X, 2084P0015X, 2084P0800X, 2084P0802X, 2084P0804X, 2084P0805X, 2084S0012X, 2084V0102X, 251S00000X, 261QM0801X, 273R00000X, 283Q00000X, 323P00000X, 363LP0808X, 364SP0808X
Mental health procedure code	90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, H0004, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2035, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120
Mental health condition management in primary care	Primary diagnosis code is a valid value in the MH-Dx-value-set.xlsx set AND Procedure code is in the set: 99201-99215 (Office), 99241-99255 (Consultation), or 99441-99444 (telephonic or online) AND (for Medicaid claims/encounters) Servicing provider taxonomy code is in the set: 101YA0400X, 101YM0800X, 101YP2500X, 103T00000X, 103TC0700X, 103TP0016X, 104100000X, 1041C0700X, 106H00000X,

163W00000X, 163WH0200X, 163WP0807X, 163WP0808X,
163WP0809X, 163WW0101X, 193200000X, 193400000X, 207LA0401X,
207LP2900X, 207P00000X, 207Q00000X, 207QA0000X, 207QA0401X,
207QA0505X, 207QG0300X, 207QH0002X, 207QS1201X, 207R00000X,
207RA0000X, 207RA0401X, 207RC0000X, 207RC0001X, 207RC0200X,
207RE0101X, 207RG0100X, 207RG0300X, 207RH0000X, 207RH0002X,
207RH0003X, 207RI0001X, 207RI0008X, 207RI0011X, 207RI0200X,
207RN0300X, 207RP1001X, 207RR0500X, 207RS0010X, 207RS0012X,
207RT0003X, 207RX0202X, 207V00000X, 207VC0200X, 207VG0400X,
207VM0101X, 207VX0000X, 207VX0201X, 208000000X, 2080A0000X,
2080H0002X, 2080P0006X, 2080P0008X, 2080P0201X, 2080P0202X,
2080P0204X, 2080P0205X, 2080P0206X, 2080P0207X, 2080P0208X,
2080P0210X, 2080P0214X, 2080P0216X, 2083P0901X, 2084A0401X,
2084F0202X, 2084N0400X, 2084N0402X, 2084P0015X, 2084P0800X,
2084P0802X, 2084P0804X, 2084P0805X, 208800000X, 208D00000X,
208M00000X, 208VP0000X, 208VP0014X, 251S00000X, 261Q00000X,
261QD1600X, 261QF0400X, 261QM0801X, 261QM1300X,
261QP0904X, 261QP0905X, 261QP2300X, 261QR0200X, 261QR0400X,
261QR0405X, 261QR1300X, 261QU0200X, 273R00000X, 282N00000X,
282NC0060X, 282NC2000X, 282NR1301X, 283Q00000X, 320800000X,
324500000X, 363LA2100X, 363LA2200X, 363LC1500X, 363LF0000X,
363LG0600X, 363LP0200X, 363LP0808X, 363LP1700X, 363LP2300X,
363LW0102X, 363LX0001X, 363LX0106X, 364S00000X, 364SF0001X,
364SP0808X, 367A00000X

For Medicare paid claims, allow any servicing provider taxonomy code
under this criterion

Service Contracting Entity: Medicaid Enrollees with Mental Health Service Needs
Medicaid Coverage Population: All Medicaid
Performance Measure: Mental Health Treatment Penetration - Broad Definition
 Dual Eligibles Included? Yes
 Third-party coverage included? No
 Age group 18+

October 26, 2016

Regional Service Area	OBSERVED			EXPECTED		
	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015
	1/13-12/13	1/14-12/14	1/15-12/15	1/13-12/13	1/14-12/14	1/15-12/15
Statewide	45.8%	44.1%	41.2%	45.8%	44.1%	41.2%
Greater Columbia	43.4%	41.8%	39.5%	41.5%	39.3%	36.8%
King	53.1%	49.6%	45.4%	50.6%	48.8%	45.1%
North Central	39.3%	38.3%	37.4%	41.7%	39.3%	37.0%
North Sound	46.6%	45.2%	40.8%	46.2%	44.6%	41.2%
Peninsula	44.9%	44.9%	42.6%	45.2%	43.9%	42.5%
Pierce	43.9%	42.2%	39.3%	46.8%	45.2%	42.2%
Southwest Washington	43.9%	40.8%	38.6%	43.6%	43.0%	40.6%
Spokane	39.8%	40.1%	39.5%	43.5%	41.9%	39.9%
Thurston-Mason	45.0%	42.3%	40.4%	44.8%	42.6%	40.2%
Timberlands	43.1%	43.8%	41.3%	42.2%	41.4%	38.6%

Regional Service Area	CY 2013		CY 2014		CY 2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
	Statewide	68,437	149,546	105,679	239,882	133,302
Greater Columbia	7,372	16,994	11,884	28,440	15,415	38,978
King	18,538	34,908	26,926	54,269	32,562	71,710
North Central	1,865	4,749	2,902	7,575	3,862	10,331
North Sound	9,907	21,265	15,938	35,283	19,804	48,543
Peninsula	3,727	8,306	6,022	13,407	7,715	18,106
Pierce	8,400	19,132	12,437	29,448	15,747	40,090
Southwest Washington	3,905	8,903	6,211	15,221	7,815	20,229
Spokane	7,403	18,604	11,957	29,790	15,912	40,301
Thurston-Mason	3,094	6,869	4,785	11,325	6,186	15,298
Timberlands	4,226	9,816	6,617	15,124	8,284	20,055

NOTES:

Different coverage groups have significantly different characteristics and experiences. Regions vary in the share of their caseloads comprised of different coverage groups. Reviewing trends and regional differences by major coverage group supports more valid comparisons of client experiences across regions. See the public reporting website for detailed information about measure specifications, attribution of clients to service contracting entities and guidance on interpretation of measure results. Information in subgroups with fewer than 10 clients in the denominator is suppressed.

Service Contracting Entity: Medicaid Enrollees with **Substance Use Disorder Treatment Needs**

Medicaid Coverage Population: All Medicaid

Performance Measure: Mental Health Treatment Penetration - Broad Definition

Dual Eligibles Included? Yes

Third-party coverage included? No

Age group 18+

October 26, 2016

Regional Service Area	CY 2013	CY 2014	CY 2015
	1/13-12/13	1/14-12/14	1/15-12/15
Statewide	57.7%	55.8%	51.2%
Greater Columbia	56.9%	55.9%	51.6%
King	65.2%	62.0%	55.9%
North Central	55.5%	53.4%	50.8%
North Sound	57.4%	55.6%	49.6%
Peninsula	54.9%	54.7%	51.6%
Pierce	55.8%	53.8%	49.0%
Southwest Washington	59.1%	53.5%	49.2%
Spokane	52.0%	52.5%	50.2%
Thurston-Mason	53.1%	49.4%	48.1%
Timberlands	53.7%	54.4%	50.1%

Regional Service Area	CY 2013		CY 2014		CY 2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
Statewide	25,306	43,869	37,874	67,929	50,345	98,251
Greater Columbia	2,621	4,603	4,037	7,222	5,516	10,683
King	6,560	10,061	9,145	14,753	11,420	20,420
North Central	699	1,259	1,014	1,899	1,433	2,821
North Sound	3,841	6,693	5,818	10,461	7,597	15,304
Peninsula	1,347	2,455	2,095	3,827	2,965	5,745
Pierce	3,179	5,701	4,559	8,477	6,187	12,618
Southwest Washington	1,476	2,499	2,229	4,163	2,909	5,910
Spokane	2,850	5,482	4,794	9,132	6,647	13,238
Thurston-Mason	1,090	2,054	1,640	3,321	2,324	4,830
Timberlands	1,643	3,062	2,543	4,674	3,347	6,682

NOTES:

Different coverage groups have significantly different characteristics and experiences. Regions vary in the share of their caseloads comprised of different coverage groups. Reviewing trends and regional differences by major coverage group supports more valid comparisons of client experiences across regions. See the public reporting website for detailed information about measure specifications, attribution of clients to service contracting entities and guidance on interpretation of measure results. Information in subgroups with fewer than 10 clients in the denominator is suppressed.

Psychiatric Inpatient Readmissions – Medicaid (PCR-P)

Description

For members 18 years of age and older, the proportion of acute inpatient psychiatric stays during the measurement year that were followed by an acute psychiatric readmission within 30 days. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of 30-Day Readmissions (numerator).

Note: Only members 18–64 years of age are reported.

Definitions

IHS	Index hospital stay. An acute psychiatric inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Include stays that meet the inclusion criteria in the denominator section. A client may have multiple qualifying discharges in the measurement period.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute psychiatric inpatient stay with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Classification Period	365 days prior to and including an Index Discharge Date.

Eligible Population

Ages	Age 18-64 as of the Index Discharge Date
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up one month during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge date.
Anchor date	Index Discharge Date.
Event/ diagnosis	An acute inpatient discharge on or between January 1 and December 1 of the measurement year.

The denominator for this measure is based on discharges, not members. Include all acute inpatient discharges for members who had one or more discharges on or between January 1 and December 1 of the measurement year.

Use the steps below to identify acute inpatient psychiatric stays.

Administrative Specification

Denominator The eligible population.

Step 1 Identify all acute inpatient psychiatric stays with a discharge date on or between January 1 and December 1 of the measurement year.

Include only acute admissions to behavioral healthcare facilities, as identified in Table 1 below.

Step 2 *Acute-to-acute transfers*: Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.

Step 3 Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4 Exclude stays with discharges for death from the observation set.

Step 5 Calculate continuous enrollment and determine whether the observation meets continuous enrollment criteria.

Table 1. Eligible Acute Inpatient Psychiatric Events

Event	Source
Community Psychiatric Hospital Admissions	ProviderOne
Evaluation & Treatment Center Admissions	ProviderOne, supplemented by DBHR Consumer Information System
Child Long-Term Inpatient Admissions	DBHR Consumer Information System
Child Study Treatment Center Admissions	DBHR Consumer Information System
Eastern and Western State Hospital Admissions	DBHR Consumer Information System

Numerator At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date from the facilities identified in Table 1.

Service Contracting Entity: Medicaid Enrollees with Mental Health Service Needs
 Medicaid Coverage Population: All Medicaid
 Performance Measure: Psychiatric Inpatient 30-Day Readmission
 Dual Eligibles Included? Yes
 Third-party coverage included? No
 Age group 18+

October 26, 2016

Regional Service Area	CY 2013	CY 2014	CY 2015
	1/13-12/13	1/14-12/14	1/15-12/15
Statewide	12.8%	13.4%	12.7%
Greater Columbia	9.9%	14.1%	10.4%
King	14.1%	15.4%	15.3%
North Central	12.5%	19.6%	13.5%
North Sound	12.4%	9.1%	11.6%
Peninsula	14.3%	9.7%	13.1%
Pierce	6.0%	13.9%	8.0%
Southwest Washington	7.1%	8.2%	12.0%
Spokane	16.8%	15.0%	13.8%
Thurston-Mason	5.7%	11.8%	9.4%
Timberlands	14.2%	11.4%	12.4%

Regional Service Area	CY 2013		CY 2014		CY 2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
Statewide	388	3,035	457	3,414	632	4,961
Greater Columbia	23	233	41	290	41	395
King	133	941	159	1,032	234	1,526
North Central	4	32	11	56	12	89
North Sound	43	348	41	450	76	654
Peninsula	22	154	14	145	31	236
Pierce	17	284	44	316	35	438
Southwest Washington	9	126	13	159	31	259
Spokane	110	653	97	648	113	816
Thurston-Mason	7	123	22	186	28	298
Timberlands	20	141	15	132	31	250

NOTES:

Different coverage groups have significantly different characteristics and experiences. Regions vary in the share of their caseloads comprised of different coverage groups. Reviewing trends and regional differences by major coverage group supports more valid comparisons of client experiences across regions. See the public reporting website for detailed information about measure specifications, attribution of clients to service contracting entities and guidance on interpretation of measure results. Information in subgroups with fewer than 10 clients in the denominator is suppressed.

Employment Rate Measure Definition (EMP)

December 27, 2016
Medicaid Version 1.2

Description

The percentage of Medicaid enrollees with any earnings reported in Employment Security Department (ESD) employment data in the measurement year.

These specifications are derived from a measure developed by the Washington State Department of Social and Health Services, in collaboration with Medicaid delivery system stakeholders, as part of the 5732/1519 performance measure development process.

Eligible Population

Ages	Separate reporting for age groups 18 – 64 and 65+
Minimum Medicaid enrollment	A minimum of 7 months of Medicaid enrollment is required in the measurement year.
Anchor date	December 31 of the measurement year for calendar-year reporting
Identification window for Behavioral Health Service Needs	January 1 of the year prior to the measurement year through December 31 of the measurement year (24 months) for calendar-year reporting. For quarterly reporting a comparable 24-month period is used, anchored to the end of quarterly reporting period.
Benefit	Medicaid
Service contracting entity attribution	For Behavioral Health Organization (BHO), Area Agency on Aging (AAA) and Managed Care Organization (MCO) reporting, members must meet the additional attribution criteria defined below: <ul style="list-style-type: none"> • BHO Mental Health populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator mental health need criteria specified in the Mental Health Service Penetration metric. • BHO Substance Use Disorder (SUD) populations must reside in the BHO catchment area for at least 7 months in the measurement year, and must meet the denominator SUD criteria specified in the SUD Treatment Penetration metric.

	<ul style="list-style-type: none"> • AAA populations must reside in the AAA catchment area for at least 7 months in the measurement year, and must receive Home- or Community-Based long-term services and supports in at least 7 months in the measurement year. • MCO populations must be enrolled with the MCO in at least 7 months in the measurement year.
<p>Claim status for service contracting entity attribution</p>	<p>Include only final paid claims or accepted encounters for BHO attribution.</p>

Denominator

Include in the measure denominator all individuals in the eligible population for the service contracting entity. In particular, note that persons who are dually eligible for Medicare or with Third-Party Liability (coverage) are included in the measure population.

Numerator

Include all members with at least one quarter in the measurement year with positive earnings recorded in ESD quarterly wage data. Note that ESD reported earnings data do not include self-employment, federal employment, or unreported earnings.

Service Contracting Entity: Medicaid Enrollees with **Mental Health** Service Needs
Medicaid Coverage Population: All Medicaid
Performance Measure: Percent Employed
 Dual Eligibles Included? Yes
 Third-party coverage included? Yes
 Age group 18+

October 26, 2016

Regional Service Area	CY 2013	CY 2014	CY 2015
	1/13-12/13	1/14-12/14	1/15-12/15
Statewide	18.6%	33.7%	38.8%
Greater Columbia	20.9%	38.2%	43.4%
King	16.6%	32.4%	37.2%
North Central	24.4%	42.3%	48.5%
North Sound	19.7%	35.2%	39.7%
Peninsula	17.8%	32.1%	37.1%
Pierce	19.7%	33.5%	39.3%
Southwest Washington	16.4%	30.0%	34.1%
Spokane	18.3%	33.3%	38.2%
Thurston-Mason	19.9%	33.4%	38.5%
Timberlands	17.1%	29.9%	34.7%

Regional Service Area	CY 2013		CY 2014		CY 2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
Statewide	37,991	203,952	111,909	331,686	154,734	399,174
Greater Columbia	4,631	22,151	14,325	37,532	20,032	46,118
King	7,942	47,765	24,609	76,001	33,268	89,523
North Central	1,538	6,311	4,409	10,430	6,096	12,573
North Sound	5,851	29,679	17,556	49,899	23,999	60,388
Peninsula	1,955	10,970	5,797	18,061	8,119	21,907
Pierce	5,300	26,937	14,013	41,857	19,967	50,744
Southwest Washington	1,962	11,936	6,171	20,589	8,316	24,387
Spokane	4,594	25,071	13,487	40,547	18,816	49,195
Thurston-Mason	1,914	9,641	5,312	15,910	7,495	19,478
Timberlands	2,304	13,491	6,230	20,860	8,626	24,861

NOTES:

Different coverage groups have significantly different characteristics and experiences. Regions vary in the share of their caseloads comprised of different coverage groups. Reviewing trends and regional differences by major coverage group supports more valid comparisons of client experiences across regions. See the public reporting website for detailed information about measure specifications, attribution of clients to service contracting entities and guidance on interpretation of measure results. Information in subgroups with fewer than 10 clients in the denominator is suppressed.

Service Contracting Entity: Medicaid Enrollees with Substance Use Disorder Treatment Needs

Medicaid Coverage Population: All Medicaid

Performance Measure: Percent Employed

Dual Eligibles Included? Yes

Third-party coverage included? Yes

Age group 18+

October 26, 2016

Regional Service Area	CY 2013	CY 2014	CY 2015
	1/13-12/13	1/14-12/14	1/15-12/15
Statewide	19.3%	33.3%	38.2%
Greater Columbia	22.2%	38.0%	43.4%
King	17.5%	32.4%	37.4%
North Central	25.6%	43.1%	48.5%
North Sound	21.6%	34.5%	38.5%
Peninsula	19.4%	32.2%	36.6%
Pierce	20.1%	32.5%	39.2%
Southwest Washington	17.7%	30.5%	34.9%
Spokane	17.2%	32.1%	36.7%
Thurston-Mason	19.5%	32.7%	38.1%
Timberlands	16.4%	29.4%	33.5%

Regional Service Area	CY 2013		CY 2014		CY 2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
Statewide	13,414	69,456	40,444	121,460	60,594	158,431
Greater Columbia	1,608	7,254	4,861	12,792	7,436	17,124
King	2,678	15,294	8,454	26,069	12,275	32,847
North Central	513	2,005	1,489	3,454	2,239	4,614
North Sound	2,323	10,751	6,590	19,090	9,427	24,504
Peninsula	758	3,900	2,222	6,900	3,396	9,269
Pierce	1,856	9,228	4,964	15,252	8,062	20,574
Southwest Washington	707	3,987	2,211	7,240	3,224	9,233
Spokane	1,472	8,552	5,043	15,701	7,552	20,580
Thurston-Mason	677	3,471	2,089	6,379	3,243	8,516
Timberlands	822	5,014	2,521	8,583	3,740	11,170

NOTES:

Different coverage groups have significantly different characteristics and experiences. Regions vary in the share of their caseloads comprised of different coverage groups. Reviewing trends and regional differences by major coverage group supports more valid comparisons of client experiences across regions. See the public reporting website for detailed information about measure specifications, attribution of clients to service contracting entities and guidance on interpretation of measure results. Information in subgroups with fewer than 10 clients in the denominator is suppressed.

Service Contracting Entity: Medicaid Enrollees with **Mental Health Service Needs**
Medicaid Coverage Population: All Medicaid
Performance Measure: Percent Arrested
 Dual Eligibles Included? Yes
 Third-party coverage included? Yes
 Age group 18+

October 26, 2016

Regional Service Area	CY 2013	CY 2014	CY 2015
	1/13-12/13	1/14-12/14	1/15-12/15
Statewide	7.1%	7.4%	7.7%
Greater Columbia	8.6%	8.6%	9.1%
King	7.2%	7.2%	7.5%
North Central	8.1%	7.7%	8.2%
North Sound	7.6%	7.5%	7.8%
Peninsula	6.7%	7.1%	6.8%
Pierce	6.6%	7.0%	7.1%
Southwest Washington	6.6%	7.2%	6.8%
Spokane	6.8%	7.4%	7.9%
Thurston-Mason	6.4%	7.6%	7.2%
Timberlands	6.2%	6.8%	8.4%

Regional Service Area	CY 2013		CY 2014		CY 2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
Statewide	14,579	203,952	24,640	331,686	30,806	399,174
Greater Columbia	1,895	22,151	3,245	37,532	4,191	46,118
King	3,456	47,765	5,510	76,001	6,740	89,523
North Central	513	6,311	808	10,430	1,025	12,573
North Sound	2,255	29,679	3,756	49,899	4,702	60,388
Peninsula	735	10,970	1,275	18,061	1,499	21,907
Pierce	1,768	26,937	2,924	41,857	3,608	50,744
Southwest Washington	786	11,936	1,487	20,589	1,663	24,387
Spokane	1,713	25,071	3,013	40,547	3,884	49,195
Thurston-Mason	620	9,641	1,205	15,910	1,410	19,478
Timberlands	838	13,491	1,417	20,860	2,084	24,861

NOTES:

Different coverage groups have significantly different characteristics and experiences. Regions vary in the share of their caseloads comprised of different coverage groups. Reviewing trends and regional differences by major coverage group supports more valid comparisons of client experiences across regions. See the public reporting website for detailed information about measure specifications, attribution of clients to service contracting entities and guidance on interpretation of measure results. Information in subgroups with fewer than 10 clients in the denominator is suppressed.

Service Contracting Entity: Medicaid Enrollees with Substance Use Disorder Treatment Needs

Medicaid Coverage Population: All Medicaid

Performance Measure: Percent Arrested

Dual Eligibles Included? Yes

Third-party coverage included? Yes

Age group 18+

October 26, 2016

Regional Service Area	CY 2013	CY 2014	CY 2015
	1/13-12/13	1/14-12/14	1/15-12/15
Statewide	17.9%	20.4%	19.9%
Greater Columbia	19.9%	23.3%	23.3%
King	19.4%	21.4%	21.1%
North Central	20.3%	21.7%	21.8%
North Sound	18.8%	21.5%	20.9%
Peninsula	16.5%	18.9%	16.8%
Pierce	15.9%	18.2%	17.7%
Southwest Washington	18.7%	21.3%	19.0%
Spokane	17.2%	19.4%	18.6%
Thurston-Mason	14.9%	19.6%	17.4%
Timberlands	14.4%	17.2%	19.6%

Regional Service Area	CY 2013		CY 2014		CY 2015	
	Numerator	Denominator	Numerator	Denominator	Numerator	Denominator
Statewide	12,417	69,456	24,812	121,460	31,506	158,431
Greater Columbia	1,444	7,254	2,980	12,792	3,986	17,124
King	2,974	15,294	5,583	26,069	6,921	32,847
North Central	408	2,005	751	3,454	1,006	4,614
North Sound	2,021	10,751	4,113	19,090	5,131	24,504
Peninsula	645	3,900	1,307	6,900	1,559	9,269
Pierce	1,466	9,228	2,772	15,252	3,639	20,574
Southwest Washington	747	3,987	1,543	7,240	1,752	9,233
Spokane	1,471	8,552	3,041	15,701	3,835	20,580
Thurston-Mason	517	3,471	1,248	6,379	1,484	8,516
Timberlands	724	5,014	1,474	8,583	2,193	11,170

NOTES:

Different coverage groups have significantly different characteristics and experiences. Regions vary in the share of their caseloads comprised of different coverage groups. Reviewing trends and regional differences by major coverage group supports more valid comparisons of client experiences across regions. See the public reporting website for detailed information about measure specifications, attribution of clients to service contracting entities and guidance on interpretation of measure results. Information in subgroups with fewer than 10 clients in the denominator is suppressed.



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

4. Access (Outpatient Penetration Rates)**

The proportion of Medicaid enrollees who received non-crisis outpatient MH services

Formula:

$$\frac{\text{Number of Medicaid clients receiving non-crisis outpatient MH services during time period}}{\text{Number of Medicaid eligible individuals during time period}}$$

Outpatient MH Penetration by Provider

Legend: DBH (blue line), KMHS (orange line), PBH (grey line), WEOS (yellow line), REGION (black dots), STATE (yellow dots)

Measurement

	REGION	DBH	KMHS	PBH	WEOS
CY 16					
JAN	4.4%	4.5%	4.3%	5.1%	3.8%
	3451/77714	313/6934	2171/50808	828/16149	147/3823
FEB	4.6%	4.4%	4.5%	5.1%	3.8%
	3615/78536	314/7090	2320/51238	840/16368	147/3840
MAR	4.8%	4.8%	4.6%	5.5%	4.3%
	3745/78493	339/7106	2357/51218	894/16348	166/3821
APR	4.7%	4.7%	4.5%	5.2%	4.2%
	3662/78736	336/7101	2313/51328	859/16460	160/3847
MAY	4.7%	4.6%	4.5%	5.2%	4.7%
	3683/78894	331/7174	2331/51365	851/16512	180/3843
JUN	4.7%	4.7%	4.6%	5.1%	4.1%
	3697/78914	334/7149	2369/51414	843/16486	160/3865
JUL	4.2%	4.8%	4.1%	4.5%	3.7%
	3348/78822	340/7062	2119/51353	751/16531	142/3876
AUG	4.4%	5.2%	4.2%	4.6%	3.5%
	3431/78859	367/7079	2168/51340	762/16558	136/3882
SEP	4.3%	5.1%	4.2%	4.5%	3.9%
	3397/78998	362/7067	2141/51508	750/16551	150/3872
OCT	4.4%	4.9%	4.3%	4.7%	4.3%
	3503/79187	349/7086	2221/51639	771/16573	167/3889
NOV	4.3%	5.1%	4.1%	4.5%	4.1%
	3411/79374	358/7081	2148/51824	749/16552	160/3917

Data Source: Profiler DW - RSNEncounterValid_2, Medicaid Eligible Population, SCOPE
Data Valid as of 3/1/2017
Target: Not yet available from the State - anticipated Spring 2017



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

3. Inpatient Utilization (Readmission Rate)**

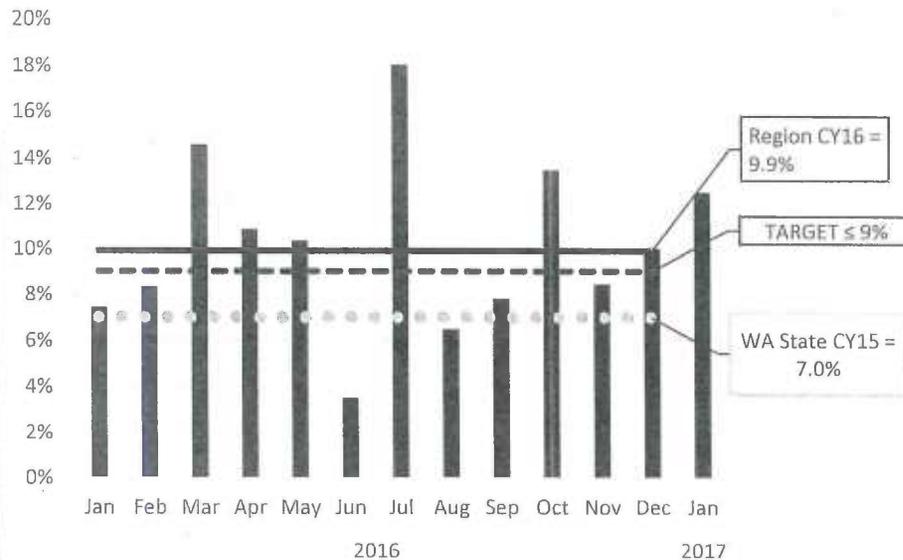
Percent of clients who were discharged from inpatient psychiatric care and were readmitted to inpatient psychiatric care within 30 days of discharge

Formula:

Number of clients readmitted to inpatient psychiatric care within 30 days of discharge within time period

Number of clients discharged from inpatient psychiatric care during time period

Region Psychiatric Inpatient Readmission Rate



Target: Within 2 points of the State's average for previous year
Source: Minimum performance standard

Measurement

	REGION	DBH	KMHS	PBH	WEOS
CY 15 TOTAL	9.1%	7.7%	9.0%	10.4%	3.8%
CY 16					
JAN	6/81	0/6	4/50	2/24	0/1
FEB	6/72	1/2	3/50	2/19	0/1
MAR	14/96	3/10	9/60	2/24	0/2
APR	10/92	1/5	5/65	4/20	0/2
MAY	9/87	2/11	7/50	0/23	0/3
JUN	3/85	0/11	1/54	2/17	0/3
JUL	11/61	1/4	8/42	1/14	1/1
AUG	5/77	0/8	4/55	1/12	0/2
SEP	5/64	0/4	4/43	1/16	0/1
OCT	12/89	2/13	9/56	1/17	0/3
NOV	7/83	1/6	5/57	1/16	0/4
DEC	8/80	2/9	4/49	2/21	0/1
CY 17					
JAN	9/72	2/12	7/43	0/14	0/3

Data Notes: Time period is calculated based on month of discharge from psychiatric inpatient facility. Review of data source pending.

Data Source: CommCare SBHO MH Readmissions Report, CommCare SBHO MH LOS Report, SCOPE. Data Valid as of 2/2017



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

2. Child and Family (C&F) Team Meetings*

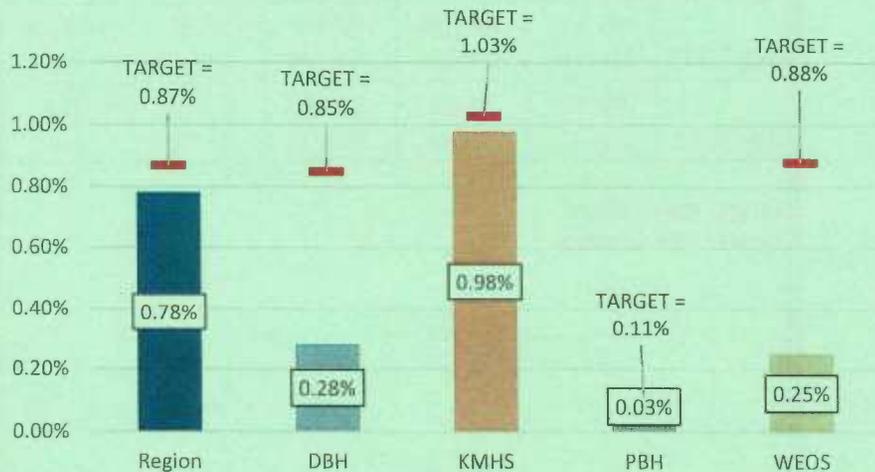
Rate of Child & Family team meetings encountered using the HT modifier

Formula:

Number of C&F team meetings (using HT modifier) that are recorded for children and youth under the age of 21 during time period

Number of children and youth services encountered in time period

Child & Family Team Meetings FY 2017* Average



*FY 2017 Average calculated from Quarters 1 and 2 2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
FY17 TARGET	0.87%	0.85%	1.03%	0.11%	0.88%
FY15 AVG	0.61%	1.02%	0.62%	0.03%	0.70%
FY16 AVG	0.79% 382/48398	0.77% 14/1818	0.94% 349/37321	0.10% 8/7881	0.80% 11/1378
1Q 2016	0.48% 51/10548	0.58% 3/520	0.57% 46/8035	0.12% 2/1726	0.00% 0/267
2Q 2016	1.01% 118/11667	1.22% 6/490	1.18% 105/8866	0.19% 4/2079	1.24% 3/242
3Q 2016	1.05% 138/13106	0.92% 3/325	1.26% 129/10199	0.09% 2/2177	0.99% 4/405
4Q 2016	0.57% 75/13067	0.41% 2/483	0.68% 69/10221	0.00% 0/1899	0.86% 4/464
1Q 2017	0.64% 68/10636	0.37% 2/539	0.80% 65/8149	0.00% 0/1639	0.32% 1/309
2Q 2017	0.91% 110/12052	0.18% 1/543	1.14% 107/9353	0.06% 1/1657	0.20% 1/499

Target: 10% increase over previous FY average
Source: QUIC designated target

Data Source: ProFiler Report - RSN Encounter Data Validation

Data Notes: HT Modifier indicates Multi-disciplinary team and is recorded by meeting lead only

Parameters: Encounters for children and youth under the age of 21

Data Valid as of 2/28/17



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

* Regional Performance Measure ** Core Performance Measure

Definition of Indicator and Measurement Standard

1. Crisis Response Timeliness*

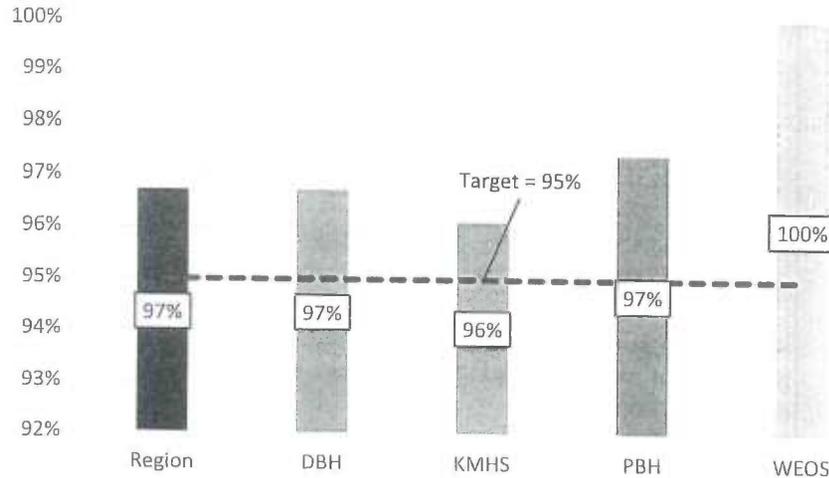
The percentage of crisis event face to face responses that occurred within 2 hours of request.

Formula:

$$\frac{\text{Number of crisis events where face to face response time was } \leq 2 \text{ hours from request during time period}}{\text{Number of crisis events for time period}}$$

Percentage of Crisis Responses within 2 hours of Request

1Q 2016 - 2Q 2017



Measurement

	REGION	DBH	KMHS	PBH	WEOS
FY	98.2%	94.3%	98.6%	98.2%	100.0%
1Q 2016	587/598	33/35	281/285	268/273	5/5
2Q 2016	95.8%	93.3%	94.6%	97.4%	100.0%
	644/672	42/45	295/312	299/307	8/8
3Q 2016	97.3%	96.4%	97.1%	97.8%	100.0%
	691/710	53/55	367/378	268/274	3/3
4Q 2016	98.2%	98.9%	97.7%	98.5%	100.0%
	658/670	88/89	301/308	265/269	4/4
1Q 2017	95.5%	100.0%	93.9%	96.5%	100.0%
	515/539	55/55	263/280	195/202	2/2
2Q 2017	95.2%	94.8%	94.8%	95.8%	N/A
	609/640	55/58	325/343	229/239	0/0

Target: 95% or above
Source: PIHP Contract

Data Source: ProFiler Report - Crisis Response Time by Agency
Data Notes: Numerator does not include crisis events that were non-emergent and/or pre-arranged.
Data Valid as of 2/16/17



SALISH BHO

ADVISORY BOARD MEETING

DATE: Friday, April 7, 2017
TIME: 10:00 AM – 12:00 PM
LOCATION: City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382

A G E N D A

<http://www.kitsapgov.com/hs/sbho/sbhoboard.htm>

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of January 27, 2017 and March 10, 2017 Minutes (Attachments 5.a, 5.b)
6. Action Item
 - a. Election of Board Officers
 - b. Washington Behavioral Health Council Annual Conference
7. Informational Items
 - a. Funding Issues
 - State Budget (Attachments 7.a.1, 7.a.2, 7.a.3, 7.a.4)
 - Actuarial Rates
 - b. SUD Practices
 - Provider Presentation
 - OST RFP
 - c. Integration
 - Health Care Authority (Attachments 7.c.1, 7.c.2)
 - BHO Budget Proviso (Attachment 7.c.3)
 - d. Quality Assurance (Attachment 7.d)
 - e. Board Priorities
8. Opportunity for Public Comment (limited to 3 minutes each)

9. Board Member Check-in

10. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHO	Behavioral Health Organization, replaced the Regional Support Network
CAP	Corrective Action Plan
CMHA	Community Mental Health Agency
CMS	Center for Medicaid & Medicare Services (federal)
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DDA	Developmental Disabilities Administration
DMHP	Designated Mental Health Professional
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FBG	Federal Block Grant (specifically MHBG and SABG)
FYSPT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IS	Information Services
ITA	Involuntary Treatment Act
LOC	Level of Care
MAT	Medical Assisted Treatment
LRA	Least Restrictive Alternative
MCO	Managed Care Organization
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QA, QI	Quality Assurance, Quality Improvement
QUIC	Quality Improvement Committee
QRT	Quality Review Team
RCW	Revised Code Washington
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SAPT	Substance Abuse Prevention Treatment
SBHO	Salish Behavioral Health Organization
SUD	Substance Use Disorder
UM	Utilization Management
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Go to <http://www.kitsapgov.com/hs/sbho/sbholicies.htm> for a full listing of definitions and acronyms

Salish Behavioral Health Organization

Agenda Briefings

April 7, 2017

6. Action Items

a. Election of Board Officers

A nominating committee was appointed at the December Advisory Board meeting to develop a slate of candidates for Chair and Vice Chair positions, with the election to be conducted at the following meeting. The Nominating Committee will provide their slate of candidates at the April meeting as a quorum was not present at the March meeting.

b. Washington Behavioral Health Council Annual Conference

The Washington Behavioral Health Council holds an annual conference which is usually attended by Board members who choose to attend. This year the conference is being held June 14 – 16 in Vancouver, Washington. Members are asked to decide who is interested in attending the conference so arrangements can be made.

7. Informational Items

a. Funding Issues

- State Budget

The House and Senate have each released their budgets for the 2017-2019 Biennium, and there are significant differences between them. Staff will outline the highlights and differences.

- Actuarial Rates

At the March meeting, staff outlined the Actuarial rate setting process and the draft rates that were distributed by the State in February. We expected that updated rates which accounted for utilization in IMDs would be provided by now, but BHOs have received no additional information. We have been told that we will be receiving a State-funded Per Member per Month capitation payment based upon the number of excluded months individuals were in IMDs during 2015. We do not know what that will be.

b. SUD Practices

- Provider Presentation

Several of the SBHOs Substance Use Disorder outpatient contractors will present on their services.

- OST RFP

The Request for Proposals for Opiate Substitution Treatment services has been released, with a due date in mid-May.

c. Integration

- HCA Integration Alternative

The Health Care Authority is pressing an alternative to the BHO proposal which provides Counties with an Advisory capacity in an integrated system. Their proposed language and a description of their alternatives is attached.

- BHO Budget Proviso

BHO representatives have been working with Legislators and legislative staff to craft language to include in a bill or as a Budget Proviso which would support the continued existence of BHOs as the state moves forward with full financial integration of healthcare. The current version of the language is attached, and staff will describe the current status.

d. Quality Assurance

Updated Regional Performance Measure reports are attached for the Board's information and review.

e. Board Priorities

Last year, the Board established priorities to work on in its initial year. These were: Healthcare Integration, Quality, SUD Practices, County 1/10th practices and use, and learning about the overall flow of funding. The Board is asked to re-examine these to determine if they remain the top priorities moving forward.

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**12:00 p.m., Friday, January 27, 2017
City of Sequim Civic Center Chambers
152 W Cedar Street, Sequim WA 38382**

CALL TO ORDER – John Freeburg, vice chair, called the meeting to order at 12:00 p.m. Russ Hartman, chair, assumed the role of chair upon his arrival.

INTRODUCTIONS – Self introductions.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS - None

APPROVAL OF THE AGENDA

Add under Action Items: 6.b Discussion of board survey regarding meeting dates.

Revised agenda was accepted without motion.

APPROVAL OF OCTOBER 28, 2016 MINUTES

MOTION: Helen Morrison moved to approve the minutes of the October 28, 2016 meeting as submitted. Lois Hoell seconded. Motion carried.

ACTION ITEMS

- Appointment of Nominating Committee for Board Officers
 - The following board members volunteered to participate in the Nominating Committee: Helen Morrison, Jennifer Kreidler-Moss, and Charles Pridgen. They will present their slate of officers at the March 3 meeting for a vote by the membership.
- Discussion of Board Schedule Survey
 - After much discussion and by majority vote, the board agreed to change the advisory board meeting dates to the first Friday of each month, beginning March 3 from 10 a.m. to 12 noon.
 - Meeting location will be determined once availability for the year is secured. (*Update: the SBHO Advisory Board is scheduled to meet in the City of Sequim Transit Center through the end of 2017*)

INFORMATION ITEM

- Background on Ombuds
 - Vivian Morey, Bridges Ombuds staff, provided the board with a brief overview of the services the Ombuds office provides, including serving as a liaison between consumers, their family members and network provider agencies, responding to and reporting grievances and, when possible, resolving issues at the lowest level possible. They provide education and referral to anyone calling into their office.

- Our region's Ombuds program has been in place for more than 20 years. The original contract was with the Dispute Resolution Center of Kitsap County to advocate for our clients and work independent of the region--that relationship continues today.
- It's been highly successful program and for many years was used by the state Ombuds Office as a shining example of how an Ombuds program should be run. Originally, the program served the region's mental health clients and providers; since April 2016, it serves the behavioral health program for both mental health and substance use disorder clients.
- They bridge the gap between the client and the provider. Staff supports clients through the grievance process, trying to resolve issues at the lowest level possible.
- Their reporting process is mandated by federal Medicaid law.

➤ BHO Integration Paper

- In 2014 the state legislature passed bill SSB 6312, which provides a framework for integrated healthcare (both physical and behavioral) in Washington State by 2020. The state executive branch, including the Health Care Authority and the Governor's office believes that also means integrating the funding streams. The Medicaid funding would be used to purchase services through Managed Care Organizations (MCOs).
- The state's BHOs developed the attached white paper to present to the state legislature in November 2016, believing there is a benefit to the involvement of locally based BHOs in the development and oversight of services to some of the most vulnerable populations in our state; if current legislation passes, the nine statewide BHOs will be eliminated by 2020.
- HB1388 proposes to move the Division of Behavioral Health and Recovery (DBHR) under the Healthcare Authority (HCA).
- The regional BHOs are advocating that DBHR doesn't get transferred to HCA and that the BHOs not be eliminated. If this legislation goes through, DBHR will lose its ability to advocate and require standards for mental health and substance use disorder services at the local level.

➤ 1115 Demonstration Grant Accountable Communities of Health Toolkit

- Elya Moore distributed some background information on Olympic Community of Health (OCH).
- Discussed the Medicaid Demonstration Transformation Project. In addition to the three required projects in Domain 1 (Value Based Payment, Workforce Development, and Population Health Management); there is one required project in each of Domains 2 and 3; and six optional projects.
- The state signed Special Terms and Conditions that stated if financing is not fully integrated by 2020, then funding for the transformation grants will cease.

➤ Opioid Project

- Funding for the project came through the Olympic Community of Health (OCH), which let a Request for Ideas to improve healthcare in our region. The SBHO submitted an Opioid Project and was awarded funding.
- Project funding was re-contracted back to OCH to hire Dr. Lisa Rey Thomas to oversee the project, who for the last seven months has been surveying community stakeholders, and collecting data to determine the scope of the problem in our region and options. The results of this information is being compiled into a final report which will be available in the near future.

➤ Substance Abuse Block Grant Funding

- Following the allocation of funding through the Request for Proposal process, the SBHO had an unallocated balance of \$304,000 in Substance Abuse Block Grant (SABG) funding.
- Staff reported that unallocated Block Grant funds cannot be carried over, like state funds, Because of the late issuance of contracts, contractors won't be able to spend all money available to them. To save funding, the SBHO will be extending SABG contracts for agencies with viable projects. Money not spent returns to the state.
- Staff was asked about integrated funding and programs for providers. Integrating mental health and substance use disorder programs is difficult at this point because the state has not rewritten the WACs and RCW to allow integration of funding and programs.

➤ Potential Funding Changes July 1

- In July, the Native American Exemption will cause an estimated 6% drop in BHO funding. There will be more discussion on this issue prior to the next budget development as this funding cut is unevenly distributed across the regional providers.
- IMDs (institutes for the mentally diseased) exemption will end June 30, 2017. Federal money can no longer be used for these services, which will need to be paid for with state funds.

➤ Western State Hospital (WSH)

- Psychiatric inpatient care will be changing as WSH will only be serving forensic inpatient services under the current plan put forth by the Executive Branch. Other patients will be forced into the community with no additional money to fund their care.
- In anticipation of this happening, large national corporations are building facilities to fill the need. BHOs will be on the hook for the costs associated with expensive inpatient care.

➤ Quality Assurance (QA)

- QA Staff reviewed the mental health quality indicators reports and answered questions from the board.

OPPORTUNITY FOR PUBLIC COMMENT - None

FOR THE GOOD OF THE ORDER

- Board Member Check-In: Russ thanked Linda for the updated pages for the board's member manuals; Jon asked about the board writing a letter to contact legislatures regarding some of the current issues discussed at today's meeting (staff suggested waiting to see what direction things would take); Russ asked that we discuss this issue with the executive board; Anne thanked Jon for always bringing the discussion back to the people we serve; Jennifer suggested that our BHO join with other BHOs, if we are going to approach the legislature; Board members thanked Linda for her work for the BHO and with the advisory board.
- Staff Report: The next meeting is Friday, March 3, at the City of Sequim Transit Center.

ADJOURNMENT - The meeting adjourned at 2:00 pm.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<u>Present</u> Roberta Charles Anne Dean John Freeburg Jolene George Russ Hartman Lois Hoell Jennifer Kreidler-Moss Helen Morrison Janet Nickolaus Charles Pridgen Steve Schermerhorn Mike Stringer Jon Stroup <u>Absent/Excused</u> Barbara Maxwell Catharine Robinson	Vivian Morey, Bridges Ombuds Ellen Epstein, RMH Services Ru Kirk, Discovery Behavioral Health Rebekah Miller, Peninsula Behavioral Health Tammey Newton, Jefferson County Public Health Andy Brastad, Clallam County HHS Kim Yacklin, Clallam County Health & Human Services Pam Brown, West End Outreach Services Joe Roszak, Kitsap Mental Health Services Elya Moore, Olympic Community of Health	Anders Edgerton Linda Ward Richelle Jordan Ileea Nehus

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**10:00 – 12:00 a.m., Friday, March 10, 2017
City of Sequim, Transit Center Meeting Room
190 W Cedar Street, Sequim WA 38382**

CALL TO ORDER – Russ Hartman, chair, called the meeting to order at 10:10 a.m.

INTRODUCTIONS – Self introductions.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS

Russell Hartman: Hearing no response from the public, meeting resumes according to the agenda.

APPROVAL OF THE AGENDA

Agenda was adjusted to place the approval of the January 27th, meeting minutes on hold, lacking a quorum to approve.

Revised agenda was approved without motion.

APPROVAL OF JANUARY 27, 2017 MINUTES - NOT APPROVED, set for approval in April 2017.

ACTION ITEMS

- Election of Board Officers will be held at the next meeting.
- Discussion of the SBHO Executive Board Schedule
 - The Board will reduce their meetings from six to four times per year. They are scheduled to meet in April, June, October, and December on the third Friday of the month from 9-11 a.m. Commissioner Robert Gelder to reside in place of Charlotte Garrido.

INFORMATION ITEM

- Funding Issues
 - Actuarial Rates: actuarial is an estimate of what services will cost in the future. They are rebased every four years. Actuaries are a calculated analysis that uses the number of services, salary, and time to develop service cost projections by adding services and dividing by member months, to calculate the rate in the base year. As long as rates are set by actuarials then the rates are set by services.
 - American Indian / Alaskan Native Exemption: In July mental health will be excluded from managed care, with services available from state providers. The state does not have requirements for “Adequate Service” with the fee for service option.
 - IMD: In July there will be a new federal rule with allowance of only 15 days per calendar month in Institutions for Mental Disease. If a stay is over 15 days the resident is no longer Medicaid eligible. No new state funds will be

available, this pushes care back to the communities.

- SUD Budget Update: Review of the Salish BHO Use Disorder Budget Report

➤ SUD Practices

- Executive Board Action on Opioid Issues: RFP Opioid Substitution Treatment DRAFT is available and ready for review. Clallam and Jefferson are currently bidding on two methadone clinics. There are three entities interested, creating competition. Currently, people are sent to Tacoma to receive services from the Daily Dose Project, the county has had to pay to transport people without a local option available. The RFP is asking for Vivitrol and Suboxone to be included. Members of the Committee will meet to discuss any further additions or revisions.

➤ Integration

- 1115 Demonstration Grant Announcement: There are currently six demonstration projects that the Olympic Communities of Health are focusing on to promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP). The purpose of these demonstrations, allows states additional flexibility to design and improve their programs and evaluate policy approaches.
 - Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
 - Providing services not typically covered by Medicaid; or
 - Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.
- For more information or to receive the OCH Newsletter contact elya@olympicch.org
- Provider Integration Efforts: Overall state initiative to integrate Substance Abuse Disorders and Mental Health with all funding going through managed care. In moving forward there are unanswered questions concerning who will be accountable when the money is distributed, and the infrastructure of the system in general.

➤ Quality Assurance

- Richelle Jordan gave a presentation on the states data. She described how counties compare with other regions in health care.

➤ County Sales Tax Efforts

- Russell Hartman Discussed next steps of BHO's and 1/10 groups coming together as active participants towards same goals. He mentioned encouraging 1/10th representatives from other counties to align in discussion of best practices and to organize efforts.

- **Russ Hartman, Board Chair**, spoke to the Executive Board's interest by asking for the committee to be thinking about what they want to present in April. Including that elections would take place next meeting.

OPPORTUNITY FOR PUBLIC COMMENT

- None

FOR THE GOOD OF THE ORDER

- Board Member Check-In: Freida Fenn, stated how she was happy to be here.
- Staff Report: The next meeting is Friday, April 7, at the City of Sequim, Transit Center

ADJOURNMENT - The meeting adjourned at 12:02 pm.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<p><u>Present</u> Freida Fenn John Freeburg Russ Hartman Jennifer Kreidler-Moss Helen Morrison Jon Stroup</p> <p><u>Absent/Excused</u> Barbara Maxwell</p>	<p>Heather Lewis, Bridges Ombuds Vivian Morey, Bridges Ombuds Elya Moore, Olympic Community of Health Joe Roszak, Kitsap Mental Health Services Adam Marquis, Jefferson Mental Health Services Wendy Sisk, Peninsula Behavioral Health Pam Brown, West End Outreach Services Ford Kessler, Safe Harbor/Beacon of Hope Kim Yacklin, Clallam County Health & Human Services Danine Johnson, West Sound Treatment Center Marlisa Thoman, West Sound Treatment Center Jaymie Doane, Klallam Counseling Rosie Boyd, Klallam Counseling Anna McEnery, Jefferson Co. Public Health Andy Brastad, Clallam Co. Health and Human Services Ellen Epstein, RMH Services</p>	<p>Anders Edgerton Hannah Shockley Richelle Jordan Ileea Nehus</p>

2017-19 Omnibus Operating Budget

Changed Items

(Dollars In Thousands)

	House Floor Striker to ESSB 5048		ESSB 5048 Senate Floor Passed		Difference	
	NGF-P	Total	NGF-P	Total	NGF-P	Total
Juvenile Rehabilitation						
<i>Policy Items</i>						
279. Facilities One-Time Costs	31	31	0	0	31	31
280. Gang Prevention and Intervention	200	200	0	0	200	200
281. Juvenile Block Grant Research	196	196	0	0	196	196
282. Juvenile Gang and Firearm Data	150	150	75	75	75	75
283. Team Child	610	610	100	100	510	510
Total	1,187	1,187	175	175	1,012	1,012
Mental Health						
<i>Policy Items</i>						
284. BH Integration Efficiencies	-546	-780	0	0	-546	-780
285. BH: Adult Street Outreach	1,660	1,660	0	0	1,660	1,660
286. BH: Crisis Walk-in Centers	2,286	3,600	6,858	10,881	-4,572	-7,281
287. BH: Housing and Stepdown Services	2,762	2,762	0	0	2,762	2,762
288. BH: Inpatient Psychiatric Increase	9,918	18,126	3,660	10,512	6,258	7,614
289. BH: Integration Transfer	-829,980	-1,910,659	0	0	-829,980	-1,910,659
290. BH: Mobile Crisis Teams	1,238	1,650	0	0	1,238	1,650
291. BH: Stepdown Residential Program	2,265	4,859	0	0	2,265	4,859
292. BH: SUD Treatment & Peer Support	0	0	774	774	-774	-774
293. BH: SUD Treatment	1,460	1,460	0	0	1,460	1,460
294. BHO Medicaid Rates	16,065	50,843	0	0	16,065	50,843
295. Children's Mental Health	0	0	62	103	-62	-103

2017-19 Omnibus Operating Budget
Changed Items
 (Dollars In Thousands)

	House Floor Striker to ESSB 5048		ESSB 5048 Senate Floor Passed		Difference	
	NGF-P	Total	NGF-P	Total	NGF-P	Total
296. Civil Ward Conversions	794	1,119	0	0	794	1,119
297. Civil Ward Underspend	-7,578	-7,578	0	0	-7,578	-7,578
298. Civil Wards at WSH	0	0	-3,369	-3,369	3,369	3,369
299. Clubhouses	0	0	1,500	3,000	-1,500	-3,000
300. Community Long-Term Inpatient Beds	8,733	18,612	0	0	8,733	18,612
301. Community Policing Program	159	159	428	428	-269	-269
302. Equipment and Software Licenses	552	552	0	0	552	552
303. Facilities One-Time Costs	1	1	0	0	1	1
304. Forensic Mental Health Office	886	886	1,170	1,170	-284	-284
305. Hospital Compliance	42,172	42,172	52,716	52,716	-10,544	-10,544
306. Hospital Overspend	20,000	20,000	0	0	20,000	20,000
307. Initiative 1433 Minimum Wage	-3,735	-17,833	0	0	-3,735	-17,833
308. Medicaid Transformation Waiver	0	19,557	0	0	0	19,557
309. Private BH Community Hospital beds	0	0	5,571	10,512	-5,571	-10,512
310. SBC Underspend	0	0	-9,680	-14,892	9,680	14,892
311. Single Bed Certification	-9,680	-14,892	0	0	-9,680	-14,892
312. Tribal Behavioral Health E&T Plan	300	300	0	0	300	300
313. Tribal Fee-for-Service Staffing	445	740	296	492	149	248
314. Trueblood Court Monitor	0	0	200	200	-200	-200
315. Zero-based budget review	0	0	0	325	0	-325
Total	-739,823	-1,762,684	60,186	72,852	-800,009	-1,835,536



BHA - Mental Health 2017-19 Biennial Budget Comparison

	Governor's Budget - Version 41			Senate Budget - Version 44			Governor / Senate Variance					
	FTE	GF-State	Other	Total	FTE	GF-State	Other	Total	FTE	GF-State	Other	Total
Tribal Behavioral Health E&T Plan	0.0	300	0	300	0.0	0	0	0	0.0	(300)	0	(300)
Integration Transfer	(64.4)	(800,479)	(1,078,915)	(1,879,394)	0.0	0	0	0	64.4	800,479	1,078,915	1,879,394
SBC Underspend	0.0	0	0	0	0.0	(9,680)	(5,212)	(14,892)	0.0	(9,680)	(5,212)	(14,892)
Reduce BHO Non-Medicaid Reserves	0.0	(5,800)	0	(5,800)	0.0	0	0	0	0.0	5,800	0	5,800
Private BH Community Hospital Beds	0.0	0	0	0	0.0	5,571	4,941	10,512	0.0	5,571	4,941	10,512
Medicaid Transformation Waiver	0.0	0	19,557	19,557	0.0	0	0	0	0.0	0	(19,557)	(19,557)
Tribal Fee-for-Service Staffing	3.0	445	295	740	2.0	296	196	492	(1.0)	(149)	(99)	(248)
Children's Mental Health (HB 1713)	0.0	0.0	0	0	0.5	62	41	103	0.5	62	41	103
State Hospitals:												
Alternative Restoration Contracts	0.0	0	0	0	0.0	6,352	0	6,352	0.0	6,352	0	6,352
Forensic Mental Health Office	0.0	0	0	0	2.0	1,170	0	1,170	2.0	1,170	0	1,170
Trueblood Court Monitor	0.0	0	0	0	0.0	200	0	200	0.0	200	0	200
Civil Wards at WSH	0.0	0	0	0	0.0	(3,369)	0	(3,369)	0.0	(3,369)	0	(3,369)
Contracted Forensic Beds	0.0	0	0	0	0.0	9,180	0	9,180	0.0	9,180	0	9,180
Hepatitis C Treatment Costs	0.0	306	87	393	0.0	306	87	393	0.0	0	0	0
Hospital Compliance	137.0	52,716	0	52,716	137.0	52,716	0	52,716	0.0	0	0	0
State Community BH Hospitals	166.9	8,027	3,233	11,260	0.0	0	0	0	(166.9)	(8,027)	(3,233)	(11,260)
Step Down Housing	0.0	4,556	0	4,556	0.0	0	0	0	0.0	(4,556)	0	(4,556)
SUD Treatment & Peer Support	21.0	3,480	0	3,480	3.0	774	0	774	(18.0)	(2,706)	0	(2,706)
Community Policing Program	0.0	159	0	159	0.0	428	0	428	0.0	269	0	269
Facilities One-Time Costs	0.0	1	0	1	0.0	0	0	0	0.0	(1)	0	(1)
BHA-Wide:												
Zero-based budget review	0.0	0	0	0	0.5	0	325	325	0.5	0	325	325
"Back of the Budget" Items:												
State Public Employee Benefits Rate	0.0	681	48	729	0.0	0	0	0	0.0	(681)	(48)	(729)
WFSE General Government	0.0	35,718	2,777	38,495	0.0	0	0	0	0.0	(35,718)	(2,777)	(38,495)
State Represented Emp Benefit Program	0.0	7,817	572	8,389	0.0	0	0	0	0.0	(7,817)	(572)	(8,389)
The Coalition of Unions Agreement	0.0	7,878	631	8,509	0.0	0	0	0	0.0	(7,878)	(631)	(8,509)
Non-Rep General Wage Increases	0.0	1,731	121	1,852	0.0	0	0	0	0.0	(1,731)	(121)	(1,852)
Non-Rep Targeted Pay Increases	0.0	1,943	145	2,088	0.0	0	0	0	0.0	(1,943)	(145)	(2,088)
WFSE Orca Transit Pass	0.0	2	0	2	0.0	0	0	0	0.0	(2)	0	(2)
Gen Govt SEIU 1199 Agreement	0.0	20,852	1,546	22,398	0.0	0	0	0	0.0	(20,852)	(1,546)	(22,398)
Vacation Leave Change - Non-rep	0.0	6	0	6	0.0	0	0	0	0.0	(6)	0	(6)
Policy Level Total	263.5	(630,576)	(1,009,321)	(1,639,897)	145.0	76,027	12,753	88,780	(118.5)	706,603	1,022,074	1,728,677
2017-19 Total	3,468.2	647,610	205,148	852,758	3,334.7	1,305,970	1,236,430	2,542,400	(133.5)	658,360	1,031,282	1,689,642



BHA - Mental Health 2017-19 Biennial Budget Comparison

	Governor's Budget - Version 41			Senate Budget - Version 44			Governor / Senate Variance					
	FTE	GF-State	Other	Total	FTE	GF-State	Other	Total	FTE	GF-State	Other	Total
Carry Forward Base	3,028.5	1,111,898	1,296,899	2,408,797	3,028.5	1,111,898	1,296,899	2,408,797	0.0	0	0	0
Maintenance Level												
Community Programs:												
Mandatory Caseload Adjustments	0.0	27,074	(68,022)	(40,948)	0.0	5,062	15,078	20,140	0.0	(22,012)	83,100	61,088
FMAP Changes	0.0	15,897	(15,897)	0	0.0	14,567	(14,567)	0	0.0	(1,330)	1,330	0
BHO Rate Adjustment	0.0	(17,933)	28,965	11,032	0.0	29,878	(53,625)	(23,747)	0.0	47,811	(82,590)	(34,779)
IMD Federal Rule Change	0.0	18,106	(18,106)	0	0.0	31,724	0	31,724	0.0	13,618	18,106	31,724
WiSe Caseload & Rates Adjustment	0.0	12,249	12,248	24,497	0.0	0	0	0	0.0	(12,249)	(12,248)	(24,497)
Secure Detox Facilities	0.0	0	0	0	0.0	(330)	(455)	(785)	0.0	(330)	(455)	(785)
Actuarial Rate Rebase Study	0.0	500	500	1,000	0.0	154	154	308	0.0	(346)	(346)	(692)
EQRO Federal Matching Rate	0.0	390	0	390	0.0	126	(126)	0	0.0	(264)	(126)	(390)
State Hospitals:												
Hospital Revenue Adjustment	0.0	(4,442)	4,442	0	0.0	(5,685)	5,685	0	0.0	(1,243)	1,243	0
Utility Rate Adjustment	0.0	330	0	330	0.0	(784)	0	(784)	0.0	(1,114)	0	(1,114)
Institution Vehicle Replacement	0.0	305	0	305	0.0	305	0	305	0.0	0	0	0
Facility Maintenance Costs	0.0	81	0	81	0.0	81	0	81	0.0	0	0	0
Equipment Replacement Costs	0.0	1,103	0	1,103	0.0	0	0	0	0.0	(1,103)	0	(1,103)
Food and Medical Adjustments	0.0	308	0	308	0.0	407	0	407	0.0	99	1,194	99
Disproportionate Share Hospital	0.0	27,815	(27,815)	0	0.0	26,621	(26,621)	0	0.0	(1,194)	1,194	0
Hospital Transitional Funding	0.0	48,358	0	48,358	0.0	0	0	0	0.0	(48,358)	0	(48,358)
Alternative Restoration Treatment	9.0	9,582	0	9,582	0.0	0	0	0	(9.0)	(9,582)	0	(9,582)
State Hospital Waitlist Reduction	26.7	17,872	608	18,480	0.0	0	0	0	(26.7)	(17,872)	(608)	(18,480)
E&T Discharge Planners	0.0	0	0	0	0.0	2,432	608	3,040	0.0	2,432	608	3,040
Forensic Evaluators	0.0	0	0	0	7.0	1,886	0	1,886	7.0	1,886	0	1,886
NGRI Capacity	0.0	0	0	0	9.7	2,006	0	2,006	9.7	2,006	0	2,006
Civil Inpatient Staff	0.0	0	0	0	4.0	902	0	902	4.0	902	0	902
ML Rate and Technical Adjustments:												
Lease Adjustment < 20,000 sq ft	0.0	256	19	275	0.0	256	19	275	0.0	0	0	0
Pension and DRS Rate Changes	0.0	5,386	394	5,780	0.0	5,386	394	5,780	0.0	0	0	0
Technical Corrections	0.0	2,904	212	3,116	0.0	2,904	212	3,116	0.0	0	0	0
Transfers	140.5	(126)	2	(124)	140.5	(126)	2	(124)	0.0	0	0	0
Workers Compensation	0.0	273	20	293	0.0	273	20	293	0.0	0	0	0
Maintenance Level Total	176.2	166,288	(82,430)	83,858	161.2	118,045	(73,222)	44,823	(15.0)	(48,243)	9,208	(39,035)
Policy Level												
Community Programs:												
Personal Needs Allowance	0.0	0	0	0	0.0	3	0	3	0.0	3	0	3
Clubhouses	0.0	0	0	0	0.0	1,500	1,500	3,000	0.0	1,500	1,500	3,000
Crisis Walk-in Centers	0.0	2,286	1,314	3,600	0.0	6,858	4,023	10,881	0.0	4,572	2,709	7,281
Housing and Stepdown Services	0.0	2,762	0	2,762	0.0	0	0	0	0.0	(2,762)	0	(2,762)
Mobile Crisis Teams	0.0	3,712	1,238	4,950	0.0	0	0	0	0.0	(3,712)	(1,238)	(4,950)
Inpatient Psychiatric Increase	0.0	20,325	38,030	58,355	0.0	3,660	6,852	10,512	0.0	(16,665)	(31,178)	(47,843)



BHA - Alcohol and Substance Abuse 2017-19 Biennial Budget Comparison

	Governor's Budget - Version 41			Senate Budget - Version 44			Governor / Senate Variance					
	FTE	GF-State	Other	Total	FTE	GF-State	Other	Total	FTE	GF-State	Other	Total
Carry Forward Base	75.3	132,318	666,788	799,106	75.3	132,318	666,788	799,106	0.0	0	0	0
Maintenance Level Changes:												
Mandatory Caseload Adjustments	0.0	(1,004)	5,306	4,302	0.0	(3,199)	3,973	774	0.0	(2,195)	(1,333)	(3,528)
FMAP Changes	0.0	9,772	(9,772)	0	0.0	9,237	(9,237)	0	0.0	(535)	535	0
BHO Rate Adjustment	0.0	4,431	(8,771)	(4,340)	0.0	(6,130)	(30,554)	(36,684)	0.0	(10,561)	(21,783)	(32,344)
IMD Federal Rule Change	0.0	25,680	(25,680)	0	0.0	26,544	0	26,544	0.0	864	25,680	26,544
Secure Detox Facilities	0.0	3,680	2,446	6,126	0.0	3,141	2,300	5,441	0.0	(539)	(1,46)	(685)
ML Rate and Technical Adjustments:												
Lease Adjustments < 20,000 sq. ft.	0.0	(119)	(27)	(146)	0.0	(119)	(27)	(146)	0.0	0	0	0
Technical Corrections	0.0	(10)	(2)	(12)	0.0	(10)	(2)	(12)	0.0	0	0	0
Workers Compensation	0.0	1	0	1	0.0	1	0	1	0.0	0	0	0
Pension and DRS Rate Changes	0.0	148	34	182	0.0	148	34	182	0.0	0	0	0
Transfers	0.0	4	0	4	0.0	4	0	4	0.0	0	0	0
Maintenance Level Total	0.0	42,583	(36,466)	6,117	0.0	29,617	(33,513)	(3,896)	0.0	(12,966)	2,953	(10,013)
Policy Level												
Prevent Opioid Overdose Death Grant	0.0	0	2,250	2,250	0.0	0	2,250	2,250	0.0	0	0	0
Opioid STR Grant	0.0	0	0	0	0.0	0	21,664	21,664	0.0	0	21,664	21,664
Integration Transfer	(75.3)	(175,565)	(632,722)	(808,287)	0.0	0	0	0	1.0	175,565	632,722	808,287
"Back of the Budget" Items:												
State Public Employee Benefits Rate	0.0	127	29	156	0.0	0	0	0	0.0	(127)	(29)	(156)
WFSE General Government	0.0	165	37	202	0.0	0	0	0	0.0	(165)	(37)	(202)
State Represented Emp Benefits Rate	0.0	56	13	69	0.0	0	0	0	0.0	(56)	(13)	(69)
Non-Rep General Wage Increase	0.0	314	71	385	0.0	0	0	0	0.0	(314)	(71)	(385)
Orca Transit Pass - Not WFSE	0.0	2	0	2	0.0	0	0	0	0.0	(2)	0	(2)
Policy Level	(75.3)	(174,901)	(630,322)	(805,223)	0.0	0	23,914	23,914	75.3	174,901	654,236	829,137
2017-19 Total	0.0	0	0	0	75.3	161,935	657,189	819,124	75.3	161,935	657,189	819,124

3	(1) MEDICAL ASSISTANCE	
4	General Fund—State Appropriation (FY 2018)	\$2,625,124,000
5	General Fund—State Appropriation (FY 2019)	\$2,740,491,000
6	General Fund—Federal Appropriation	\$13,515,963,000
7	General Fund—Private/Local Appropriation	\$269,449,000
8	Emergency Medical Services and Trauma Care Systems	
9	Trust Account—State Appropriation	\$15,086,000
10	Hospital Safety Net Assessment Account—State	
11	Appropriation	\$725,012,000
12	Medicaid Fraud Penalty Account—State Appropriation	\$18,450,000
13	Dedicated Marijuana Account—State Appropriation	
14	(FY 2018)	\$44,117,000
15	Dedicated Marijuana Account—State Appropriation	
16	(FY 2019)	\$45,439,000
17	Medical Aid Account—State Appropriation	\$528,000
18	Criminal Justice Treatment Account—State Appropriation. .	\$12,978,000
19	Problem Gambling Account—State Appropriation.	\$1,453,000
20	TOTAL APPROPRIATION.	\$20,014,090,000

21 The appropriations in this section are subject to the following
22 conditions and limitations:

23 (a) PHYSICAL HEALTH CARE

24 (i) Sufficient amounts are appropriated in this subsection to
25 implement the medicaid expansion as defined in the social security
26 act, section 1902(a)(10)(A)(i)(VIII).

27 (ii) Medicaid payment rates, as calculated by the health care
28 authority pursuant to the appropriations in this act, bear a
29 reasonable relationship to the costs incurred by efficiently and
30 economically operated facilities for providing quality services and
31 will be sufficient to enlist enough providers so that care and
32 services are available to the extent that such care and services are
33 available to the general population in the geographic area. The
34 legislature finds that the cost reports, payment data from the
35 federal government, historical utilization, economic data, and
36 clinical input constitute reliable data upon which to determine the
37 payment rates.

38 (iii) Based on quarterly expenditure reports and caseload
39 forecasts, if the health care authority estimates that expenditures

1 is not enacted by June 30, 2017, the amounts provided in this
2 subsection shall lapse.

3 (2) \$12,000 of the general fund—state appropriation for fiscal
4 year 2018, \$12,000 of the general fund—state appropriation for fiscal
5 year 2019, and \$24,000 of the general fund—federal appropriation are
6 provided solely for the implementation of Second Substitute House
7 Bill No. 1402 (incapacitated persons/rights). If the bill is not
8 enacted by June 30, 2017, the amounts provided in this subsection
9 shall lapse.

10 NEW SECTION. **Sec. 212. FOR THE STATE HEALTH CARE AUTHORITY**

11 During the 2017-2019 fiscal biennium, the health care authority
12 shall provide support and data as required by the office of the state
13 actuary in providing the legislature with health care actuarial
14 analysis, including providing any information in the possession of
15 the health care authority or available to the health care authority
16 through contracts with providers, plans, insurers, consultants, or
17 any other entities contracting with the health care authority.

18 Information technology projects or investments and proposed
19 projects or investments impacting time capture, payroll and payment
20 processes and systems, eligibility, case management, and
21 authorization systems within the health care authority are subject to
22 technical oversight by the office of the chief information officer.

23 The health care authority shall not initiate any services that
24 require expenditure of state general fund moneys unless expressly
25 authorized in this act or other law. The health care authority may
26 seek, receive, and spend, under RCW 43.79.260 through 43.79.282,
27 federal moneys not anticipated in this act as long as the federal
28 funding does not require expenditure of state moneys for the program
29 in excess of amounts anticipated in this act. If the health care
30 authority receives unanticipated unrestricted federal moneys, those
31 moneys shall be spent for services authorized in this act or in any
32 other legislation providing appropriation authority, and an equal
33 amount of appropriated state general fund moneys shall lapse. Upon
34 the lapsing of any moneys under this subsection, the office of
35 financial management shall notify the legislative fiscal committees.
36 As used in this subsection, "unrestricted federal moneys" includes
37 block grants and other funds that federal law does not require to be

1 the University of Washington tele-pain pain management program and
2 pain management call center to advance primary care provider
3 knowledge of complex pain management issues, including opioid
4 addiction.

5 (b) BEHAVIORAL HEALTH

6 (i) For the purposes of this subsection, amounts provided for
7 behavioral health organizations shall also be available for the
8 authority to contract with entities that assume the responsibilities
9 of behavioral health organizations in regions in which the authority
10 is purchasing medical and behavioral health services through fully
11 integrated contracts pursuant to RCW 71.24.380.

12 (ii) The authority shall evaluate adding a tele-pyschiatry
13 consultation benefit for medicaid covered individuals. The authority
14 shall submit a report with the cost associated with adding such a
15 benefit to the governor and appropriate committees of the legislature
16 by October 1, 2017.

17 (iii) \$6,590,000 of the general fund—state appropriation for
18 fiscal year 2018, \$6,590,000 of the general fund—state appropriation
19 for fiscal year 2019, and \$7,620,000 of the general fund—federal
20 appropriation are provided solely for the authority and behavioral
21 health organizations to continue to contract for implementation of
22 high-intensity programs for assertive community treatment (PACT)
23 teams. In determining the proportion of medicaid and nonmedicaid
24 funding provided to behavioral health organizations with PACT teams,
25 the authority shall consider the differences between behavioral
26 health organizations in the percentages of services and other costs
27 associated with the teams that are not reimbursable under medicaid.
28 The authority may allow behavioral health organizations which have
29 nonmedicaid reimbursable costs that are higher than the nonmedicaid
30 allocation they receive under this section to supplement these funds
31 with local dollars or funds received under section 212(1)(b)(xvi) of
32 this act. The authority and behavioral health organizations shall
33 maintain consistency with all essential elements of the PACT
34 evidence-based practice model in programs funded under this section.

35 (iv) From the general fund—state appropriations in this
36 subsection, the authority shall assure that behavioral health
37 organizations reimburse the department of social and health services
38 aging and long term support administration for the general fund—state
39 cost of medicaid personal care services that enrolled behavioral

1 health organization consumers use because of their psychiatric
2 disability.

3 (v) \$3,520,000 of the general fund—federal appropriation is
4 provided solely for the authority to maintain a pilot project to put
5 peer bridging staff into each behavioral health organization as part
6 of the state psychiatric liaison teams to promote continuity of
7 service as individuals return to their communities. The authority
8 must collect data and submit a report to the office of financial
9 management and the appropriate committees of the legislature on the
10 impact of peer staff on state hospital discharges and community
11 placements by December 1, 2017.

12 (vi) \$2,000,000 of the general fund—state appropriation for
13 fiscal year 2018, \$4,286,000 of the general fund—state appropriation
14 for fiscal year 2019, and \$1,726,000 of the general fund—federal
15 appropriation are provided solely for enhancement of community mental
16 health services. These amounts must be used for new crisis triage
17 centers, mobile crisis teams, and housing and recovery support
18 programs. The authority must seek proposals from behavioral health
19 organizations for the use of these funds based on regional
20 priorities. The authority must not use any of these amounts for
21 services in facilities that are subject to federal funding
22 restrictions that apply to institutions for mental diseases.

23 (vii) \$29,134,000 of the general fund—state appropriation for
24 fiscal year 2018 and \$29,134,000 of the general fund—state
25 appropriation for fiscal year 2019 are provided solely to assist
26 behavioral health organizations with the costs of providing services
27 to medicaid clients receiving services in psychiatric facilities
28 classified as institutions of mental diseases. In fiscal year 2018,
29 the authority must distribute these amounts proportionate to the
30 number of bed days for medicaid clients in institutions for mental
31 diseases that were excluded from behavioral health organization
32 fiscal year 2018 capitation rates because they exceeded the amounts
33 allowed under federal regulations. In fiscal year 2019, the authority
34 must distribute these funds based on a formula in which seventy-five
35 percent are distributed proportionate to the number of bed days for
36 medicaid clients in institutions for mental diseases that were
37 excluded from behavioral health organization fiscal year 2019
38 capitation rates because they exceeded the amounts allowed under
39 federal regulations and twenty-five percent are distributed

1 proportionate to the estimated medicaid caseload of the behavioral
2 health organizations. The authority must also use these amounts to
3 directly pay for costs in institutions of mental disease facilities
4 for American Indian and Alaska Natives who opt to receive behavioral
5 health services on a fee for service basis. The amounts used for
6 these individuals must be reduced from the allocation of the
7 behavioral health organization where the individual resides. If a
8 behavioral health organization receives more funding through this
9 subsection than is needed to pay for the cost of their medicaid
10 clients in institutions for mental diseases, they must use the
11 remainder of the amounts to provide other services not covered under
12 the medicaid program.

13 (viii) \$830,000 of the general fund—state appropriation for
14 fiscal year 2018 and \$830,000 of the general fund—state appropriation
15 for fiscal year 2019 are provided solely for behavioral health
16 organizations to contract with local entities to develop a street
17 outreach program. This program will utilize peer supports to engage
18 adults with mental health illness who may have not yet been engaged
19 in mental health treatment with the goal of reducing jail admissions
20 and involuntary commitments.

21 (ix) \$3,278,000 of the dedicated marijuana account—state
22 appropriation for fiscal year 2018 and \$3,278,000 of the dedicated
23 marijuana account—state appropriation for fiscal year 2019 are
24 provided solely for a memorandum of understanding with the department
25 of social and health services juvenile rehabilitation administration
26 to provide substance abuse treatment programs for juvenile offenders.
27 Of the amounts provided in this subsection:

28 (A) \$1,130,000 of the dedicated marijuana account—state
29 appropriation for fiscal year 2018 and \$1,130,000 of the dedicated
30 marijuana account—state appropriation for fiscal year 2019 are
31 provided solely for alcohol and substance abuse treatment programs
32 for locally committed offenders. The juvenile rehabilitation
33 administration shall award these funds as described in section 203(4)
34 of this act.

35 (B) \$282,000 of the dedicated marijuana account—state
36 appropriation for fiscal year 2017 and \$282,000 of the dedicated
37 marijuana account—state appropriation for fiscal year 2019 are
38 provided solely for the expansion of evidence-based treatments and
39 therapies as described in section 203(2) of this act.

1 (x) During the 2017-19 fiscal biennium, any amounts provided in
2 this section that are used for case management services for pregnant
3 and parenting women must be contracted directly between the authority
4 and providers rather than through contracts with behavioral health
5 organizations.

6 (xi) \$81,930,000 of the general fund—state appropriation for
7 fiscal year 2018 and \$81,930,000 of the general fund—state
8 appropriation for fiscal year 2019 are provided solely for persons
9 and services not covered by the medicaid program. To the extent
10 possible, levels of behavioral health organization spending shall be
11 maintained in the following priority order: Crisis and commitment
12 services; community inpatient services; and residential care
13 services, including personal care and emergency housing assistance.
14 These amounts must be distributed to behavioral health organizations
15 proportionate to the fiscal year 2017 allocation of flexible
16 nonmedicaid funds. The authority must include the following language
17 in medicaid contracts with behavioral health organizations unless
18 they are provided formal notification from the center for medicaid
19 and medicare services that the language will result in the loss of
20 federal medicaid participation: "The contractor may voluntarily
21 provide services that are in addition to those covered under the
22 state plan, although the cost of these services cannot be included
23 when determining payment rates unless including these costs are
24 specifically allowed under federal law or an approved waiver."

25 (xii) The authority is authorized to continue to contract
26 directly, rather than through contracts with behavioral health
27 organizations for children's long-term inpatient facility services.

28 (xiii) \$1,125,000 of the general fund—state appropriation for
29 fiscal year 2018 and \$1,125,000 of the general fund—state
30 appropriation for fiscal year 2019 are provided solely for the
31 Spokane county behavioral health organization to implement services
32 to reduce utilization and the census at eastern state hospital. Such
33 services shall include:

34 (A) High intensity treatment team for persons who are high
35 utilizers of psychiatric inpatient services, including those with co-
36 occurring disorders and other special needs;

37 (B) Crisis outreach and diversion services to stabilize in the
38 community individuals in crisis who are at risk of requiring
39 inpatient care or jail services;

1 (C) Mental health services provided in nursing facilities to
2 individuals with dementia, and consultation to facility staff
3 treating those individuals; and

4 (D) Services at the sixteen-bed evaluation and treatment
5 facility.

6 At least annually, the Spokane county behavioral health
7 organization shall assess the effectiveness of these services in
8 reducing utilization at eastern state hospital, identify services
9 that are not optimally effective, and modify those services to
10 improve their effectiveness.

11 (xiv) \$1,204,000 of the general fund—state appropriation for
12 fiscal year 2018 and \$1,204,000 of the general fund—state
13 appropriation for fiscal year 2019 are provided solely to reimburse
14 Pierce and Spokane counties for the cost of conducting 180-day
15 commitment hearings at the state psychiatric hospitals.

16 (xv) Behavioral health organizations may use local funds to earn
17 additional federal medicaid match, provided the locally matched rate
18 does not exceed the upper-bound of their federally allowable rate
19 range, and provided that the enhanced funding is used only to provide
20 medicaid state plan or waiver services to medicaid clients.
21 Additionally, behavioral health organizations may use a portion of
22 the state funds allocated in accordance with (b)(x) of this
23 subsection to earn additional medicaid match, but only to the extent
24 that the application of such funds to medicaid services does not
25 diminish the level of crisis and commitment, community inpatient,
26 residential care, and outpatient services presently available to
27 persons not eligible for medicaid.

28 (xvi) \$2,291,000 of the general fund—state appropriation for
29 fiscal year 2018 and \$2,291,000 of the general fund—state
30 appropriation for fiscal year 2019 are provided solely for mental
31 health services for mentally ill offenders while confined in a county
32 or city jail and for facilitating access to programs that offer
33 mental health services upon release from confinement. The authority
34 must collect information from the behavioral health organizations on
35 their plan for using these funds, the numbers of individuals served,
36 and the types of services provided and submit a report to the office
37 of financial management and the appropriate fiscal committees of the
38 legislature by December 1st of each year of the biennium.

1 (xvii) Within the amounts appropriated in this section, funding
2 is provided for the authority to develop and phase in intensive
3 mental health services for high needs youth consistent with the
4 settlement agreement in *T.R. v. Dreyfus and Porter*.

5 (xviii) The authority must establish minimum and maximum funding
6 levels for all reserves allowed under behavioral health organization
7 contracts and insert contract language that clearly states the
8 requirements and limitations. The authority must monitor and ensure
9 that behavioral health organization reserves do not exceed maximum
10 levels. The authority must monitor behavioral health organization
11 revenue and expenditure reports and must require a behavioral health
12 organization to submit a corrective action plan on how it will spend
13 its excess reserves within a reasonable period of time, when its
14 reported reserves exceed maximum levels established under the
15 contract. The authority must review and approve such plans and
16 monitor to ensure compliance. If the authority determines that a
17 behavioral health organization has failed to provide an adequate
18 excess reserve corrective action plan or is not complying with an
19 approved plan, the authority must reduce payments to the behavioral
20 health organization in accordance with remedial actions provisions
21 included in the contract. These reductions in payments must continue
22 until the authority determines that the behavioral health
23 organization has come into substantial compliance with an approved
24 excess reserve corrective action plan.

25 (xix) \$446,000 of the general fund—state appropriation for fiscal
26 year 2018, \$446,000 of the general fund—state appropriation for
27 fiscal year 2019, and \$178,000 of the general fund—federal
28 appropriation are provided solely for the University of Washington's
29 evidence-based practice institute which supports the identification,
30 evaluation, and implementation of evidence-based or promising
31 practices. The institute must work with the authority to develop a
32 plan to seek private, federal, or other grant funding in order to
33 reduce the need for state general funds. The authority must collect
34 information from the institute on the use of these funds and submit a
35 report to the office of financial management and the appropriate
36 fiscal committees of the legislature by December 1st of each year of
37 the biennium.

38 (xx) Within the amounts appropriated in this section, the
39 authority may contract with the University of Washington and

1 community-based providers for the provision of the parent-child
2 assistance program or other specialized chemical dependency case
3 management providers for pregnant, post-partum, and parenting women.
4 For all contractors: (i) Service and other outcome data must be
5 provided to the authority by request; and (ii) indirect charges for
6 administering the program shall not exceed ten percent of the total
7 contract amount.

8 (xxi) \$3,500,000 of the general fund—federal appropriation (from
9 the substance abuse prevention and treatment federal block grant) is
10 provided solely for the continued funding of existing county drug and
11 alcohol use prevention programs.

12 (xxii) \$200,000 of the dedicated marijuana account—state
13 appropriation for fiscal year 2018 and \$200,000 of the dedicated
14 marijuana account—state appropriation for fiscal year 2019 are
15 provided solely for a contract with the Washington state institute
16 for public policy to conduct cost-benefit evaluations of the
17 implementation of chapter 3, Laws of 2013 (Initiative Measure No.
18 502).

19 (xxiii) \$500,000 of the dedicated marijuana account—state
20 appropriation for fiscal year 2018 and \$500,000 of the dedicated
21 marijuana account—state appropriation for fiscal year 2019 are
22 provided solely to design and administer the Washington state healthy
23 youth survey and the Washington state young adult behavioral health
24 survey.

25 (xxiv) \$396,000 of the dedicated marijuana account—state
26 appropriation for fiscal year 2018 and \$396,000 of the dedicated
27 marijuana account—state appropriation for fiscal year 2019 are
28 provided solely for maintaining increased services to pregnant and
29 parenting women provided through the parent child assistance program.

30 (xxv) \$250,000 of the dedicated marijuana account—state
31 appropriation for fiscal year 2018 and \$250,000 of the dedicated
32 marijuana account—state appropriation for fiscal year 2019 are
33 provided solely for a grant to the office of superintendent of public
34 instruction to provide life skills training to children and youth in
35 schools that are in high needs communities.

36 (xxvi) \$386,000 of the dedicated marijuana account—state
37 appropriation for fiscal year 2018 and \$386,000 of the dedicated
38 marijuana account—state appropriation for fiscal year 2019 are

1 provided solely to maintain increased prevention and treatment
2 services provided by tribes to children and youth.

3 (xxvii) \$2,684,000 of the dedicated marijuana account—state
4 appropriation for fiscal year 2018, \$2,684,000 of the dedicated
5 marijuana account—state appropriation for fiscal year 2019, and
6 \$1,900,000 of the general fund—federal appropriation are provided
7 solely to maintain increased residential treatment services for
8 children and youth.

9 (xxviii) \$250,000 of the dedicated marijuana account—state
10 appropriation for fiscal year 2018 and \$250,000 of the dedicated
11 marijuana account—state appropriation for fiscal year 2019 are
12 provided solely for training and technical assistance for the
13 implementation of evidence based, research based, and promising
14 programs which prevent or reduce substance use disorders.

15 (xxix) \$2,434,000 of the dedicated marijuana account—state
16 appropriation for fiscal year 2018 and \$2,434,000 of the dedicated
17 marijuana account—state appropriation for fiscal year 2019 are
18 provided solely for expenditure into the home visiting services
19 account.

20 (xxx) \$2,500,000 of the dedicated marijuana account—state
21 appropriation for fiscal year 2018 and \$2,500,000 of the dedicated
22 marijuana account—state appropriation for fiscal year 2019 are
23 provided solely for grants to community-based programs that provide
24 prevention services or activities to youth, including programs for
25 school-based resource officers. These funds must be utilized in
26 accordance with RCW 69.50.540.

27 (xxxii) Within the amounts provided in this section, behavioral
28 health organizations must provide outpatient chemical dependency
29 treatment for offenders enrolled in the medicaid program who are
30 supervised by the department of corrections pursuant to a term of
31 community supervision. Contracts with behavioral health organizations
32 must require that behavioral health organizations include in their
33 provider network specialized expertise in the provision of
34 manualized, evidence-based chemical dependency treatment services for
35 offenders. The department of corrections and the authority must
36 develop a memorandum of understanding for department of corrections
37 offenders on active supervision who are medicaid eligible and meet
38 medical necessity for outpatient substance use disorder treatment.
39 The agreement will ensure that treatment services provided are

1 coordinated, do not result in duplication of services, and maintain
2 access and quality of care for the individuals being served. The
3 authority must provide all necessary data, access, and reports to the
4 department of corrections for all department of corrections offenders
5 that receive medicaid paid services.

6 (xxxii) \$140,000 of the general fund—state appropriation for
7 fiscal year 2018 and \$140,000 of the general fund—federal
8 appropriation are provided solely for the authority to incorporate
9 long-term inpatient care as defined in RCW 71.24.025 into the
10 psychiatric managed care capitation risk model. The model shall be
11 submitted to the governor and appropriate committees of the
12 legislature by October 1, 2017. The model must integrate civil
13 inpatient psychiatric hospital services including ninety and one
14 hundred eighty day commitments provided in state hospitals or
15 community settings into medicaid managed care capitation rates and
16 nonmedicaid contracts. The model should phase-in the financial risk
17 such that managed care organizations bear full financial risk for
18 long-term civil inpatient psychiatric hospital commitments beginning
19 January 2020. The model must address strategies to ensure that the
20 state is able to maximize the state's allotment of federal
21 disproportionate share funding.

22 (xxxiii) \$4,959,000 of the general fund—state appropriation for
23 fiscal year 2018, \$4,959,000 of the general fund—state appropriation
24 for fiscal year 2019, and \$8,202,000 of the general fund—federal
25 appropriation are provided solely for the authority to increase rates
26 for community hospitals which provide a minimum of 730 medicaid
27 psychiatric days. The authority must increase both medicaid and
28 nonmedicaid psychiatric per-diem reimbursement rates for these
29 providers within these amounts. The rate increases for providers must
30 be set so as not to exceed the amounts provided within this
31 subsection. The rate increase related to nonmedicaid clients must be
32 done to maintain the provider at the same percentage as currently
33 required under WAC 182-550-4800. In addition, the authority is
34 authorized to accelerate the process for establishing provider-
35 specific per diem rates for new psychiatric hospitals and units that
36 provide or commit to provide more than 730 medicaid psychiatric bed
37 days per year.

38 (xxxiv) \$150,000 of the general fund—state appropriation for
39 fiscal year 2018 and \$150,000 of the general fund—state appropriation

1 for fiscal year 2019 are provided solely for the authority to
2 collaborate with tribal governments and develop a plan for
3 establishing an evaluation and treatment facility that will
4 specialize in providing care specifically to the American Indian and
5 Alaska Native population. The plan must include options for
6 maximizing federal participation and ensuring that utilization will
7 be based on medical necessity.

8 (xxxv) \$1,466,000 of the general fund—state appropriation for
9 fiscal year 2018, \$7,103,000 of the general fund—state appropriation
10 for fiscal year 2019, and \$9,715,000 of the general fund—federal
11 appropriation are provided solely for the authority to contract with
12 community hospitals or freestanding evaluation and treatment centers
13 to provide up to forty-eight long-term inpatient care beds as defined
14 in RCW 71.24.025. The authority must seek proposals and contract
15 directly for these services rather than contracting through
16 behavioral health organizations. The authority must coordinate with
17 the department of social and health services in developing the
18 contract requirements, selecting contractors, and establishing
19 processes for identifying patients that will be admitted to these
20 facilities. The authority must not use any of the amounts provided
21 under this subsection for contracts with facilities that are subject
22 to federal funding restrictions that apply to institutions of mental
23 diseases.

24 (xxxvi) \$2,265,000 of the general fund—state appropriation for
25 fiscal year 2019 and \$2,594,000 of the general fund—federal
26 appropriation are provided solely to increase the number of
27 psychiatric residential treatment beds for individuals transitioning
28 from psychiatric inpatient settings. The authority must seek
29 proposals from behavioral health organizations for the use of these
30 amounts and coordinate with the department of social and health
31 services in awarding these funds. The authority must not allow for
32 any of the amounts provided under this subsection to be used for
33 services in facilities that are subject to federal funding
34 restrictions that apply to institutions of mental diseases.

35 (xxxvii) \$7,972,000 of the general fund—state appropriation for
36 fiscal year 2018, \$8,093,000 of the general fund—state appropriation
37 for fiscal year 2019, and \$34,778,000 of the general fund—federal
38 appropriation are provided solely for the authority to increase
39 medicaid capitation payments for behavioral health organizations. The

1 authority must work with the actuaries responsible for certifying
2 behavioral health capitation rates to adjust average salary
3 assumptions in order to implement this increase. In developing
4 further updates for medicaid managed care rates for behavioral health
5 services, the authority must include and make available all
6 applicable documents and analysis to legislative staff from the
7 fiscal committees throughout the process. The authority must require
8 the actuaries to develop and submit rate ranges for each behavioral
9 health organization prior to certification of specific rates.

10 (xxxviii) \$1,125,000 of the general fund—federal appropriation is
11 provided solely for the authority to develop a memorandum of
12 understanding with the department of health for implementation of
13 Engrossed Second Substitute House Bill No. 1426 (prescription
14 monitoring program data). The authority must use these amounts to
15 reimburse the department of health for costs incurred through the
16 implementation of the bill.

17 (xxxix) In fiscal year 2018, the number of nonforensic beds
18 allocated for use by behavioral health organizations at eastern state
19 hospital shall be 192 per day and the number of nonforensic beds
20 allocated for use by behavioral health organizations at western state
21 hospital shall be 557 per day. In fiscal year 2019, the authority
22 must reduce the number of beds allocated for use by behavioral health
23 organizations at western state hospital by 30 beds and repurpose a
24 civil ward to provide forensic services. The contracted beds provided
25 under section 212(1)(b)(xxxiv) shall be allocated to the behavioral
26 health organizations in lieu of beds at the state hospital and be
27 incorporated in their allocation of state hospital patient days of
28 care for the purposes of calculating reimbursements pursuant to RCW
29 71.24.310.

30 (xxxx) The authority must complete an update of the state quality
31 strategy required under federal managed care regulations and submit
32 to the center for medicaid and medicare services by October 1, 2017.
33 The authority must provide a report to the office of financial
34 management and the appropriate committees of the legislature by
35 December 1, 2017, which includes the following: (a) A copy of the
36 quality strategy submitted to the center for medicaid and medicare
37 services, (b) identification of all performance measures that are
38 currently being measured for behavioral health organizations, and
39 managed care organizations and the variations in performance among
40 these entities, (c) identification of any performance measures that

1 NEW SECTION. **Sec. 204. FOR THE DEPARTMENT OF SOCIAL AND HEALTH**
2 **SERVICES—MENTAL HEALTH PROGRAM**

3 (1) COMMUNITY SERVICES/REGIONAL SUPPORT NETWORKS

4	General Fund—State Appropriation (FY 2018).	\$383,695,000
5	General Fund—State Appropriation (FY 2019).	\$405,902,000
6	General Fund—Federal Appropriation.	\$992,257,000
7	General Fund—Private/Local Appropriation.	\$17,864,000
8	Dedicated Marijuana Account—State Appropriation	
9	(FY 2018).	\$3,684,000
10	Dedicated Marijuana Account—State Appropriation	
11	(FY 2019).	\$3,684,000
12	TOTAL APPROPRIATION.	\$1,807,086,000

13 The appropriations in this subsection are subject to the
14 following conditions and limitations:

15 (a) For the purposes of this subsection, the term "regional
16 support networks," includes, effective April 1, 2016, behavioral
17 health organizations which assume the duties of regional support
18 networks pursuant to chapter 225, Laws of 2014 (2SSB 6312).

19 (b) \$81,180,000 of the general fund—state appropriation for
20 fiscal year 2018 and \$81,180,000 of the general fund—state
21 appropriation for fiscal year 2019 are provided solely for persons
22 and services not covered by the medicaid program. To the extent
23 possible, levels of regional support network spending shall be
24 maintained in the following priority order: Crisis and commitment
25 services; community inpatient services; and residential care
26 services, including personal care and emergency housing assistance.
27 The department must allow regional support networks to use medicaid
28 capitation payments to provide services to medicaid enrollees that
29 are in addition to those covered under the state plan in accordance
30 with the conditions established under federal regulations governing
31 medicaid managed care contracts and subject to federal approval by
32 the center for medicaid and medicare services.

33 (c) \$6,590,000 of the general fund—state appropriation for fiscal
34 year 2018, \$6,590,000 of the general fund—state appropriation for
35 fiscal year 2019, and \$7,620,000 of the general fund—federal
36 appropriation are provided solely for the department and regional
37 support networks to continue to contract for implementation of high-
38 intensity programs for assertive community treatment (PACT) teams. In
39 determining the proportion of medicaid and nonmedicaid funding

1 provided to regional support networks with PACT teams, the department
2 shall consider the differences between regional support networks in
3 the percentages of services and other costs associated with the teams
4 that are not reimbursable under medicaid. The department may allow
5 regional support networks which have nonmedicaid reimbursable costs
6 that are higher than the nonmedicaid allocation they receive under
7 this section to supplement these funds with local dollars or funds
8 received under section 204(1)(e) of this act. The department and
9 regional support networks shall maintain consistency with all
10 essential elements of the PACT evidence-based practice model in
11 programs funded under this section.

12 (d) The number of nonforensic beds allocated for use by
13 behavioral health organizations at eastern state hospital shall be
14 192 per day. The number of nonforensic beds allocated for use by
15 behavioral health organizations at western state hospital shall be
16 557 per day in fiscal year 2018. By transitioning patients with long
17 term care needs into enhanced community settings and contracting with
18 licensed local community hospitals for 48 local community hospital
19 beds to provide treatment to individuals on a 90 or 180 day
20 involuntary commitment order, the department must reduce the number
21 of nonforensic beds allocated for use by behavioral health
22 organizations at western state hospital to 497 beginning January 1,
23 2019. The department must allocate the 48 local community hospital
24 beds to the behavioral health organizations according to the current
25 allocation methodology for western state hospital beds as a
26 replacement for the reduction in western state hospital beds.

12 00/28
27 (e) \$5,571,000 of the general fund—state appropriation for
28 fiscal year 2019 and \$4,941,000 of the general fund—federal
29 appropriation are provided solely for the department to contract with
30 community hospitals for up to 48 beds certified for long-term
31 inpatient psychiatric care, beginning January 1, 2019, to serve
32 patients court-ordered for 90 or 180 day stays under the involuntary
33 treatment act.

34 (f) \$1,801,000 of the general fund—state appropriation for fiscal
35 year 2018 and \$1,811,000 of the general fund—state appropriation for
36 fiscal year 2019 are provided solely for the department to implement
37 an increase to inpatient psychiatric rates for care provided in
38 community hospitals. The department will work with the health care

1 authority and the office of financial management to implement this
2 policy.

3 (g) From the general fund—state appropriations in this
4 subsection, the secretary of social and health services shall assure
5 that regional support networks reimburse the aging and disability
6 services administration for the general fund—state cost of medicaid
7 personal care services that enrolled regional support network
8 consumers use because of their psychiatric disability.

9 (h) The department is authorized to continue to contract
10 directly, rather than through contracts with regional support
11 networks, for children's long-term inpatient facility services.

12 (i) \$750,000 of the general fund—state appropriation for fiscal
13 year 2018 and \$750,000 of the general fund—state appropriation for
14 fiscal year 2019 are provided solely to continue performance-based
15 incentive contracts to provide appropriate community support services
16 for individuals with severe mental illness who were discharged from
17 the state hospitals as part of the expanding community services
18 initiative. These funds will be used to enhance community residential
19 and support services provided by regional support networks through
20 other state and federal funding.

21 (j) \$1,125,000 of the general fund—state appropriation for fiscal
22 year 2018 and \$1,125,000 of the general fund—state appropriation for
23 fiscal year 2019 are provided solely for the Spokane regional support
24 network to implement services to reduce utilization and the census at
25 eastern state hospital. Such services shall include:

26 (i) High intensity treatment team for persons who are high
27 utilizers of psychiatric inpatient services, including those with co-
28 occurring disorders and other special needs;

29 (ii) Crisis outreach and diversion services to stabilize in the
30 community individuals in crisis who are at risk of requiring
31 inpatient care or jail services;

32 (iii) Mental health services provided in nursing facilities to
33 individuals with dementia, and consultation to facility staff
34 treating those individuals; and

35 (iv) Services at the sixteen-bed evaluation and treatment
36 facility.

37 At least annually, the Spokane regional support network shall
38 assess the effectiveness of these services in reducing utilization at

1 eastern state hospital, identify services that are not optimally
2 effective, and modify those services to improve their effectiveness.

3 (k) \$1,204,000 of the general fund—state appropriation for fiscal
4 year 2018 and \$1,204,000 of the general fund—state appropriation for
5 fiscal year 2019 are provided solely to reimburse Pierce and Spokane
6 counties for the cost of conducting 180-day commitment hearings at
7 the state psychiatric hospitals.

8 (l) Regional support networks may use local funds to earn
9 additional federal medicaid match, provided the locally matched rate
10 does not exceed the upper-bound of their federally allowable rate
11 range, and provided that the enhanced funding is used only to provide
12 medicaid state plan or waiver services to medicaid clients.
13 Additionally, regional support networks may use a portion of the
14 state funds allocated in accordance with (b) of this subsection to
15 earn additional medicaid match, but only to the extent that the
16 application of such funds to medicaid services does not diminish the
17 level of crisis and commitment, community inpatient, residential
18 care, and outpatient services presently available to persons not
19 eligible for medicaid.

20 (m) \$2,291,000 of the general fund—state appropriation for fiscal
21 year 2018 and \$2,291,000 of the general fund—state appropriation for
22 fiscal year 2019 are provided solely for mental health services for
23 mentally ill offenders while confined in a county or city jail and
24 for facilitating access to programs that offer mental health services
25 upon release from confinement.

26 (n) Within the amounts appropriated in this section, funding is
27 provided for the department to develop and phase in intensive mental
28 health services for high needs youth consistent with the settlement
29 agreement in *T.R. v. Dreyfus and Porter*.

30 (o) \$9,184,000 of the general fund—state appropriation for fiscal
31 year 2018, \$11,405,000 of the general fund—state appropriation for
32 fiscal year 2019, and \$17,680,000 of the general fund—federal
33 appropriation are provided solely for enhancement of community mental
34 health services. The department must contract these funds for the
35 operation of community programs in which the department determines
36 there is a need for capacity that allows individuals to be diverted
37 or transitioned from the state hospitals including but not limited
38 to: (i) Community hospital or free standing evaluation and treatment
39 services providing short-term detention and commitment services under

1 the involuntary treatment act to be located in the geographic areas
2 of the King regional support network, the Spokane regional support
3 network outside of Spokane county, and the Thurston Mason regional
4 support network; (ii) one new full program of an assertive community
5 treatment team in the King regional support network and two new half
6 programs of assertive community treatment teams in the Spokane
7 regional support network and the Pierce regional support network; and
8 (iii) three new recovery support services programs in the Grays
9 Harbor regional support network, the greater Columbia regional
10 support network, and the north sound regional support network. In
11 contracting for community evaluation and treatment services, the
12 department may not use these resources in facilities that meet the
13 criteria to be classified under federal law as institutions for
14 mental diseases. If the department is unable to come to a contract
15 agreement with a designated regional support network for any of the
16 services identified above, it may consider contracting for that
17 service in another regional support network that has the need for
18 such service.

19 (p) \$1,500,000 of the general fund—state appropriation for fiscal
20 year 2019 and \$1,500,000 of the general fund—federal appropriation
21 are provided solely to implement clubhouses as a statewide medicaid
22 program under the department's 1915(b) waiver services. The
23 department must take appropriate steps to amend its waiver with the
24 center for medicare and medicaid services to authorize clubhouse
25 services beginning July 1, 2018. If the department is unable to
26 obtain a waiver for these services, the department must report to the
27 governor and appropriate committees of the legislature by December
28 10, 2017, identifying any barriers to obtaining the amendment and the
29 steps taken to comply with this requirement.

30 (q) \$6,858,000 of the general fund—state appropriation for fiscal
31 year 2019 and \$4,023,000 of the general fund—federal appropriation
32 are provided solely to establish a combination of six new crisis
33 walk-in or stabilization facilities, with the placement of at least
34 two facilities in King county and one in Pierce county. Walk-in
35 centers will allow individuals in mental health crisis to stay up to
36 23 hours under observation with stabilization centers allowing
37 slightly longer short-term stays. Services in crisis walk-in centers
38 may include crisis stabilization and intervention, individual
39 counseling, peer support, medication management, education, and

1 referral assistance. The department shall coordinate placement of
2 crisis centers not identified in this subsection, to maximize
3 coverage and to avoid potential duplication of crisis services. The
4 department shall monitor each center's effectiveness at lowering the
5 rate of state psychiatric hospital admissions.

6 (r) \$1,000 of the general fund—state appropriation for fiscal
7 year 2018 and \$2,000 of the general fund—state appropriation for
8 fiscal year 2019 are provided solely for the implementation of Senate
9 Bill No. 5118 (personal needs allowance). If the bill is not enacted
10 by June 30, 2017, the amounts provided in this subsection shall
11 lapse.

12 (2) INSTITUTIONAL SERVICES

13	General Fund—State Appropriation (FY 2018).	\$244,523,000
14	General Fund—State Appropriation (FY 2019).	\$251,628,000
15	General Fund—Federal Appropriation.	\$147,533,000
16	General Fund—Private/Local Appropriation.	\$52,428,000
17	TOTAL APPROPRIATION.	\$696,112,000

18 The appropriations in this subsection are subject to the
19 following conditions and limitations:

20 (a) The state psychiatric hospitals may use funds appropriated in
21 this subsection to purchase goods and supplies through hospital group
22 purchasing organizations when it is cost-effective to do so.

23 (b) \$26,358,000 of the general fund—state appropriation for
24 fiscal year 2018 and \$26,358,000 of the general fund—state
25 appropriation for fiscal year 2019 are provided solely to meet the
26 requirements of the systems improvement agreement with the centers
27 for medicare and medicaid services as outlined in seven conditions of
28 participation and to maintain federal funding. The department shall
29 specifically account for all spending related to the agreement and
30 reconcile it back to the original funding plan. The department shall
31 report back to the governor and the appropriate legislative
32 committees every six months beginning December 1, 2017, regarding
33 current spending, to include any underspending, and progress towards
34 meeting the federal requirements.

35 (c) \$311,000 of the general fund—state appropriation for fiscal
36 year 2018 and \$310,000 of the general fund—state appropriation for
37 fiscal year 2019 are provided solely for a community partnership
38 between western state hospital and the city of Lakewood to support

1 community policing efforts in the Lakewood community surrounding
2 western state hospital. The amounts provided in this subsection
3 (2)(b) are for the salaries, benefits, supplies, and equipment for
4 one full-time investigator, one full-time police officer, and one
5 full-time community service officer at the city of Lakewood.

6 (d) \$231,000 of the general fund—state appropriation for fiscal
7 year 2019 is provided solely for a community partnership between
8 eastern state hospital and the city of Medical Lake to support
9 community policing efforts in the community surrounding eastern state
10 hospital. The amount provided in this subsection must be negotiated
11 and result in an agreement to include dedicated staff and services at
12 eastern state hospital similar to the program implemented by the city
13 of Lakewood for western state hospital.

14 (e) \$45,000 of the general fund—state appropriation for fiscal
15 year 2018 and \$45,000 of the general fund—state appropriation for
16 fiscal year 2019 are provided solely for payment to the city of
17 Lakewood for police services provided by the city at western state
18 hospital and adjacent areas.

19 (f) \$19,000 of the general fund—state appropriation for fiscal
20 year 2018 and \$19,000 of the general fund—state appropriation for
21 fiscal year 2019 are provided solely for payment to the city of
22 Medical Lake for police services provided by the city at eastern
23 state hospital and adjacent areas.

24 (g) \$28,053,000 of the general fund—state appropriation for
25 fiscal year 2018 and \$28,053,000 of the general fund—state
26 appropriation for fiscal year 2019 are provided solely for competency
27 restoration beds. These funds must be used to maintain current
28 forensic beds and to increase forensic bed capacity at western state
29 hospital and eastern state hospital. The department may contract some
30 of these amounts for forensic beds at alternative locations if the
31 secretary determines that is necessary to do so.

32 (h) The appropriations in this section include sufficient funding
33 for the implementation of Senate Bill No. 5894 (behavioral health
34 system).

35 (3) SPECIAL PROJECTS

36	General Fund—State Appropriation (FY 2018)	\$498,000
37	General Fund—State Appropriation (FY 2019)	\$499,000
38	General Fund—Federal Appropriation	\$6,294,000
39	TOTAL APPROPRIATION	\$7,291,000

1 The appropriations in this subsection are subject to the
2 following conditions and limitations: \$446,000 of the general fund—
3 state appropriation for fiscal year 2018, \$446,000 of the general
4 fund—state appropriation for fiscal year 2019, and \$178,000 of the
5 general fund—federal appropriation are provided solely for the
6 University of Washington's evidence-based practice institute which
7 supports the identification, evaluation, and implementation of
8 evidence-based or promising practices. The institute must work with
9 the department to develop a plan to seek private, federal, or other
10 grant funding in order to reduce the need for state general funds.

11 (4) PROGRAM SUPPORT

12	General Fund—State Appropriation (FY 2018)	\$9,937,000
13	General Fund—State Appropriation (FY 2019)	\$9,288,000
14	General Fund—Federal Appropriation	\$11,859,000
15	General Fund—Private/Local Appropriation	\$502,000
16	Performance Audits of Government Account—State 17 Appropriation	\$325,000
18	TOTAL APPROPRIATION	\$31,911,000

19 The appropriations in this subsection are subject to the
20 following conditions and limitations:

21 (a) In accordance with RCW 43.20B.110, 43.135.055, and 71.24.035,
22 the department is authorized to adopt license and certification fees
23 in fiscal years 2018 and 2019 to support the costs of the regulatory
24 program. The department's fee schedule shall have differential rates
25 for providers with proof of accreditation from organizations that the
26 department has determined to have substantially equivalent standards
27 to those of the department, including but not limited to the joint
28 commission on accreditation of health care organizations, the
29 commission on accreditation of rehabilitation facilities, and the
30 council on accreditation. To reflect the reduced costs associated
31 with regulation of accredited programs, the department's fees for
32 organizations with such proof of accreditation must reflect the lower
33 costs of licensing for these programs than for other organizations
34 which are not accredited.

35 (b) Within the amounts appropriated in this section, funding is
36 provided for the department to continue to develop the child
37 adolescent needs and strengths assessment tool and build workforce
38 capacity to provide evidence based wraparound services for children,

1 consistent with the settlement agreement in *T.R. v. Dreyfus and*
2 *Porter*.

3 (c) \$62,000 of the general fund—state appropriation for fiscal
4 year 2018 and \$41,000 of the general fund—federal appropriation are
5 provided solely for the implementation of Second Substitute Senate
6 Bill No. 5749 (children's mental health). If the bill is not enacted
7 by June 30, 2017, the amounts provided in this subsection shall
8 lapse.

9 (d) \$325,000 of the performance audit of state government account
10 —state appropriation is provided solely for the department to conduct
11 a zero-based budget review of the division of mental health to be
12 submitted with their 2019-2021 biennial budget request. Information
13 and analysis submitted by the department for the zero-based review
14 under this subsection shall include:

15 (i) A statement of the statutory basis or other basis for the
16 creation of each program and the history of each program that is
17 being reviewed;

18 (ii) A description of how each program fits within the strategic
19 plan and goals of the agency and an analysis of the quantified
20 objectives of each program within the agency;

21 (iii) Any available performance measures indicating the
22 effectiveness and efficiency of each program;

23 (iv) A description with supporting cost and staffing data of each
24 program and the populations served by each program, and the level of
25 funding and staff required to accomplish the goals of the program if
26 different than the actual maintenance level;

27 (v) An analysis of the major costs and benefits of operating each
28 program and the rationale for specific expenditure and staffing
29 levels;

30 (vi) An analysis estimating each program's administrative and
31 other overhead costs;

32 (vii) An analysis of the levels of services provided; and

33 (viii) An analysis estimating the amount of funds or benefits
34 that actually reach the intended recipients.

35 NEW SECTION. **Sec. 205. FOR THE DEPARTMENT OF SOCIAL AND HEALTH**
36 **SERVICES—DEVELOPMENTAL DISABILITIES PROGRAM**

37 (1) COMMUNITY SERVICES
38 General Fund—State Appropriation (FY 2018) \$595,690,000

1	General Fund—State Appropriation (FY 2019)	\$625,693,000
2	General Fund—Federal Appropriation	\$1,237,393,000
3	General Fund—Private/Local Appropriation	\$534,000
4	TOTAL APPROPRIATION.	\$2,459,310,000

5 The appropriations in this subsection are subject to the
6 following conditions and limitations:

7 (a) Individuals receiving services as supplemental security
8 income (SSI) state supplemental payments shall not become eligible
9 for medical assistance under RCW 74.09.510 due solely to the receipt
10 of SSI state supplemental payments.

11 (b) In accordance with RCW 18.51.050, 18.20.050, 70.128.060, and
12 43.135.055, the department is authorized to increase nursing
13 facility, assisted living facility, and adult family home fees as
14 necessary to fully support the actual costs of conducting the
15 licensure, inspection, and regulatory programs. The license fees may
16 not exceed the department's annual licensing and oversight activity
17 costs and shall include the department's cost of paying providers for
18 the amount of the license fee attributed to medicaid clients.

19 (i) The current annual renewal license fee for adult family homes
20 shall be \$225 per bed beginning in fiscal year 2018 and \$225 per bed
21 beginning in fiscal year 2019. A processing fee of \$2,750 shall be
22 charged to each adult family home when the home is initially
23 licensed. This fee is nonrefundable.

24 (ii) The current annual renewal license fee for assisted living
25 facilities shall be \$106 per bed beginning in fiscal year 2018 and
26 \$106 per bed beginning in fiscal year 2019.

27 (iii) The current annual renewal license fee for nursing
28 facilities shall be \$359 per bed beginning in fiscal year 2018 and
29 \$359 per bed beginning in fiscal year 2019.

30 (c) \$25,400,000 of the general fund—state appropriation for
31 fiscal year 2019 and \$32,318,000 of the general fund—federal
32 appropriation are provided solely for health benefits for homecare
33 workers at a rate of \$3.04 per department paid hour of work provided
34 to a multi-employer health benefits trust. This rate is sufficient to
35 ensure that no beneficiaries will lose health benefits, dental
36 benefits, or vision benefits, but modifications to the benefit plan,
37 reserve levels, ancillary programs, or trust operating costs may be
38 necessary. Modifications to the benefit plan may include, but are not
39 limited to, monthly premiums, medical deductibles, prescription drug

Options for behavioral health services responsibility in integrated managed care

	Medicaid services/ Medicaid clients	Non-Medicaid services/ Medicaid clients	Non-Medicaid services/non- Medicaid clients	MHBG/SAPT	Crisis	Services Remaining with DSHS	County Oversight
Model 1: Procured ASO	MCOs assume responsibility for Medicaid services for Medicaid clients	MCOs assume responsibility for non-Medicaid services paid by state funds for Medicaid clients	Contracted out to ASO within available funds: Includes state funding, CJTA, jail transition services, block grant funds for SUD treatment	Contracted out to ASO e.g.: Mobile crisis outreach team; SUD peer support; crisis training for first responders; NAMI activities; some non-covered lab tests.	Contracted out to ASO, MCO's reimburse ASO for Medicaid client services	DSHS directly contracts for CLIP, State Hospital.	County staff convene elected officials quarterly; keep elected officials informed through Early Warning System reports; meet with providers regularly and convey issues of concern to HCA and MCOS. In all models, local funding stays under the authority of the county.
Model 2: County retains role as ASO	MCOs assume responsibility for Medicaid services for Medicaid clients	County retains responsibility for BHSC contract (room and board, state funded mandates) OR MCOs assume responsibility for non-Medicaid services paid by state funds for Medicaid clients	County retains responsibility for non-Medicaid clients using state-only funds, CJTA, proviso funds, etc.	County retains responsibility for block grant funded services	County retains responsibility for crisis services – MCOs reimburse County for Medicaid crisis	DSHS directly contracts with CLIP, State Hospital	Other oversight of programs TBD in local design: Family Youth System Partnership Round Table; Children's Long-term Inpatient Program; Consumer BH Advisory Board

	Medicaid services/ Medicaid clients	Non-Medicaid services/ Medicaid clients	Non-Medicaid services/non- Medicaid clients	MHBG/SAPT	Crisis	Services Remaining with DSHS	County Oversight
Model 3: Hybrid model, county assumes non-Medicaid responsibilities and can choose to subcontract some functions out or do in- house	MCOs assume responsibility for Medicaid services for Medicaid clients	County retains responsibility for BHSC contract (room and board, state funded mandates) OR MCOs assume responsibility for non-Medicaid services paid by state funds for Medicaid clients	County directly manages services for non-Medicaid clients or chooses to subcontract to third-party ASO. May choose to directly manage some funds such as CJTA, Designated Marijuana Account, jail transitions proviso, etc.	County directly contracts for block grant funded services or chooses to subcontract through third-party ASO	County directly manages crisis services or chooses to subcontract through third-party ASO. MCOs reimburse Medicaid crisis	DSHS directly contracts with CLIP, State Hospital	

HCA Integration Alternative Language

Upon full adoption by a regional service area of integrated managed care, a county legislative authority or authorities may direct the formation of a regional health care advisory committee, consisting at a minimum of county and other local elected officials, for the following purposes:

- (a) Monitoring the region-wide performance of fully integrated managed care plans.
- (b) Advising the state on policy matters associated with the Medicaid program.
- (c) Hearing from consumers and providers concerning their experience with integrated managed care.
- (d) Ensuring that the state is holding managed care plans accountable for all contractual provisions.
- (e) Coordinating funding streams for behavioral health, housing and other vital community supports with the state and managed care plans, and (f) any other purpose related to the coordination, monitoring and successful implementation of integrated managed care within the region.

BHO Recommended Amendment or Proviso Language

The Health Care Authority (HCA) shall collaborate with regions to create an interlocal leadership structure administered by the County Behavioral Health Organizations and the Apple Health MCOs serving that region if requested by the counties of that region. This structure would have primary responsibility for the design and implementation of the full integration model for that region that assures clients are at the center of care delivery and that it supports integrated physical and behavioral health care at the provider level. To ensure an optimal transition, MCO's shall contract with BHO's for a minimum of two years from the launch date of fully integrated managed care in the region.

After the transition period, the MCOs awarded the contract, must offer BHOs right of first refusal to sub-contract as a Behavioral Health Administrative Service Organization (BHASO) for non-Medicaid and certain Medicaid clients. The MCOs and BHASO shall determine, in partnership, which services shall be administered by each entity to fully support a "bi-directional" system of care. The HCA shall administer and manage the contracts between the MCO's and BHASOs

In regions that make such an agreement, MCOs and the contracted BHASO would jointly develop accountability measures and health outcome goals and agree upon common performance measures that include reductions in costly services, including, but not limited to, jail services, emergency department utilization and inpatient hospitalization.



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

* Regional Performance Measure ** Core Performance Measure

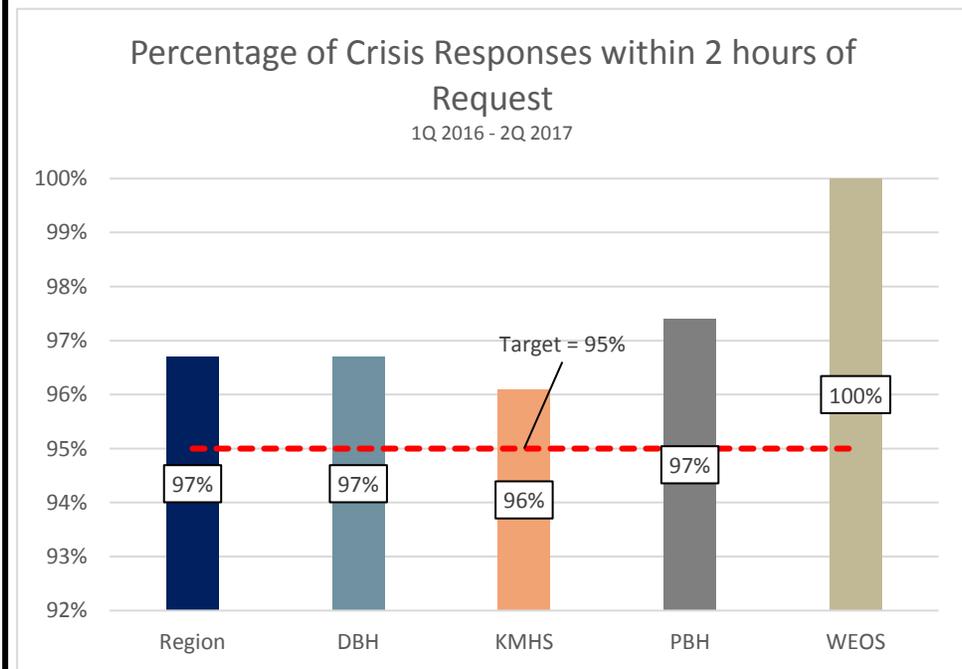
Definition of Indicator and Measurement Standard

1. Crisis Response Timeliness*

The percentage of crisis event face to face responses that occurred within 2 hours of request.

Formula:

$$\frac{\text{Number of crisis events where face to face response time was } \leq 2 \text{ hours from request during time period}}{\text{Number of crisis events for time period}}$$



Measurement

	REGION	DBH	KMHS	PBH	WEOS
FY	98.2%	94.3%	98.6%	98.2%	100.0%
1Q 2016	587/598	33/35	281/285	268/273	5/5
2Q 2016	95.8%	93.3%	94.6%	97.4%	100.0%
	644/672	42/45	295/312	299/307	8/8
3Q 2016	97.3%	96.4%	97.1%	97.8%	100.0%
	691/710	53/55	367/378	268/274	3/3
4Q 2016	98.2%	98.9%	97.7%	98.5%	100.0%
	658/670	88/89	301/308	265/269	4/4
1Q 2017	95.5%	100.0%	93.9%	96.5%	100.0%
	515/539	55/55	263/280	195/202	2/2
2Q 2017	95.2%	94.8%	94.8%	95.8%	N/A
	609/640	55/58	325/343	229/239	0/0

Target: 95% or above
Source: PIHP Contract

Data Source: ProFiler Report - Crisis Response Time by Agency
Data Notes: Numerator does not include crisis events that were non-emergent and/or pre-arranged.
Data Valid as of 2/16/17



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

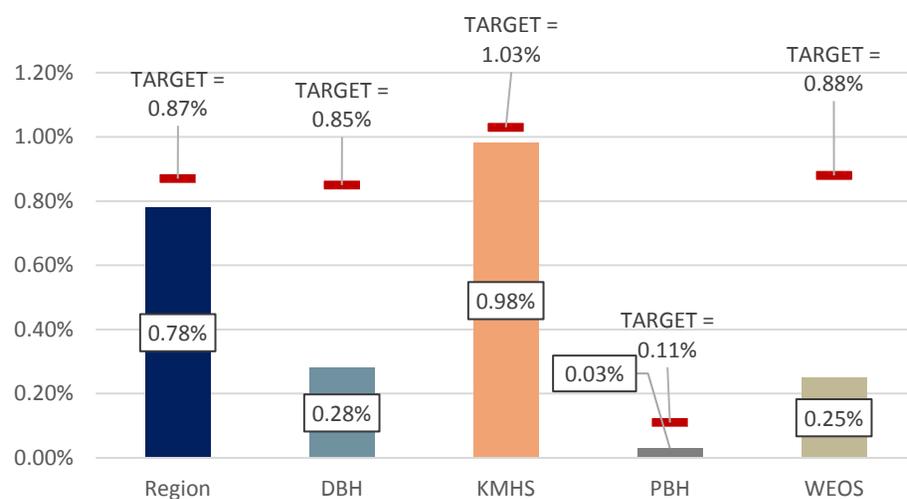
2. Child and Family (C&F) Team Meetings*

Rate of Child & Family team meetings encountered using the HT modifier

Formula:

$$\frac{\text{Number of C\&F team meetings (using HT modifier) that are recorded for children and youth under the age of 21 during time period}}{\text{Number of children and youth services encountered in time period}}$$

Child & Family Team Meetings FY 2017* Average



*FY 2017 Average calculated from Quarters 1 and 2 2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
FY17 TARGET	0.87%	0.85%	1.03%	0.11%	0.88%
FY15 AVG	0.61%	1.02%	0.62%	0.03%	0.70%
FY16 AVG	0.79% 382/48398	0.77% 14/1818	0.94% 349/37321	0.10% 8/7881	0.80% 11/1378
1Q 2016	0.48% 51/10548	0.58% 3/520	0.57% 46/8035	0.12% 2/1726	0.00% 0/267
2Q 2016	1.01% 118/11667	1.22% 6/490	1.18% 105/8866	0.19% 4/2079	1.24% 3/242
3Q 2016	1.05% 138/13106	0.92% 3/325	1.26% 129/10199	0.09% 2/2177	0.99% 4/405
4Q 2016	0.57% 75/13067	0.41% 2/483	0.68% 69/10221	0.00% 0/1899	0.86% 4/464
1Q 2017	0.64% 68/10636	0.37% 2/539	0.80% 65/8149	0.00% 0/1639	0.32% 1/309
2Q 2017	0.91% 110/12052	0.18% 1/543	1.14% 107/9353	0.06% 1/1657	0.20% 1/499

Target: 10% increase over previous FY average
Source: QUIC designated target

Data Source: ProFiler Report - RSN Encounter Data Validation

Data Notes: HT Modifier indicates Multi-disciplinary team and is recorded by meeting lead only

Parameters: Encounters for children and youth under the age of 21

Data Valid as of 2/28/17



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

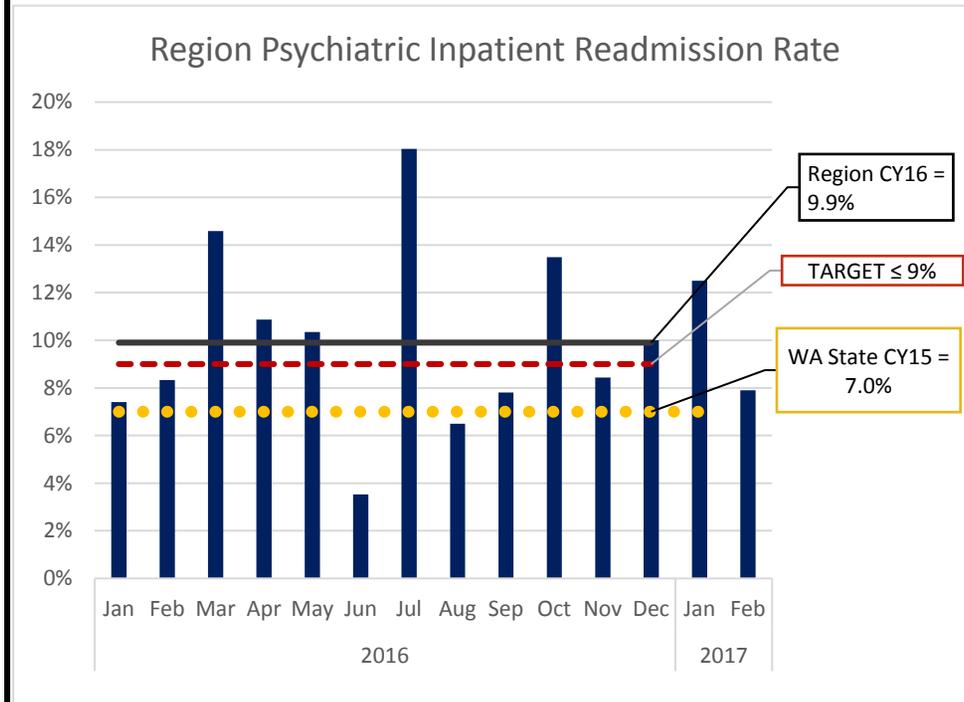
Definition of Indicator and Measurement Standard

3. Inpatient Utilization (Readmission Rate)**

Percent of clients who were discharged from inpatient psychiatric care and were readmitted to inpatient psychiatric care within 30 days of discharge

Formula:

$$\frac{\text{Number of clients readmitted to inpatient psychiatric care within 30 days of discharge within time period}}{\text{Number of clients discharged from inpatient psychiatric care during time period}}$$



Target: Within 2 points of the State's average for previous year

Source: Minimum performance standard

Data Notes: Time period is calculated based on month of discharge from psychiatric inpatient facility. Review of data source pending.

Measurement

	REGION	DBH	KMHS	PBH	WEOS
CY 15 TOTAL	9.1% 84/924	7.7% 5/65	9.0% 55/611	10.4% 23/222	3.8% 1/26
CY 16					
JAN	7.4% 6/81	0.0% 0/6	8.0% 4/50	8.3% 2/24	0.0% 0/1
FEB	8.3% 6/72	50.0% 1/2	6.0% 3/50	10.5% 2/19	0.0% 0/1
MAR	14.6% 14/96	30.0% 3/10	15.0% 9/60	8.3% 2/24	0.0% 0/2
APR	10.9% 10/92	20.0% 1/5	7.7% 5/65	20.0% 4/20	0.0% 0/2
MAY	10.3% 9/87	18.2% 2/11	14.0% 7/50	0.0% 0/23	0.0% 0/3
JUN	3.5% 3/85	0.0% 0/11	1.9% 1/54	11.8% 2/17	0.0% 0/3
JUL	18.0% 11/61	25.0% 1/4	19.0% 8/42	7.1% 1/14	100% 1/1
AUG	6.5% 5/77	0.0% 0/8	7.3% 4/55	8.3% 1/12	0.0% 0/2
SEP	7.8% 5/64	0.0% 0/4	9.3% 4/43	6.3% 1/16	0.0% 0/1
OCT	13.5% 12/89	15.4% 2/13	16.1% 9/56	5.9% 1/17	0.0% 0/3
NOV	8.4% 7/83	16.7% 1/6	8.8% 5/57	6.3% 1/16	0.0% 0/4
DEC	10.0% 8/80	22.2% 2/9	8.2% 4/49	9.5% 2/21	0.0% 0/1
CY 17					
JAN	12.5% 9/72	16.7% 2/12	16.3% 7/43	0.0% 0/14	0.0% 0/3
FEB	7.9% 6/79	20.0% 1/5	8.5% 4/47	5.6% 1/18	0.0% 0/6

Data Source: CommCare SBHO MH Readmissions Report, CommCare SBHO MH LOS Report, SCOPE. Data Valid as of 3/2017



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

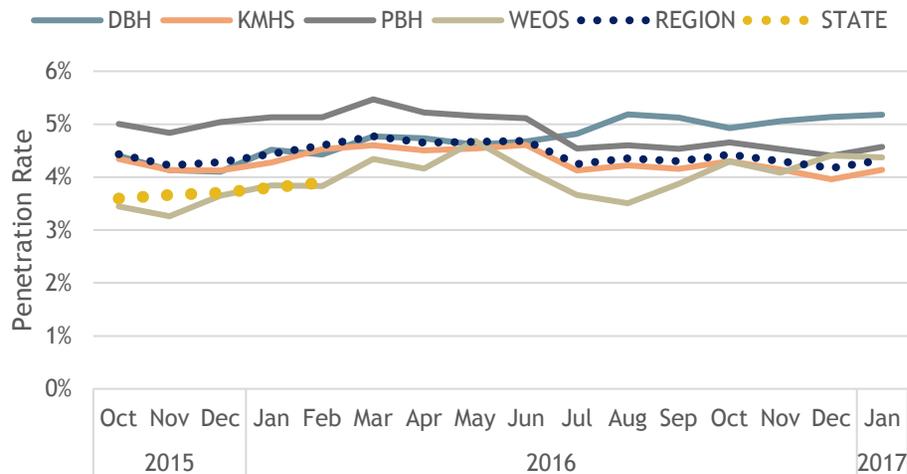
4. Access (Outpatient Penetration Rates)**

The proportion of Medicaid enrollees who received non-crisis outpatient MH services

Formula:

$$\frac{\text{Number of Medicaid clients receiving non-crisis outpatient MH services during time period}}{\text{Number of Medicaid eligible individuals during time period}}$$

Outpatient MH Penetration by Provider



Target: Not yet available from the State - anticipated Spring 2017

Data Source: Profiler DW - RSNEncounterValid_2, Medicaid Eligible Population, SCOPE
Data Notes: Regional count unduplicates clients completely.

Data Valid as of 3/29/2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
CY 16	4.4%	4.5%	4.3%	5.1%	3.8%
JAN	3451/77714	313/6934	2171/50808	828/16149	147/3823
FEB	3615/78536	314/7090	2320/51238	840/16368	147/3840
MAR	3745/78493	339/7106	2357/51218	894/16348	166/3821
APR	3662/78736	336/7101	2313/51328	859/16460	160/3847
MAY	3683/78894	331/7174	2331/51365	851/16512	180/3843
JUN	3697/78914	334/7149	2369/51414	843/16486	160/3865
JUL	3348/78822	340/7062	2119/51353	751/16531	142/3876
AUG	3431/78859	367/7079	2168/51340	762/16558	136/3882
SEP	3397/78998	362/7067	2141/51508	750/16551	150/3872
OCT	3503/79187	349/7086	2221/51639	771/16573	167/3889
NOV	3411/79374	358/7081	2148/51824	749/16552	160/3917
DEC	3320/79609	365/7108	2056/51936	732/16620	174/3945
CY 17	4.3%	5.2%	4.1%	4.6%	4.4%
JAN	3427/79222	367/7084	2136/51651	758/16578	171/3909



SALISH BHO

ADVISORY BOARD MEETING

DATE: Friday, May 5, 2017
TIME: 10:00 AM – 12:00 PM
LOCATION: City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382

A G E N D A

<http://www.kitsapgov.com/hs/sbho/sbhoboard.htm>

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of April 7, 2017 Minutes (Attachment 5)
6. Action Item
 - a. Medicaid Budget (Attachments 6.a.1; 6.a.2; 6.a.3; 6.a.4; 6.a.5; 6.a.6)
7. Informational Items
 - a. Funding Issues
 - State Budget (Attachment 7.a)
 - b. SUD Practices
 - OST RFP
 - c. Integration
 - Discussion of Health Care Authority Incentives (Attachments 7.c.1; 7.c.2; 7.c.3; 7.c.4; 7.c.5)
 - d. Quality Assurance (Attachment 7.d)
 - e. Board Priorities
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Board Member Check-in
10. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHO	Behavioral Health Organization, replaced the Regional Support Network
CAP	Corrective Action Plan
CMHA	Community Mental Health Agency
CMS	Center for Medicaid & Medicare Services (federal)
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DDA	Developmental Disabilities Administration
DMHP	Designated Mental Health Professional
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FBG	Federal Block Grant (specifically MHBG and SABG)
FYSVRT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IMD	Institutes for the Mentally Diseased
IS	Information Services
ITA	Involuntary Treatment Act
LOC	Level of Care
MAT	Medical Assisted Treatment
LRA	Least Restrictive Alternative
MCO	Managed Care Organization
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QA, QI	Quality Assurance, Quality Improvement
QUIC	Quality Improvement Committee
QRT	Quality Review Team
RCW	Revised Code Washington
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SAPT	Substance Abuse Prevention Treatment
SBHO	Salish Behavioral Health Organization
SUD	Substance Use Disorder
UM	Utilization Management
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Go to <http://www.kitsapgov.com/hs/sbho/sbholicies.htm> for a full listing of definitions and acronyms

6. Action Item

a. Medicaid Budget

The state Legislature is still in session, but the Medicaid rates for July have been released, and the SBHO has begun to put together our July budget based on those rates and last biennium's State and Block Grant allocations. Staff will walk through the attachments to the mailing, which include: Rate building, Revenue Projections, SUD FY 18 Budget, Mental Health Revenue for FY 17 compared to FY 18, Medicaid Distribution to Mental Health Providers, and Twelve Month Medicaid Funding Levels for Mental Health providers. This proposal includes the use of \$300,000 of Medicaid reserves to make up for the loss of the revenue associated with the American Indian/Alaskan Native (AI/AN) exemption that West End Outreach will experience in July. The Board is asked to make a recommendation to the Executive Board regarding the proposed distribution of Medicaid funds.

7. Informational Items

a. Funding Issues

- **State Budget**

The House and Senate have not made a lot of progress on the state budget as of this writing. One area of concern remains the IMD (Institution for Mentally Diseased) change in July and how that is being approached by the state. Attached is the "IMD Analysis" completed for the state by Mercer, which staff will walk the Board through. It clearly demonstrates the re-pricing of the Medicaid eligible expenses to help build the Medicaid rates, while leaving state dollars at their 2015 levels. This amounts to a cut of approximately \$25,000,000 to the system each year.

b. SUD Practices

- **OST RFP**

The Request for Proposals for Opiate Substitution Treatment services has been released, and proposals are due May 11. A bidder's conference was held, and one potential bidder attended. An RFP Review committee is scheduled for May 18th.

c. Integration

- **Discussion of Health Care Authority Incentives**

The issue of transitioning to Fully Integrated Managed Care (FIMC) has been moved to the front burner by the Health Care Authority through a broadly released set of documents, which are attached for the Board's

review. The SBHO has developed a separate document which questions some of the HCAs statements and assumptions and is also attached.

In order for the Counties within the Salish BHO to become fully integrated, the county Commissioners are required to sign binding letters of intent, and the SBHO Executive Board will be discussing this at their meeting scheduled for May 19.

d. Quality Assurance

Updated Regional Performance Measure reports are attached for the Board's information and review.

e. Board Priorities

Last year, the Board established priorities to work on in its initial year. These were: Healthcare Integration, Quality, SUD Practices, County 1/10th practices and use, and learning about the overall flow of funding. The Board is asked to continue their discussion of these to determine if they remain the top priorities moving forward.

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**10:00 a.m., Friday, April 7, 2017
City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382**

CALL TO ORDER – Russel Hartman, Chair, called the meeting to order at 10:02am.

INTRODUCTIONS – Self introductions.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS - None

APPROVAL OF THE AGENDA

Agenda was adjusted to move items 6.a Election of Board Offices and 6.b Washington Behavioral Health Council Annual Conference to follow Informational Items to allow Jennifer Kreidler-Moss, member of the Nominating Committee, to be present.

Revised agenda was accepted without motion.

APPROVAL OF January 27, 2017 MINUTES

MOTION: Lois Hoell moved to approve the minutes of the January 27, 2017 meeting as submitted. Jon Stroup seconded. Motion carried.

APPROVAL OF March 10, 2017 MINUTES

MOTION: John Freeburg moved to approve the minutes of the March 10, 2017 meeting with updates being made to the Attendance portion so that all board members are listed as being present or absent/excused. Jon Stroup seconded. Motion carried.

INFORMATION ITEM

➤ Funding Issues

- Staff presented information on the most recent State and House Budgets
- House Budget– Legislature is still in session; therefore we do not have a budget for July 1, 2017.
- Integration Transfer: The House wants to integrate funding into the Health Care Authority and remove it entirely from DSHS. The Senate has not gone along with it.
- State hospitals are a prime focus for the Legislative and Governor’s budgets because of the scrutiny from the Federal Government and the threat to revenue associated with state hospitals. The Governor’s budget wants to eventually close state hospitals and move those beds to community hospitals. This session, the House moved 48 beds from the state hospitals to community hospitals (long-term hospital beds) in hopes of reducing the current 60-70 patient waitlist for long-term care in a state

hospital.

- There are 40 Budget Provisos in the current House budget. This means the money is more restricted on how it is spent in the community.
- The House and Senate took very different approaches for funding schools and this most likely will carry over to our budget. We might not have a budget for some time. We do know that this is the last session that we will have a split legislature so we need to act now if we want anything for our communities.
- As of July 1, we will no longer be allowed to use Medicaid money for extended stays in IMD's. We can only use it for 15 days in month. If someone needs 16 days, we must use state money. Combined, the House and Senate, are giving us 2.3 million dollars for IMD care instead of 4 million. This is a big issue and we are in early discussions to change some of our residential care facilities around so that we can better maximize care to our communities.

➤ Actuarial Rates

- State has published final rates and the state did an extraordinary job in making King County whole. The first analysis showed that King County services were 20% below where they should be and that they were going to have to take that hit. However, when the final rates came out, King County only took a .6% hit.
- The Actuarial process is complete and the rates have been sent to the Federal Government for approval (90 day waiting period).
- The SBHO got the largest increase in the state; a 10% increase. Greater Columbia (9 counties in SE Washington) is taking a 13% hit.

➤ SUD Practices

- Provider Presentation: No providers were present to speak. SBHO staff spoke on behalf and addressed the differences between mental health providers and substance abuse providers.
- Mental health providers always look to meet the needs of the patients with outpatient services before committing a patient for inpatient services. However, substance abuse providers typically do an assessment and as long as the patient meets specific criteria, the patient gets sent to residential inpatient services. This appears to often be done without exploring other options such as outpatient services first.
- It is going to take time to address these issues and to find the balance of getting both mental health and substance abuse providers to change their mindset on the intake process. It will continue to be a difficult process but one we must work on as this could significantly help with the IMD issue.

➤ OST RFP:

- A lot of criticism was received about using the term OST as it is outdated terminology. We will continue using OST as that is what is used in WAC and the most important thing is getting the program licensed. It is

important that we use consistent terminology in the course of development. A House bill is currently in process to change the terminology to OTP (Opiate Treatment Program). Once that bill is passed, then we can look at changing the name.

- The RFP will go out very soon. Replies are due back by May 11. A review committee of: Helen Morrison and Jennifer Kreidler-Moss was formed to review the replies between May 15 and May 23. The replies will be brought back to the board for review.

➤ Integration

- Health Care Authority (HCA): The HCA wants all BHO's to be integrated into Managed Care Organizations by the year 2020 and have all behavioral health run through the HCA. Materials were presented that address the plans for integration. A lot of the information that the HCA is marketing is factually misrepresented. SBHO staff are working to develop a response to the HCA materials.
- Managed care companies will not take the time to go through the steps to fight for mental health and substance abuse issues the way a BHO does. Managed care does not have a history of recognizing a problem, writing a proposal, and taking that to the state for funding to develop new programs. BHO's are very important to the community and the individuals of those communities, but we are currently fighting for our lives.
- BHO Budget Proviso: Counties are being incentivized to sign away from the BHO model with a one-time payment to the county that does not have to financially support behavioral health. The county would also forfeit behavioral healthcare authority forever. This would be a huge hit to the communities as the SBHO budget is 53 million and the one-time payment would not come close to that. The HCA would set-up advisory councils for each county. At this point, it is not clear what is going to happen; the Executive branch is very interested in moving this forward.

➤ Quality Assurance (QA)

- QA Staff reviewed the mental health quality indicators reports and answered questions from the board. The Board asked for a report on CAPS to be presented at each meeting so that they do not have to continually ask for it.

➤ Board Priorities

- Russ brought up the board priorities from the past year to see if any adjustments need to be made to them. The current board priorities are: funding, SUD practices, integration, QA, and 1/10 of 1% groups in each of the counties.
- Jon would like us to coordinate better with other facilities and entities; Jennifer would like us to focus on the integration and specifically what we

would like if BHO's were to disappear and to strategize on what that scenario would realistically look like; Helen and Charles would like us to continue focusing on SUD practices and continuing to educate ourselves on SUD practices; Freida would like us to focus on having separate conversations with children and adult care in relation to the five priorities as they are very different; Steve would like us to focus on exploring the law enforcement and the criminal side of care.

- Board members all agreed that we need to continue to focus on the five established priorities with a critical focus on integration. Russ also would like the board to focus on the 1/10 of 1% groups and how they are maximizing SBHO money.
- Lower board priorities will be included on the agenda for next month for review.

ACTION ITEMS

➤ Election of Board Officers

- The Nominating committee (Jennifer Kreidler-Moss, Helen Morrison, and Charles Pridgen) nominated Russ Hartman to re-run as Chair of the Advisory Board for a one year term, ending December 2017.
- The Nominating Committee, nominated Lois Hoell and Jon Stroup to run as Vice Chair. Lois withdrew her name from contention as she was happy with Jon Stroup serving the roll of Vice Chair
- It was also discussed that under our Bylaws, we need to appoint a new Nominating Committee in October of 2017 and hold elections in December of 2017.

MOTION: Lois Hoell moved the board to appoint Russ Hartman as Chair for one year and Jon Stroup as Vice Chair. Catharine Robinson seconded. Motion carried.

➤ Washington Behavioral Health Council Annual Conference

- The Washington Behavioral Health Council Annual Conference will be June 14-16 in Vancouver, WA. If you are interested in attending, please let SBHO Staff, Alexandra Hardy, know before the May Advisory Board Meeting. You are to make your own hotel reservations and we will reimburse you for the hotel and travel expenses.

OPPORTUNITY FOR PUBLIC COMMENT – Stephen Workman (Jefferson County) stated he has a natural interest in behavioral health in the community and is very interested in the jail and law enforcement side of behavioral health. Steve thanked the board members for all of their hard work and was grateful for the acronym list. Steve also asked about the different boards in the SBHO.

FOR THE GOOD OF THE ORDER

- Staff Report: The SBHO is fully staffed and operational.

- Board Member Check-In: John was in Spokane for an interesting Ombuds training the previous week; Jon thanked the public for attending and was thankful that the SBHO is fully staffed and operational; Jennifer recognized Jon and Lois for stepping up to serve the board and thanked Russ for sticking in for another year; Anders is very thankful for the board and recognized that we all want the same thing and is grateful that we can all work together.
- The next meeting is Friday, May 5, 2017 at the City of Sequim Transit Center.

ADJOURNMENT - The meeting adjourned at 11:57am.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<p><u>Present</u> Anne Dean John Freeburg Freida Fenn Russ Hartman Lois Hoell Jennifer Kreidler-Moss Helen Morrison Charles Pridgen Steve Schermerhorn Jon Stroup Catharine Robinson</p> <p><u>Absent/Excused</u> Janet Nickolaus Mike Stringer Jolene George Barbara Maxwell Roberta Charles</p>	<p>Ellen Epstein, RMH Services Lisa Rey Thomas, Olympic Community of Health Andy Brastad, Clallam County HHS Joe Roszak, Kitsap Mental Health Services Tanya MacNeil, West End Outreach Services Stephen Workman, Jefferson County Citizen Adam Marquis, Discovery Behavioral Healthcare Chris Jael, NAMI of CC Wendy Sisk, Peninsula Behavioral Health</p>	<p>Anders Edgerton Alexandra Hardy Richelle Jordan Ileea Nehus Ginger Wotzka Martiann Lewis Toby Bingham</p>

Salish BHO Medicaid Rates - July 2017

Current (pre July 1, 2017) rates

	Disabled Adults	Non-Disabled Adults	Disabled Children	Non-Disabled Children	Expansion
MH	109.82	17.47	78.82	11.7	33.6
SUD	13.84	15.2	14.66	4.26	24.12
Total	123.66	32.67	93.48	15.96	57.72

Rates from 2/8 rate book

	Disabled Adults	Non-Disabled Adults	Disabled Children	Non-Disabled Children	Expansion
MH portion	115.4	15.68	68.58	12.15	20.08
SUD Portion	6.27	7.84	2.76	1.92	10.43
Total	121.67	23.52	71.34	14.07	30.51

Data Book

Data Book Inflated to Contract Rates

Contract Rate from 2/14/17 rate sheet					
	Disabled Adults	Non-Disabled Adults	Disabled Children	Non-Disabled Children	Expansion
	155.31	34.97	93.48	18.87	51.74

Rates from 2/8 rate book inflated to contract rate

	Disabled Adults	Non-Disabled Adults	Disabled Children	Non-Disabled Children	Expansion
MH	147.31	23.31	89.86	16.29	34.05
SUD	8.00	11.66	3.62	2.58	17.69
Total	155.31	34.97	93.48	18.87	51.74

Current Rate Split based on last data book

Monthly Revenue Based on New Rates and AI/AN Exemption			
	Total	MH	SUD
Current Monthly Revenue	\$ 3,647,755	\$ 2,511,025	\$ 1,136,731
Revenue with New Rates Excluding AI/AN	\$ 3,910,000	\$ 2,840,800	\$ 1,062,500

Annual SBHO Revenue with AI/AN Exemption and House Budget		
	MH	SUD
Total	\$ 46,920,000	\$ 34,089,600
\$		12,750,000

SBHO FY 18 Substance Use Disorder Budget

Estimated Revenue						
DMA	State	IMD Backfill	SAPT	CJTA	Medicaid	TOTAL
\$ 226,560	\$ 1,400,000	\$ 821,000	\$ 1,548,783	\$ 452,000	\$ 12,750,000	\$ 17,198,343

Total Expenditures							
	DMA Funding	State	IMD Backfill	SAPT	CJTA	Medicaid	Total
Total Outpatient		\$ 900,000		\$ 600,000	\$ 226,000	\$ 8,050,000	\$ 9,776,000
Residential		\$ 300,000	\$ 821,000	\$ 700,000	\$ 226,000	\$ 2,000,000	\$ 4,047,000
Detox Clallam		\$ 20,000				\$ 300,000	\$ 320,000
Detox KRC		\$ 30,000				\$ 360,000	\$ 390,000
Admin		\$ 77,500				\$ 439,400	\$ 516,900
Special Projects/Unallocated	\$ 226,560			\$ 248,743		\$ 1,587,000	\$ 2,062,303
Total Expenditures	\$ 226,560	\$ 1,327,500	\$ 821,000	\$ 1,548,743	\$ 452,000	\$ 12,736,400	\$ 17,112,203

SBHO FY 17 Annual Budget with FY 18

Revenue	FY 17	FY 18
Medicaid base	\$ 25,950,000	\$ 34,400,000
Medicaid PACT	\$ 380,000	\$ 355,000
Medicaid PACT II	\$ 715,000	\$ 670,000
Medicaid Triage	\$ 280,000	\$ 261,000
WISe	\$ 4,061,117	
Total Local Plus Federal Match	\$ 356,700	\$ 356,700
Total Medicaid	\$ 27,681,700	\$ 40,103,817

SBHO Medicaid Distribution to MH Providers

	Medicaid Revenue April 2016- March 2017	FY 2018 Estimated Medicaid Revenue	Estimated Revenue without AI/AN Exemption	AIAN Compensation	Percent Change, FY 17 - 18	Change with AI/AN Compensation
KMHS	\$ 18,215,000	\$ 21,641,656	\$ 22,605,236		19%	19%
PBH	\$ 5,236,000	\$ 6,682,765	\$ 7,269,670		28%	28%
JMHS	\$ 2,121,000	\$ 2,966,913	\$ 3,039,442		40%	40%
WEOS	\$ 1,125,000	\$ 983,666	\$ 1,565,702	\$ 300,000	-13%	14%

SBHO Budget for FY 2018
 Twelve Month Funding Levels

	Medicaid	AIAN Compensation	actual Medicaid revenue April - March	Medicaid Add-ons						Medicaid Total
				Wise	PACT	PACT II	Crisis Center	Local Match		
KIMHS	\$ 21,641,656		\$ 18,215,000	\$ 2,106,000	\$ 352,272	\$ 667,560		\$ 54,500	\$ 24,821,988	
PBH	\$ 6,682,765		\$ 5,236,000	\$ 1,134,000			\$ 259,608		\$ 8,076,373	
JMHS	\$ 2,966,913		\$ 2,121,000	\$ 810,000				\$ 175,000	\$ 3,951,913	
WEOS	\$ 983,666	\$ 300,000	\$ 1,125,000					\$ 127,166	\$ 1,410,832	
RMH Services	\$ 16,068								\$ 16,068	
RSN Administration	\$ 1,190,000								\$ 1,190,000	
CommCare (Utilization M)	\$ 460,000								\$ 460,000	
NAMIs	\$ -									
Dispute Resolution Cente	\$ 84,000								\$ 84,000	
DRC QRT	\$ 75,000								\$ 75,000	
Tribes										
TOTAL	\$ 34,100,068			\$ 4,050,000	\$ 352,272	\$ 667,560	\$ 259,608	\$ 356,666	\$ 40,086,174	

This summary reflects the estimated dollars expended for IMDs based on the current list of IMD facilities and provisions outlined in the Final Rule. The list of IMD facilities is subject to change. All identified IMD dollars, both allowable and unallowable, were excluded from the CY 2015 Data Book. Allowable IMD dollars will be incorporated into the rate setting process but repriced at the State Plan rate by BHO and modality.

	A	B	C = B / A	D = A - B	E	
IMD Total by BHO						
BHO	IMD/Non-IMD	Total Dollars ¹	Unallowable Dollars - Total ²	Percent Unallowable	Allowable Dollars	Allowable Repriced ³
Greater Columbia	IMD	\$ 1,829,000	\$ 923,000	50.5%	\$ 906,000	\$ 1,929,000
Great Rivers	IMD	\$ 1,358,000	\$ 503,000	37.0%	\$ 856,000	\$ 1,702,000
King	IMD	\$ 23,065,000	\$ 14,574,000	63.2%	\$ 8,490,000	\$ 12,717,000
North Central	IMD	\$ 367,000	\$ 141,000	38.4%	\$ 227,000	\$ 448,000
North Sound	IMD	\$ 4,581,000	\$ 2,398,000	52.3%	\$ 2,183,000	\$ 4,406,000
Pierce	IMD	\$ 2,692,000	\$ 1,263,000	46.9%	\$ 1,429,000	\$ 2,806,000
Salish	IMD	\$ 1,441,000	\$ 700,000	48.6%	\$ 741,000	\$ 1,599,000
Spokane	IMD	\$ 4,678,000	\$ 3,284,000	70.2%	\$ 1,394,000	\$ 2,997,000
Southwest	IMD	\$ 1,348,000	\$ 677,000	50.2%	\$ 671,000	\$ 1,397,000
Thurston Mason	IMD	\$ 1,125,000	\$ 566,000	50.3%	\$ 559,000	\$ 1,048,000
Total	IMD	\$ 42,484,000	\$ 25,029,000	58.9%	\$ 17,456,000	\$ 31,049,000

¹Statewide CY 2015 dollars reflective of consideration for completion and other base data adjustments (including AI/AN exclusions). Does not yet include consideration for trend and administrative costs, which are accounted for separately.

²Total dollars in months where the aggregate count of days at an IMD for an individual within a single month exceeds 15 days.

³Reflects repricing allowable IMD days at the BHO specific State Plan rate applicable to each modality.

In accordance with the Final Rule, if the aggregate count of days in an IMD for an individual in a single month exceeds 15 days, all services delivered to that individual during that month are not eligible for FFP under the capitation rate. As such, the below summary reflects the estimated non-IMD dollars for individuals in months in which they exceeded the 15 day aggregate limit. These dollars were excluded from the CY 2015 Data Book.

	A	B	C = B / A	
Non-IMD Total by BHO				
BHO	IMD/Non-IMD	Total Dollars ¹	Unallowable Dollars - Total ²	Percent Unallowable
Greater Columbia	Non-IMD	\$ 52,999,000	\$ 288,000	0.5%
Great Rivers	Non-IMD	\$ 32,269,000	\$ 109,000	0.3%
King	Non-IMD	\$ 131,639,000	\$ 1,632,000	1.2%
North Central	Non-IMD	\$ 10,849,000	\$ 39,000	0.4%
North Sound	Non-IMD	\$ 76,726,000	\$ 473,000	0.6%
Pierce	Non-IMD	\$ 72,627,000	\$ 637,000	0.9%
Salish	Non-IMD	\$ 29,372,000	\$ 121,000	0.4%
Spokane	Non-IMD	\$ 65,276,000	\$ 520,000	0.8%
Southwest	Non-IMD	\$ 42,949,000	\$ 196,000	0.5%
Thurston Mason	Non-IMD	\$ 26,558,000	\$ 91,000	0.3%
Total	Non-IMD	\$ 541,264,000	\$ 4,106,000	0.8%

¹Statewide CY 2015 dollars reflective of consideration for completion and other base data adjustments (including AI/AN exclusions). Does not yet include consideration for trend and administrative costs, which are accounted for separately.

²Total dollars in months where the aggregate count of days at an IMD for an individual within a single month exceeds 15 days.

In accordance with the Final Rule, if the aggregate count of days in an IMD for an individual in a single month exceeds 15 days, all services delivered to that individual during that month are not eligible for FFP under the capitation rate. As such, the below summary reflects the unique user and user month counts for individuals in months in which they exceeded the 15 day aggregate limit in CY 2015. Utilization and membership for these individuals were excluded from the CY 2015 Data Book.

BHO	IMD Excess Stay Counts	
	Users	User Months
Greater Columbia	447	1,141
Great Rivers	204	458
King	1,415	3,699
North Central	70	178
North Sound	871	2,239
Pierce	535	1,353
Salish	314	846
Spokane	784	2,177
Southwest	358	793
Thurston Mason	204	498
Total	5,090	13,322

From: MaryAnne Lindeblad

Sent: April 5, 2017

Subject: Integrated Managed Care Update

Good Afternoon,

You may be aware that the state's recently approved Medicaid Transformation Demonstration provides incentives to regions that choose to adopt integrated physical and behavioral health through managed care prior to 2020. Allow me to share draft documents providing details regarding proposed demonstration incentive funding that we hope you will find helpful as you consider "mid-adopter" integration in 2018 or 2019. Please note the specific incentives outlined in the documents are pending approval from the Centers for Medicare and Medicaid Services and legislative appropriation for demonstration funding.

The documents provide:

- Details regarding proposed waiver incentive funds that the Accountable Communities of Health (ACHs) are eligible for if their region moves forward with implementing integrated managed care on an earlier timeline.
- Key dates, including the final due date for binding letters of intent (Sept. 1, 2017) and the final dates available for "mid-adopter" implementation. These dates are November 1, 2018 or January 1, 2019.

As you know, the decision to move forward with integrated managed care before 2020 is a decision of the County Authority. A letter will be forthcoming shortly from the Health Care Authority to all County Authorities outlining these key dates and the submission process for binding letters of intent.

MaryAnne Lindeblad
Medicaid Director
Medicaid Directors Office
office: 360-725-1863
maryanne.lindeblad@hca.wa.gov

Washington State
Health Care Authority

www.hca.wa.gov    

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.

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.

TRANSITIONAL COUNTIES

SPOKANE REGION

Okanogan is currently assigned to the Spokane Regional Service Area and is covered by the Spokane BHO; however, in 2020 this county will transition to the North Central region. If the Spokane region wants to transition to integrated managed care early and be a “mid-adopter” does the county authority in Okanogan have to sign a binding letter of intent?

If the Spokane Region wants to transition to integrated managed care on an earlier timeline, the county authority in Okanogan does **not** have to submit a binding letter of intent with the other counties in the Spokane region. However, in that case, Okanogan County **would** need to transition to the North Central region at such time as the Spokane region implements integrated managed care and a separate binding letter of intent would need to be submitted by Okanogan County to facilitate this.

In order for the Spokane Region to transition early, two things need to occur:

- Binding letter of intent from Adams, Ferry, Lincoln, Pend Oreille, Stevens, and Spokane counties
- Binding letter of intent from Okanogan County, to move into North Central early

GREATER COLUMBIA REGION

Klickitat County is currently assigned to the Greater Columbia Regional Services Area and is covered by the Greater Columbia BHO; however, in 2020 this county will transition to the Southwest Washington region. If the Greater Columbia Region wants to transition to integrated managed care early and be a “mid-adopter” does the county authority in Klickitat have to sign a binding letter of intent?

If the Greater Columbia Region wants to transition to integrated managed care on an earlier timeline, the county authorities in Klickitat do **not** have to submit a binding letter of intent with the other counties in the Greater Columbia region. However, in that case, Klickitat County **would** need to transition to the Southwest Washington region at such time as the Greater Columbia region implements integrated managed care and a separate binding letter of intent would need to be submitted by Klickitat County facilitate this.

In order for the Greater Columbia Region to transition early, two things needs to occur:

- Binding letter of intent from Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, and Yakima counties
- Binding letter of intent from Klickitat, to move into Southwest Washington early

INCENTIVES FOR MID-ADOPTERS OF INTEGRATED MANAGED CARE

Counties that commit to implementing integrated managed care before 2020 will be eligible for significant incentive funds to deliver improved coordinated health care for people in their region.

How does Medicaid Demonstration incentive funding work?

This information is dependent on the approval of the Funding and Mechanics Protocol currently under review by CMS, and pending Washington legislative appropriation for the Medicaid Demonstration:

As currently proposed, here's how the math works: The incentive payments eligible to each region is calculated using a base rate of up to \$2 million and a per member rate based on total attributed Medicaid beneficiaries.

Proposed integration incentive methodology = [\$2 million] + [\$36 x Total Attributed Medicaid Beneficiaries] x [Phase Weight]

The incentives for integrated managed care will be distributed in two phases: delivery of binding letter(s) of intent and implementation. These phases represent two key activities towards integration. ACHs and partnering providers are eligible for an incentive payment for completion of each phase.

Based on the proposed methodology, estimates for incentives available to each region are as follows:

Accountable Community of Health*	Regional Client Count	Eligible Incentives for Binding Letter of Intent	Eligible Incentives for Implementation	Total Incentives for Integrated Managed Care
Better Health Together	188,757	\$3,518,000	\$5,277,000	\$8,795,000
Cascade Pacific Action Alliance	179,382	\$3,382,000	\$5,074,000	\$8,457,000
Greater Columbia ACH	243,934	\$4,312,000	\$6,468,000	\$10,781,000
King County ACH	407,352	\$6,665,000	\$9,998,000	\$16,664,000
Olympic Community of Health	81,819	\$1,978,000	\$2,967,000	\$4,945,000
Pierce County ACH	221,396	\$3,988,000	\$5,982,000	\$9,970,000
North Sound ACH	267,923	\$4,658,000	\$6,987,000	\$11,645,000

**Southwest ACH and North Central ACH have already committed to or implemented integrated managed care and are not reflected in this table as a result.*

A FEW BASIC FACTS

1. Integration of physical and behavioral health care for Apple Health (Medicaid) clients is on a firm path.

The state Health Care Authority (HCA) is moving forward to meet the legislative direction under [E2SSB 6312](#) to integrate behavioral health benefits into the Apple Health managed care program so that clients have access to the full complement of medical and behavioral health services through a single managed care plan. Regions statewide are required to integrate no later than 2020.

2. Evidence supports integrated health care is better for patients.

A strong body of evidence for integrated care has emerged over the past 20 years, particularly for depression but increasingly for other conditions, including anxiety disorders, PTSD and co-morbid medical conditions such as heart disease, diabetes and cancer. While mental health and primary care historically have been siloed, evolving payment models are spurring more integrated models of care. This wave of innovation is particularly important in safety net health systems, which serve a high proportion of uninsured and Medicaid patients — and where poverty, language barriers, and other social determinants of health may contribute to the complex physical and behavioral health needs of patients.

3. Regions that move to integrated care before 2020 can earn additional incentive funds.

Senate Bill 6312 allows the county authority or authorities within a region to elect to move forward with integrated managed care on an earlier timeline if desired. Under the Medicaid Demonstration, regions that implement integrated managed care before 2020 will be eligible for additional incentive payments through their Accountable Community of Health. These “mid-adopter” regions can earn these particular incentive dollars. The incentive would be in addition to funds ACHs and regional partners can receive for implementing a set of projects selected from the Demonstration Project Toolkit, pending legislative appropriation of these incentives.

4. By design, counties and BHOs play important roles in the transition so that local needs are addressed.

The transition to integrated managed care starts by building from the strong foundation set by behavioral health organizations (BHOs), which have taken the first step in integrating behavioral health services (E2SSB 6312 directed the integration of mental health and chemical dependency purchasing as a first step to full integration by 2020). 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.

5. Two key steps will signal a region’s eligibility for incentive payments.

The incentives for integrated managed care will be distributed in two phases:

1. The county submits binding letter(s) of intent to the state Medicaid director no later than September 1, 2017.
2. Implementation of new integrated MCOs in the region begins on November 1, 2018, OR January 1, 2019. Regions are eligible for an incentive payment for completion of each phase, pending legislative appropriation of these incentives.

Next steps

1. How can the Accountable Community of Health in my region earn the Demonstration incentives?

Regions are eligible to earn the Demonstration incentives if they elect to move forward with integrated managed care on an earlier timeline than is required in [Senate Bill 6312](#).

The incentives will be provided, pending legislative appropriation, through ACHs in two installments based on the achievement of:

1. Submission of a binding letter of intent signed by the County Authority or authorities in the region to the Washington State Health Care Authority **by September 1, 2017**;
2. Implementation of integrated managed care effective November 1, 2018, or January 1, 2019.

2. Who has the authority to sign the binding letter of intent?

In statute, the county authority is defined as “the board of county commissioners, county council, or county executive having authority to establish a community mental health program, or two or more of the county authorities specified in this subsection which have entered into an agreement to provide a community mental health program.” (RCW 71.24.025). In a multi-county regional service area, the county authorities for *all counties in the region* must sign the binding letter of intent. The Health Care Authority will send a formal letter to all counties informing them of the date and process to submit a binding letter of intent.

3. Do the incentive dollars have to be used for the transformation projects that are selected by the ACH?

No. These incentives are for partnering providers in regions that implement integrated managed care before January 1, 2020. They are complementary to but separate from funds for specific transformation projects.

4. If the incentives are not going to be used to fund the projects, what are they for?

The incentive payments earned for integrated managed care milestones are intended to be used to assist providers and the region with the process of transitioning to integrated managed care. This could include using funds to assist with the uptake of new billing systems or technical assistance for behavioral health providers who are not accustomed to conducting traditional medical billing or working with managed care plan business processes. Additionally the incentive payments can further support and build upon the region’s work to implement integrated clinical models.

Before funds are disbursed to providers, they must be reflected in project plans. These plans are reviewed by an independent assessor, and ultimately approved by the Health Care Authority.

5. Why would a region choose to implement in November 2018 versus January 2019? Are there additional incentives for choosing November 2018?

The transition to integrated managed care requires significant focus, resources and dedication from the Health Care Authority, DSHS, providers, the transitioning BHO, and managed care plans. The HCA strongly recommends regions consider a November 2018 start date so that mid-adopter implementation can be staged. This will allow resources for each region to be more focused during the critical transition days. Incentive funds for November and January start dates are the same, pending legislative appropriation.

6. If the region does not want to move forward early, when will the region transition to integrated managed care? If the region does not move forward early, will there still be incentive dollars available?

Senate Bill 6312 directs the state to fully integrate the purchasing of medical and behavioral health services through a managed care health system no later than January 1, 2020. An integrated managed care model will be in place in all regions by January 1, 2020. Only “mid-adopter” regions can receive the proposed incentive dollars tied to integrated managed care.

7. My region needs more information. Who do we contact?

For questions about integrated managed care, please contact Isabel Jones: Isabel.Jones@hca.wa.gov or 360-725-0862.

For questions about the Medicaid Demonstration funds, please contact Kali Klein: Kali.Klein@hca.wa.gov or 360-725-1240.

A Salish Perspective on HCA Arguments for FIMC

(Fully [financially] Integrated Managed Care)

1. What Does 2ESSB 6312 Really Say About Integration?

6312 requires that physical and Behavioral Healthcare be integrated by 2020. In fact, the bill is silent about the integration of FUNDING for these services. Integrated CARE is the goal, and care integration is being accomplished independent of financial integration. In fact, the effort needed to create financial integration is actually distracting, by either taking energy away from efforts to integrate clinical care or actually causing services that are currently clinically integrated to become fiscally less stable resulting in less integration rather than more. Integration efforts are numerous today, including behavioral health agencies contracted with BHOs that have physicians practicing on-site, medical practices that have mental health professionals in-house, and nearly every option in between. All of these levels of integration are occurring without any mandated fiscal integration. Furthermore, these examples of current clinical integration are supported by local control and without the proposed fiscal integration.

2. What About These Financial Incentives?

The financial incentives being offered by the HCA are one-time inducements to encourage Counties to sign letters of intent. Yet the financial incentives will not be controlled by signing counties, but by the local Accountable Communities of Health or ACH, which in most cases is a brand-new entity with no track record and little County representation or connection. The ACH is an independent incorporated body with no legislative authority, and no legal responsibility to the local population.

3. What About The Future?

Counties have a serious choice to make. When Healthcare and Behavioral Health are financially integrated, Counties will no longer control over \$1,000,000,000 annually in direct care services which is purchased through Behavioral Health Organizations today. Counties will no longer have the authority to make decisions about the mix of programs to address local needs, or have any decision making about programs which are NOT meeting local needs. If a new need, such as the current Opioid crisis appears on the horizon, Counties will not participate in determining the best course of action for their citizens to address the crisis, and will be dependent upon for-profit health insurers to make the decisions when it comes to choosing wise investments in their communities.

Once counties make this decision, it will be forever. Clark and Skamania Counties made the decision in April of 2016, and there has been no time or opportunity to evaluate changes associated with the decision to this date. At the very least, a thorough and impartial evaluation of integration efforts in that pilot region should take place prior to moving forward.

4. What About Integration Beyond Those Served By BHOs?

BHOs currently are responsible for serving the most chronically ill individuals in our state. In that role, they serve about 10% of the Medicaid population. The HCA and MCO plans could and should integrate care for the rest of the Medicaid population. However, as demonstrated throughout the state, clinical integration is in no way dependent upon the Counties giving up their responsibility and instead should be encouraged.

5. Do The Mentally Ill Have Shorter Lives?

Yes they do, though studies differ as to the magnitude, from the HCA quoted 25 years to another study which determined an 8 year difference. The mentally ill are disproportionately dependent upon the Medicaid healthcare system for care, are disproportionately poor, homeless, unemployed and disconnected from society. They also have virtually no access to dental care. All of these facts together create an environment that makes good health a very difficult thing to achieve. Poor dental care alone has been shown in many studies to lead to shorter life spans, and the integration of behavioral health with physical healthcare will do nothing to solve the dental care crisis. Yet we do have a county that currently has the integration of mental health, substance use disorders, medical care AND dental care for this most difficult to serve population, a feat that has been accomplished without any proposed fiscal integration.

6. Isn't The Opportunity To Become A Behavioral Health Administrative Organization Worth Exploring?

Behavioral Health Organizations (BHO) today are providing managed behavioral healthcare to the entire Medicaid population. As the entity responsible for ALL behavioral health, the BHO can and does spread the risk involved with operating Crisis Services across a very large budget and span of programs. If the BHO were responsible for only Crisis services and certain non-Medicaid funding sources, the risk associated with operating Crisis programs would increase substantially. This option is certainly worthy of exploration, but the risks should be kept in mind.

7. What About Administrative Costs?

While it is true that current Medicaid contracts with the state limit administrative costs to for-profit health insurers between 8.5 to 11.8% of the contract, the Salish Behavior Health Organization (SBHO) spends approximately 3.6% of its funding on administration. For the SBHO alone, this amounts to approximately 3.4 million dollars that currently goes to our provider network and direct client services annually and supports local jobs. Under the proposed fiscal integration model, that money will instead be directed to administrative costs and usually not locally spent. Statewide, the overall effect could be close to \$50,000,000 annually. Additionally, when Southwest Washington RSN became fully integrated, the local region lost all reserves that had been held by the RSN. For the SBHO, as of December 31, 2016, this amounted to \$7,700,000, most of which we will re-direct to services over time if the BHO continues to control them.



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

* Regional Performance Measure ** Core Performance Measure

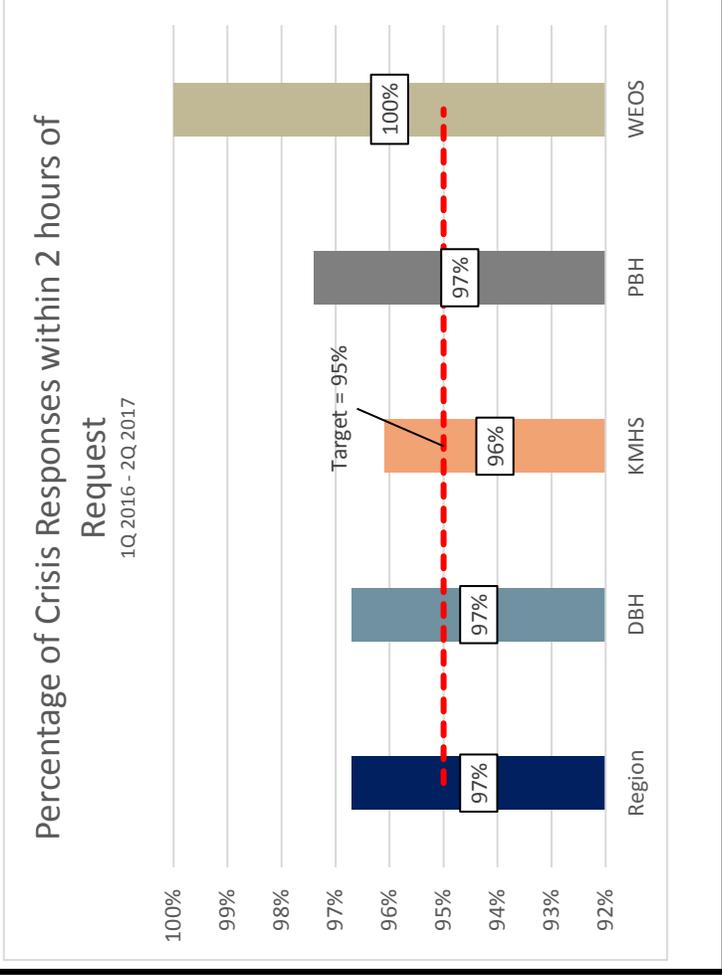
Definition of Indicator and Measurement Standard

1. Crisis Response Timeliness*

The percentage of crisis event face to face responses that occurred within 2 hours of request.

Formula:

$$\frac{\text{Number of crisis events where face to face response time was } \leq 2 \text{ hours from request during time period}}{\text{Number of crisis events for time period}}$$



Measurement									
		REGION		DBH	KMHS	PBH	WEOS		
FY		98.2%	587/598	94.3%	281/285	98.2%	100.0%		
1Q 2016				33/35		268/273	5/5		
2Q 2016		95.8%	644/672	93.3%	295/312	97.4%	100.0%		
3Q 2016		97.3%	691/710	96.4%	367/378	97.8%	100.0%		
4Q 2016		98.2%	658/670	98.9%	301/308	98.5%	100.0%		
1Q 2017		95.5%	515/539	100.0%	263/280	96.5%	100.0%		
2Q 2017		95.2%	609/640	94.8%	325/343	95.8%	N/A		

Target: 95% or above
Source: PIHP Contract

Data Source: Profiler Report - Crisis Response Time by Agency
Data Notes: Numerator does not include crisis events that were non-emergent and/or pre-arranged.
Data Valid as of 2/16/17



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

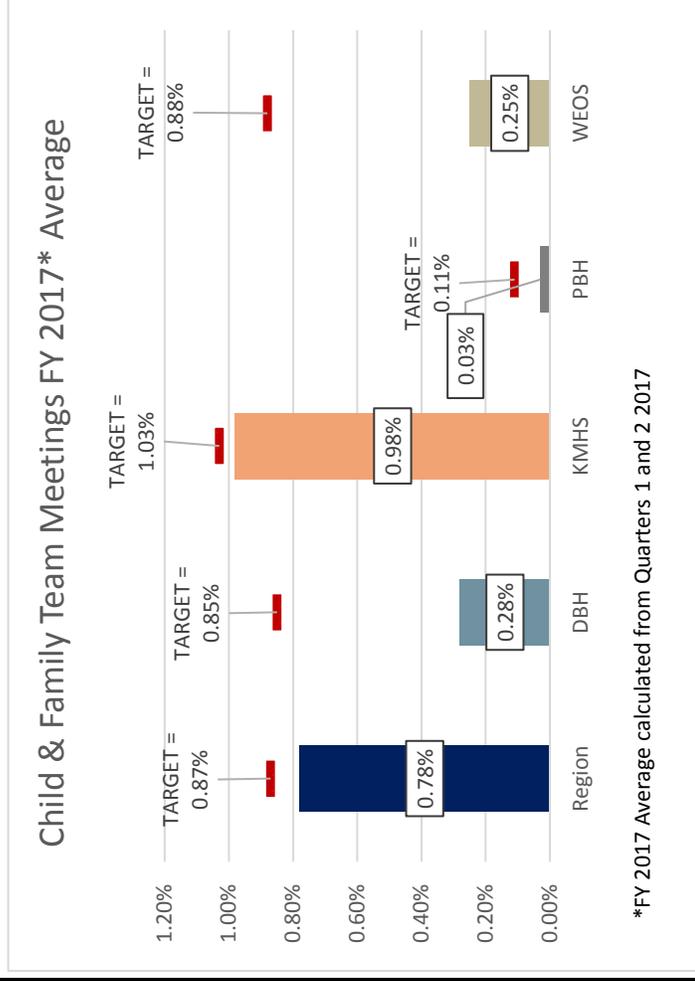
2. Child and Family (C&F) Team Meetings*

Rate of Child & Family team meetings encountered using the HT modifier

Formula:

Number of C&F team meetings (using HT modifier) that are recorded for children and youth under the age of 21 during time period

Number of children and youth services encountered in time period



*FY 2017 Average calculated from Quarters 1 and 2 2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
FY17 TARGET	0.87%	0.85%	1.03%	0.11%	0.88%
FY15 AVG	0.61%	1.02%	0.62%	0.03%	0.70%
FY16 AVG	0.79% 382/48398	0.77% 14/1818	0.94% 349/37321	0.10% 8/7881	0.80% 11/1378
1Q 2016	0.48% 51/10548	0.58% 3/520	0.57% 46/8035	0.12% 2/1726	0.00% 0/267
2Q 2016	1.01% 118/11667	1.22% 6/490	1.18% 105/8866	0.19% 4/2079	1.24% 3/242
3Q 2016	1.05% 138/13106	0.92% 3/325	1.26% 129/10199	0.09% 2/2177	0.99% 4/405
4Q 2016	0.57% 75/13067	0.41% 2/483	0.68% 69/10221	0.00% 0/1899	0.86% 4/464
1Q 2017	0.64% 68/10636	0.37% 2/539	0.80% 65/8149	0.00% 0/1639	0.32% 1/309
2Q 2017	0.91% 110/12052	0.18% 1/543	1.14% 107/9353	0.06% 1/1657	0.20% 1/499

Target: 10% increase over previous FY average
Source: QUIC designated target

Data Source: Profiler Report - RSN Encounter Data Validation
Data Notes: HT Modifier indicates Multi-disciplinary team and is recorded by meeting lead only
Parameters: Encounters for children and youth under the age of 21
Data Valid as of 2/28/17



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

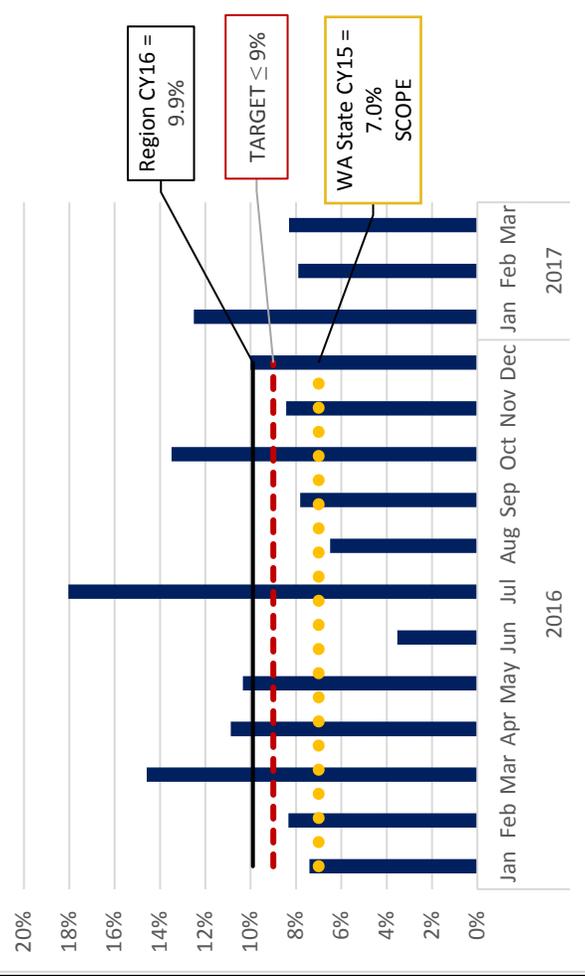
3. Inpatient Utilization (Readmission Rate)**

Percent of clients who were discharged from inpatient psychiatric care and were readmitted to inpatient psychiatric care within 30 days of discharge

Formula:

Number of clients readmitted to inpatient psychiatric care within 30 days of discharge within time period
 Number of clients discharged from inpatient psychiatric care during time period

Region Psychiatric Inpatient Readmission Rate



Target: Within 2 points of the State's average for previous year
Source: Minimum performance standard
Data Notes: Time period is calculated based on month of discharge from psychiatric inpatient facility. Review of data source pending.
Data Source: CommCare SBHO MH Readmissions Report, CommCare SBHO MH LOS Report, SCOPE. Data Valid as of 4/2017

Measurement										
	REGION	DBH	KMHS	PBH	WEOS					
CY	9.1%	7.7%	9.0%	10.4%	3.8%					
15 TOTAL	84/924	5/65	55/611	23/222	1/26					
CY 16										
FEB	8.3%	50.0%	6.0%	10.5%	0.0%					
	6/72	1/2	3/50	2/19	0/1					
MAR	14.6%	30.0%	15.0%	8.3%	0.0%					
	14/96	3/10	9/60	2/24	0/2					
APR	10.9%	20.0%	7.7%	20.0%	0.0%					
	10/92	1/5	5/65	4/20	0/2					
MAY	10.3%	18.2%	14.0%	0.0%	0.0%					
	9/87	2/11	7/50	0/23	0/3					
JUN	3.5%	0.0%	1.9%	11.8%	0.0%					
	3/85	0/11	1/54	2/17	0/3					
JUL	18.0%	25.0%	19.0%	7.1%	100%					
	11/61	1/4	8/42	1/14	1/1					
AUG	6.5%	0.0%	7.3%	8.3%	0.0%					
	5/77	0/8	4/55	1/12	0/2					
SEP	7.8%	0.0%	9.3%	6.3%	0.0%					
	5/64	0/4	4/43	1/16	0/1					
OCT	13.5%	15.4%	16.1%	5.9%	0.0%					
	12/89	2/13	9/56	1/17	0/3					
NOV	8.4%	16.7%	8.8%	6.3%	0.0%					
	7/83	1/6	5/57	1/16	0/4					
DEC	10.0%	22.2%	8.2%	9.5%	0.0%					
	8/80	2/9	4/49	2/21	0/1					
CY 17										
JAN	12.5%	16.7%	16.3%	0.0%	0.0%					
	9/72	2/12	7/43	0/14	0/3					
FEB	7.9%	20.0%	8.5%	5.6%	0.0%					
	6/79	1/5	4/47	1/18	0/6					
MAR	8.3%	0.0%	11.8%	4.8%	0.0%					
	7/84	0/11	6/51	1/21	0/1					



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

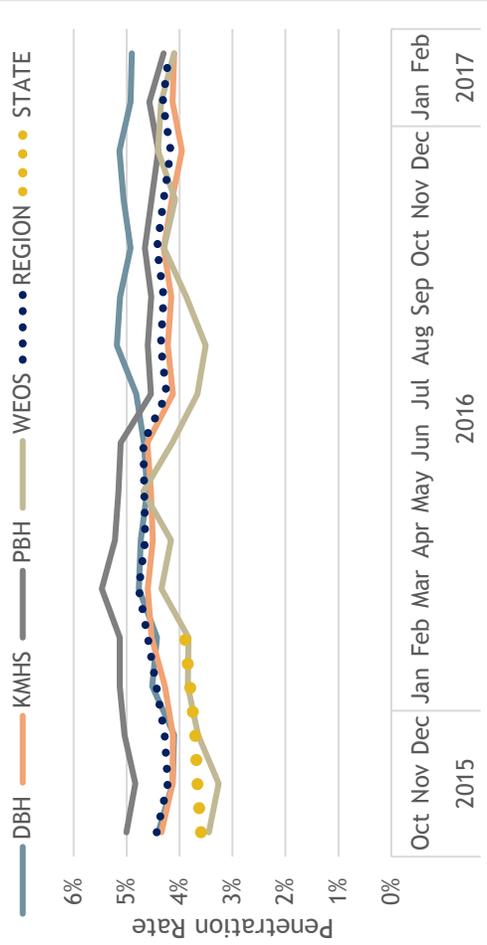
4. Access (Outpatient Penetration Rates)**

The proportion of Medicaid enrollees who received non-crisis outpatient MH services

Formula:

$$\frac{\text{Number of Medicaid clients receiving non-crisis outpatient MH services during time period}}{\text{Number of Medicaid eligible individuals during time period}}$$

Outpatient MH Penetration by Provider



Target: Not yet available from the State - anticipated Spring 2017

Data Source: Profiler DW - RSNEncounterValid_2, Medicaid Eligible Population, SCOPE

Data Notes: Regional count unduplicates clients completely.

Data Valid as of 4/25/2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
<u>CY 16</u>	4.4%	4.5%	4.3%	5.1%	3.8%
JAN	3451/77714	313/6934	2171/50808	828/16149	147/3823
FEB	4.6%	4.4%	4.5%	5.1%	3.8%
	3615/78536	314/7090	2320/51238	840/16368	147/3840
MAR	4.8%	4.8%	4.6%	5.5%	4.3%
	3745/78493	339/7106	2357/51218	894/16348	166/3821
APR	4.7%	4.7%	4.5%	5.2%	4.2%
	3662/78736	336/7101	2313/51328	859/16460	160/3847
MAY	4.7%	4.6%	4.5%	5.2%	4.7%
	3683/78894	331/7174	2331/51365	851/16512	180/3843
JUN	4.7%	4.7%	4.6%	5.1%	4.1%
	3697/78914	334/7149	2369/51414	843/16486	160/3865
JUL	4.2%	4.8%	4.1%	4.5%	3.7%
	3348/78822	340/7062	2119/51353	751/16531	142/3876
AUG	4.4%	5.2%	4.2%	4.6%	3.5%
	3431/78859	367/7079	2168/51340	762/16558	136/3882
SEP	4.3%	5.1%	4.2%	4.5%	3.9%
	3397/78998	362/7067	2141/51508	750/16551	150/3872
OCT	4.4%	4.9%	4.3%	4.7%	4.3%
	3503/79187	349/7086	2221/51639	771/16573	167/3889
NOV	4.3%	5.1%	4.1%	4.5%	4.1%
	3411/79374	358/7081	2148/51824	749/16552	160/3917
DEC	4.2%	5.1%	4.0%	4.4%	4.4%
	3317/79609	365/7108	2054/51936	732/16620	174/3945
<u>CY 17</u>	4.3%	4.9%	4.1%	4.6%	4.4%
JAN	3422/79222	349/7084	2136/51651	758/16578	170/3909
FEB	4.2%	4.9%	4.1%	4.3%	4.1%
	339/79383	349/7084	2105/51651	724/16712	163/3936



SALISH BHO

ADVISORY BOARD MEETING

DATE: Friday, June 2, 2017
TIME: 10:00 AM – 12:00 PM
LOCATION: City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382

A G E N D A

<http://www.kitsapgov.com/hs/sbho/sbhoboard.htm>

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of May 5, 2017 Minutes (Attachment 5)
6. Action Item
 - a. Substance Use Disorder Budget
7. Informational Items
 - a. Funding Issues
 - 1) State Budget
 - b. SUD Practices
 - 1) OST RFP Update
 - c. Integration
 - 1) Continued Discussion Regarding Full Integration
 - d. Quality Assurance (Attachment 7.d)
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Board Member Check-in
10. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHO	Behavioral Health Organization, replaced the Regional Support Network
CAP	Corrective Action Plan
CMHA	Community Mental Health Agency
CMS	Center for Medicaid & Medicare Services (federal)
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DDA	Developmental Disabilities Administration
DMHP	Designated Mental Health Professional
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FBG	Federal Block Grant (specifically MHBG and SABG)
FYSPT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IMD	Institutes for the Mentally Diseased
IS	Information Services
ITA	Involuntary Treatment Act
LOC	Level of Care
MAT	Medical Assisted Treatment
LRA	Least Restrictive Alternative
MCO	Managed Care Organization
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QA, QI	Quality Assurance, Quality Improvement
QUIC	Quality Improvement Committee
QRT	Quality Review Team
RCW	Revised Code Washington
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SAPT	Substance Abuse Prevention Treatment
SBHO	Salish Behavioral Health Organization
SUD	Substance Use Disorder
UM	Utilization Management
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Go to <http://www.kitsapgov.com/hs/sbho/sbhopolicies.htm> for a full listing of definitions and acronyms

SBHO Advisory Board

Agenda Briefings June 2, 2017

1. Action Item

a. Substance Use Disorder Budget

The need to reserve significant non-Medicaid funds to pay for residential services due to the IMD rule change has created the need to significantly modify the distribution of State and Substance Abuse Block Grant (SABG) funding. Staff will provide handouts describing how funds are currently distributed, how they have been used and billing histories, and recommendations for July allocations.

2. Informational Items

a. Funding Issues

1) State Budget

The lack of clarity (and budget) continues. Staff will provide any insights available.

b. SUD Practices

1) OST RFP Update

The RFP Review committee met May 18th, and has asked for the opportunity to meet with the one applicant to ask follow up questions regarding their proposal. That meeting is tentatively scheduled for June 19th.

c. Integration

1) Continued Discussion Regarding Full Integration

The issue of transitioning to Fully Integrated Managed Care (FIMC) and was discussed by the SBHO Executive Board at their meeting scheduled for May 19. Staff and members present at the meeting will provide an update. The Executive Board will consider the topic again at their June 16th meeting, and hopes to make recommendations back to constituent counties regarding this decision, which needs to be made by September.

d. Quality Assurance

The QA staff will present updated statistics and a first draft of a dashboard we are working on bringing up.

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**Friday, May 5, 2017
10:00 a.m.-12:00 p.m.
City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382**

CALL TO ORDER – Russel Hartman, Chair, called the meeting to order at 10:05 a.m.

INTRODUCTIONS – Self introductions were conducted around the room.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS - None

APPROVAL OF THE AGENDA

Agenda was accepted without motion.

APPROVAL OF April 7, 2017 MINUTES

MOTION: Anne Dean moved to approve the minutes of the January 27, 2017 meeting as submitted. Lois Hoell seconded. Motion carried unanimously.

ACTION ITEM

- Medicaid Budget
 - SBHO staff spoke on the most recent Medicaid budget proposals.
 - Our mental health providers have worked hard to build up productivity and expand service delivery (going back to July 2015) to get the SBHO some of the best rates in the state. They are one of the only regions to see significant rate increases.
 - Designated Marijuana Account (DMA) – The DMA has very specific expenditures as written and passed by the state. The DMA has a quarter of a million dollars written into the SBHO budget, but it has not been used as of its specificity (It is designated for youth SUD services who are not Medicaid eligible). The SBHO is analyzing likelihood of preparing an RFP to determine how the funds are to be allocated. The SBHO plans to coordinate with the 1/10 of 1% groups when an RFP goes out as the groups are currently putting a good portion of their funds towards SUD services for youth which fits the specificity of the DMA fund. This can potentially help the 1/10 of 1% groups better leverage their funds.
 - The AI/AN Exemption will likely have a significant impact on West End Outreach Services (WEOS) as those individuals who identify as AI/AN are able to opt in or opt out on a monthly basis. SBHO staff proposed transferring \$300,000 from the Medicaid reserves to assist WEOS through the transition until more data is collected on the impact the exemption will have.
 - SBHO staff asked for the board's approval of the budget based on the preliminary numbers calculated by the division so that contracts can be finalized. The budgets were based on the SBHO receiving the same amount of funding from the state as it did in the previous year. The budget will have to be amended once the state has its final numbers.

MOTION: Lois Hoell moved to approve the proposed preliminary budget. Janet Nikolaus seconded. Motion carried unanimously.

INFORMATIONAL ITEMS

➤ Funding Issues

State Budget

- SBHO staff presented on the data reports.
- IMD's account for 85-90% of SUD services. In the first year of providing SUD services, the SBHO had over 4 million dollars in expenditures. This is an area of concern.
- We are starting with a \$700,000 hole in the state budget as the actuaries inflated the Medicaid side of expenses, but not the state side of expenses. It is being advocated to get the \$700,000 back as the SBHO's costs have significantly gone up. The SBHO will not know until the state budget is finalized.

SUD Practices - OST RFP

- A bidder's conference was held with one bidder showing up, but the SBHO has received other inquiries. Proposals are due on May 11, 2017.
- The SBHO did not include a budget as the costs of running a facility are unknown and we want to see what the bidders propose.
- The Review Committee from the Advisory Board along with Lisa Rey Thomas (OCH), Chris Frank (Clallam County Public Health Officer) and Susan Turner (Kitsap County Public Health Officer) will review the bids for the RFP on May 18, 2017. An update will be provided at the next meeting.

Integration

- In 2014, Bill 6312 was passed to establish BHO's. This also set the framework to move all healthcare dollars, including behavioral healthcare dollars, over to managed care facilities and operations by 2020. The state is very vested in having full integration of funds and treatments.
- The state has been divided into 10 different regional service areas with common insurers. To become a mid-adopter, the county authority must sign a letter of intent to integrate by September 15, 2017. It is now upon our region to decide if they are to become a mid-adopter. County Commissioners will have the final say in what will happen to the BHO in our region.
- For the state, a lot hinges on every region playing this game and working in harmony. The other force is the Section 1115 district waiver, a 1.25-billion-dollar waiver that specifies the state receiving these funds only if full integration of healthcare in the state occurs. The pressure is on the state to make this happen.
- In the states rubric of integrated care, BHO's will go away completely and managed care facilities would contract directly with providers. An amendment to Bill 1388, which is currently in the back of the house, would allow the development of a leadership table in each regional service area. Counties would lead the development of the leadership table with the assistance of managed care facilities and the Health Care Authority.
- The board needs to explore its options before making a decision on integration. What is the risk to us and our communities if we do not go along with mid

enrollment? Would it be worth it to develop a proposal that integrates healthcare into the SBHO? What do the commissioners envision in a fully integrated system? These items will be taken to the Executive Board for further discussion and presented at the next Advisory Board meeting.

➤ Quality Assurance

- SBHO staff presented on the QA data reports.
- The SBHO QA staff are working on creating an internal data system that will provide more detailed and accurate information.

➤ Board Priorities

- The board agreed at the April 7, 2017 meeting that the five priorities the board previously established, should continue to be a focus for this year. These priorities include; funding, SUD practices, integration, QA, and 1/10 of 1% groups in each of the counties. As additional ideas or thoughts come up, please send them to Anders Edgerton and Russ Hartman so that they can be addressed.

OPPORTUNITY FOR PUBLIC COMMENT

- Pam Brown -Thank you for supporting Clallam County and not cutting services for our folks.
- Ellen Epstein -Regarding the AI/AN exemption; if a tribal member wants to receive services from the SBHO, where would the funds go? Tribal members will have the opportunity to opt in or out of SBHO services on a monthly basis.
- Vivian Morey -Would Ombuds services go away if the BHO opted for early integration? Ombuds services would remain in place.

FOR THE GOOD OF THE ORDER

- Board Member Check-In:
 - Russ – We continue to live in very interesting times.
 - Janet - Agreed with Russ; these are interesting times.
 - John – Submitted his letter of resignation as he is on the QRT Board and according to SBHO Bylaws, this is a conflict of interest.

- The next meeting is Friday, June 2, 2017 at the City of Sequim Transit Center.

ADJOURNMENT - The meeting adjourned at 11:59 a.m.

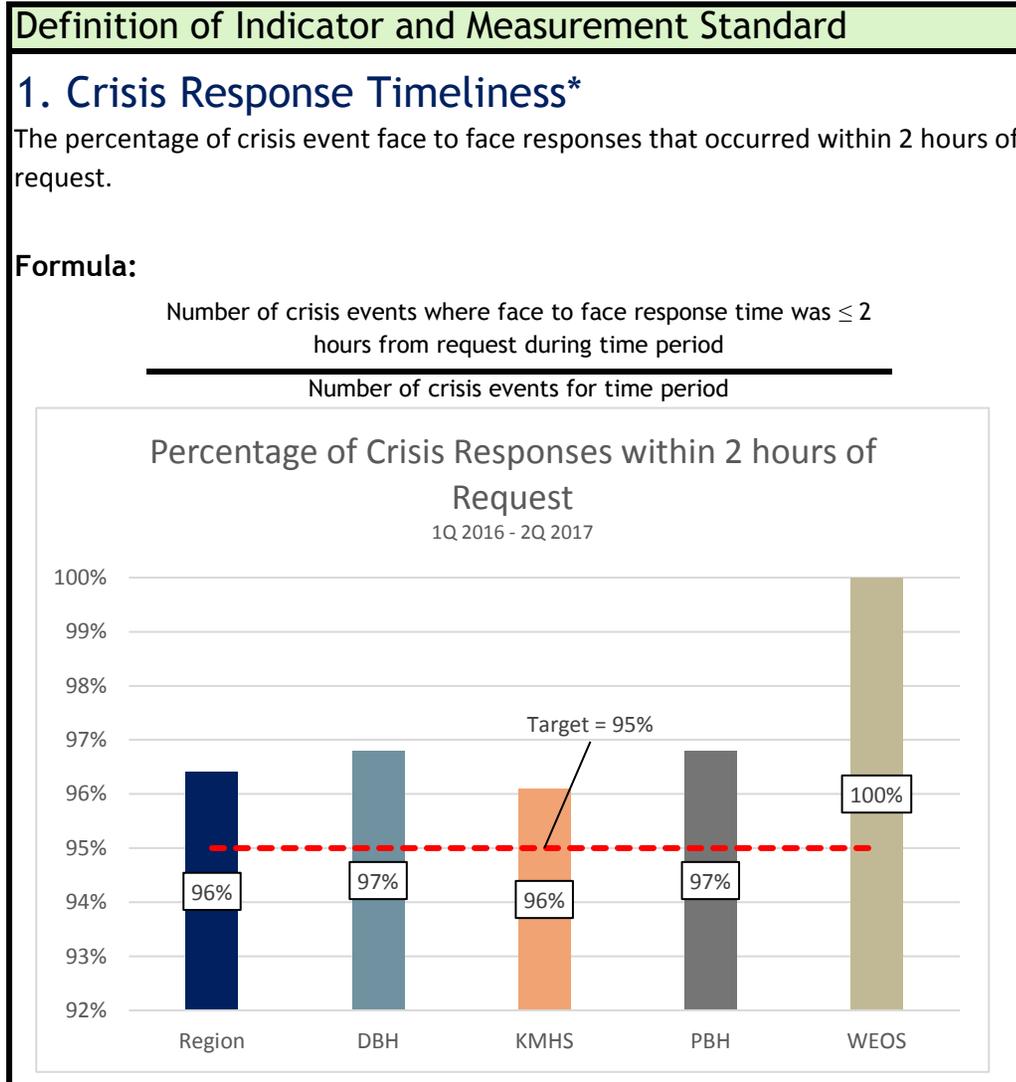
ATTENDANCE

MEMBERS	GUESTS	STAFF
<u>Present</u> Anne Dean John Freeburg Janet Nickolaus Roberta Charles Russ Hartman Lois Hoell Jolene George <u>Absent/Excused</u> Helen Morrison Charles Pridgen Steve Schermerhorn Jon Stroup Catharine Robinson Mike Stringer Jennifer Kreidler-Moss Freida Fenn	Ellen Epstein, RMH Services Lisa Rey Thomas, Olympic Community of Health Vivian Morey, Ombuds Pam Brown, WEOS Vicki Lowe, AIHC/Jamestown Mike Glenn, Jefferson Healthcare Carol Ru Kirk, Discovery Behavioral Healthcare Dunia Faulx, Jefferson Healthcare Wendy Sisk, Peninsula Behavioral Health	Anders Edgerton Alexandra Hardy



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

* Regional Performance Measure ** Core Performance Measure



Measurement

	REGION	DBH	KMHS	PBH	WEOS
FY	98.2%	94.3%	98.6%	98.2%	100.0%
1Q 2016	587/598	33/35	281/285	268/273	5/5
2Q 2016	95.8%	93.3%	94.6%	97.4%	100.0%
	644/672	42/45	295/312	299/307	8/8
3Q 2016	97.3%	96.4%	97.1%	97.8%	100.0%
	691/710	53/55	367/378	268/274	3/3
4Q 2016	98.2%	98.9%	97.7%	98.5%	100.0%
	658/670	88/89	301/308	265/269	4/4
1Q 2017	95.5%	100.0%	93.9%	96.5%	100.0%
	515/539	55/55	263/280	195/202	2/2
2Q 2017	95.2%	94.8%	94.8%	95.8%	N/A
	609/640	55/58	325/343	229/239	0/0
3Q 2017	94.6%	97.6%	95.8%	92.7%	100.0%
	561/593	41/42	277/289	242/261	1/1

Target: 95% or above
Source: PIHP Contract

Data Source: ProFiler Report - Crisis Response Time by Agency
Data Notes: Numerator does not include crisis events that were non-emergent and/or pre-arranged.
Data Valid as of 5/23/17



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

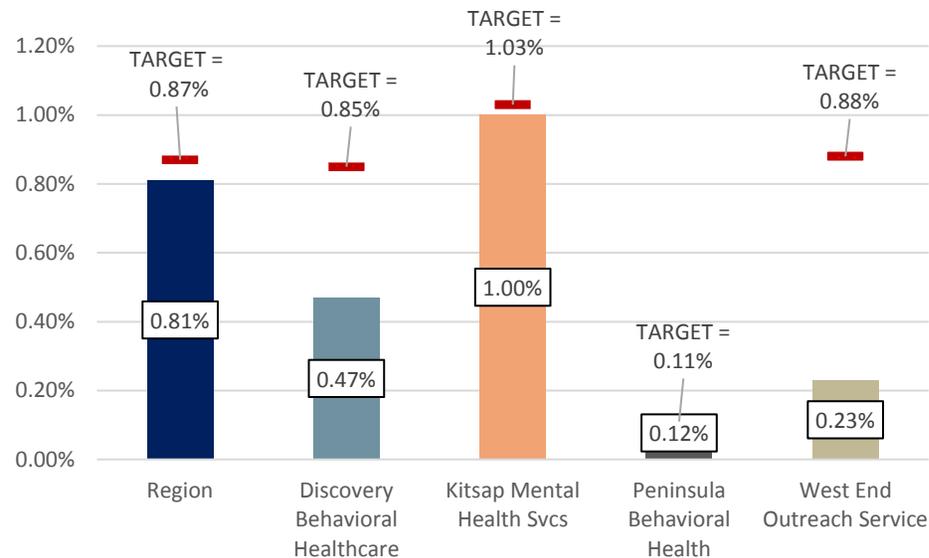
2. Child and Family (C&F) Team Meetings*

Rate of Child & Family team meetings encountered using the HT modifier

Formula:

$$\frac{\text{Number of C\&F team meetings (using HT modifier) that are recorded for children and youth under the age of 21 during time period}}{\text{Number of children and youth services encountered in time period}}$$

Child & Family Team Meetings FY 2017* Average



*FY 2017 Average calculated from Quarters 1, 2, & 3 2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
FY17 TARGET	0.87%	0.85%	1.03%	0.11%	0.88%
FY15 AVG	0.61%	1.02%	0.62%	0.03%	0.70%
FY16 AVG	0.79% 382/48398	0.77% 14/1818	0.94% 349/37321	0.10% 8/7881	0.80% 11/1378
1Q 2016	0.48% 51/10548	0.58% 3/520	0.57% 46/8035	0.12% 2/1726	0.00% 0/267
2Q 2016	1.01% 118/11667	1.22% 6/490	1.18% 105/8866	0.19% 4/2079	1.24% 3/242
3Q 2016	1.05% 138/13106	0.92% 3/325	1.26% 129/10199	0.09% 2/2177	0.99% 4/405
4Q 2016	0.57% 75/13067	0.41% 2/483	0.68% 69/10221	0.00% 0/1899	0.86% 4/464
1Q 2017	0.64% 68/10636	0.37% 2/539	0.80% 65/8149	0.00% 0/1639	0.32% 1/309
2Q 2017	0.91% 110/12052	0.18% 1/543	1.14% 107/9353	0.06% 1/1657	0.20% 1/499
3Q 2017	0.85% 104/12173	0.72% 6/832	1.02% 92/8999	0.27% 5/1847	0.20% 1/495

Target: 10% increase over previous FY average

Source: QUIC designated target

Data Source: ProFiler Report - RSN Encounter Data Validation

Data Notes: HT Modifier indicates Multi-disciplinary team and is recorded by meeting lead only

Parameters: Encounters for children and youth under the age of 21

Data Valid as of 5/23/17



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

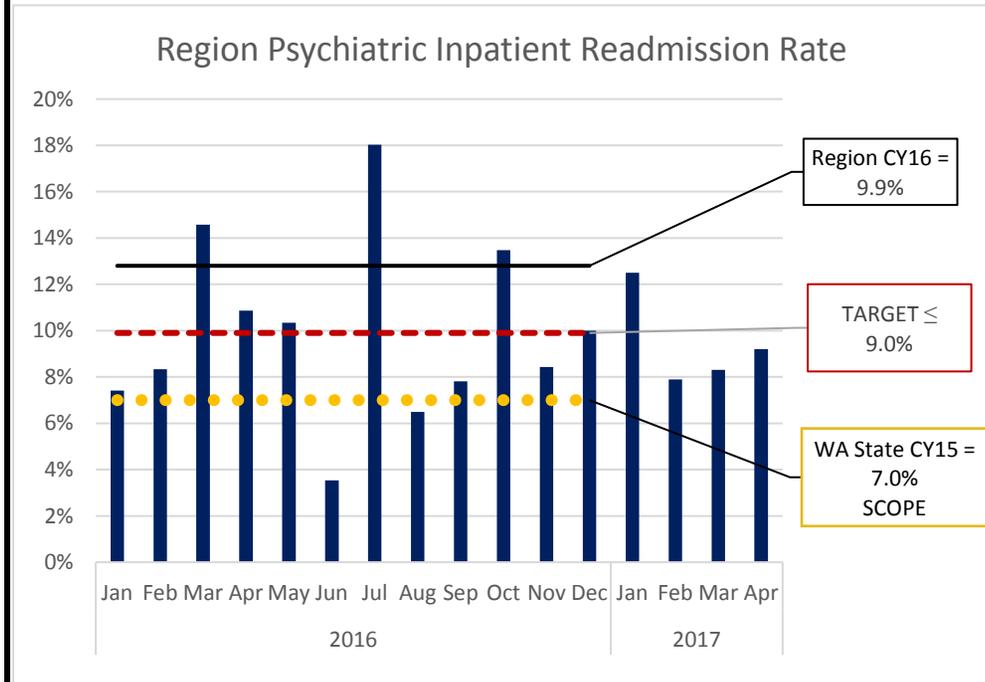
Definition of Indicator and Measurement Standard

3. Inpatient Utilization (Readmission Rate)**

Percent of clients who were discharged from inpatient psychiatric care and were readmitted to inpatient psychiatric care within 30 days of discharge

Formula:

$$\frac{\text{Number of clients readmitted to inpatient psychiatric care within 30 days of discharge within time period}}{\text{Number of clients discharged from inpatient psychiatric care during time period}}$$



Target: Within 2 points of the State's average for previous year

Source: Minimum performance standard

Data Notes: Time period is calculated based on month of discharge from psychiatric inpatient facility. Review of data source pending.

Data Source: CommCare SBHO MH Readmissions Report, CommCare SBHO MH LOS Report, SCOPE.

Measurement

	REGION	DBH	KMHS	PBH	WEOS
CY 15 TOTAL	9.1% 84/924	7.7% 5/65	9.0% 55/611	10.4% 23/222	3.8% 1/26
CY 16 MAR	14.6% 14/96	30.0% 3/10	15.0% 9/60	8.3% 2/24	0.0% 0/2
APR	10.9% 10/92	20.0% 1/5	7.7% 5/65	20.0% 4/20	0.0% 0/2
MAY	10.3% 9/87	18.2% 2/11	14.0% 7/50	0.0% 0/23	0.0% 0/3
JUN	3.5% 3/85	0.0% 0/11	1.9% 1/54	11.8% 2/17	0.0% 0/3
JUL	18.0% 11/61	25.0% 1/4	19.0% 8/42	7.1% 1/14	100% 1/1
AUG	6.5% 5/77	0.0% 0/8	7.3% 4/55	8.3% 1/12	0.0% 0/2
SEP	7.8% 5/64	0.0% 0/4	9.3% 4/43	6.3% 1/16	0.0% 0/1
OCT	13.5% 12/89	15.4% 2/13	16.1% 9/56	5.9% 1/17	0.0% 0/3
NOV	8.4% 7/83	16.7% 1/6	8.8% 5/57	6.3% 1/16	0.0% 0/4
DEC	10.0% 8/80	22.2% 2/9	8.2% 4/49	9.5% 2/21	0.0% 0/1
CY 17 JAN	12.5% 9/72	16.7% 2/12	16.3% 7/43	0.0% 0/14	0.0% 0/3
FEB	7.9% 6/79	20.0% 1/5	8.5% 4/47	5.6% 1/18	0.0% 0/6
MAR	8.3% 7/84	0.0% 0/11	11.8% 6/51	4.8% 1/21	0.0% 0/1
APR	9.2% 6/65	0.0% 0/6	11.4% 5/44	7.1% 1/14	0.0% 0/1

Data Valid as of 5/2017



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

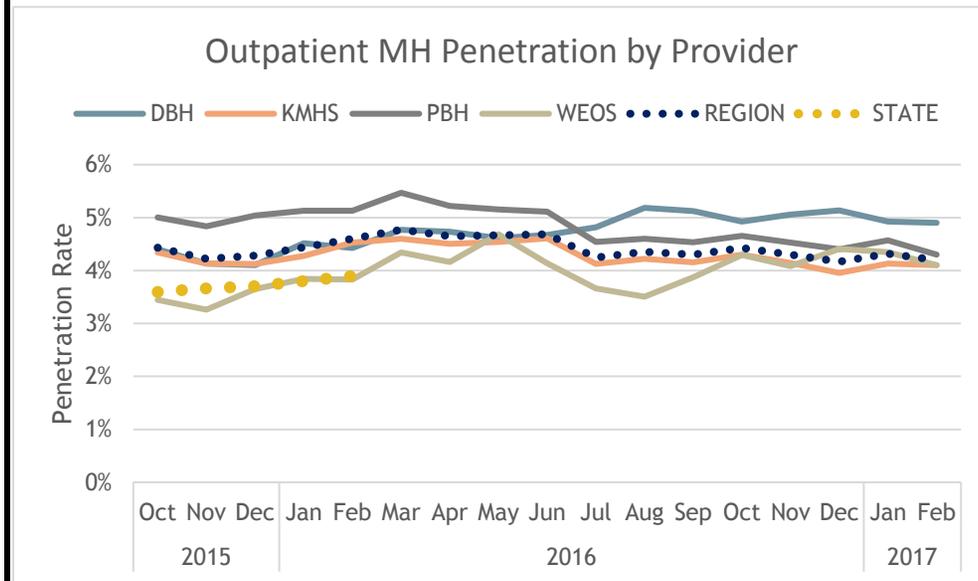
Definition of Indicator and Measurement Standard

4. Access (Outpatient Penetration Rates)**

The proportion of Medicaid enrollees who received non-crisis outpatient MH services

Formula:

$$\frac{\text{Number of Medicaid clients receiving non-crisis outpatient MH services during time period}}{\text{Number of Medicaid eligible individuals during time period}}$$



Target: Not yet available from the State - anticipated Spring 2017
 Data Source: Profiler DW - RSNEncounterValid_2, Medicaid Eligible Population, SCOPE
 Data Notes: Regional count unduplicates clients completely.
 Data Valid as of 4/25/2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
CY 16	4.4%	4.5%	4.3%	5.1%	3.8%
JAN	3451/77714	313/6934	2171/50808	828/16149	147/3823
FEB	3615/78536	314/7090	2320/51238	840/16368	147/3840
MAR	3745/78493	339/7106	2357/51218	894/16348	166/3821
APR	3662/78736	336/7101	2313/51328	859/16460	160/3847
MAY	3683/78894	331/7174	2331/51365	851/16512	180/3843
JUN	3697/78914	334/7149	2369/51414	843/16486	160/3865
JUL	3348/78822	340/7062	2119/51353	751/16531	142/3876
AUG	3431/78859	367/7079	2168/51340	762/16558	136/3882
SEP	3397/78998	362/7067	2141/51508	750/16551	150/3872
OCT	3503/79187	349/7086	2221/51639	771/16573	167/3889
NOV	3411/79374	358/7081	2148/51824	749/16552	160/3917
DEC	3317/79609	365/7108	2054/51936	732/16620	174/3945
CY 17	4.3%	4.9%	4.1%	4.6%	4.4%
JAN	3422/79222	349/7084	2136/51651	758/16578	170/3909
FEB	339/79383	349/7084	2105/51651	724/16712	163/3936



SALISH BHO

ADVISORY BOARD MEETING

DATE: Friday, August 4, 2017
TIME: 10:00 AM – 12:00 PM
LOCATION: City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382

A G E N D A

<http://www.kitsapgov.com/hs/sbho/sbhoboard.htm>

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of June 2, 2017 Minutes (Attachment 5)
6. Action Items
 - a. Opiate Treatment Program Recommendation
 - b. Establish RFP Committees (Attachment 6.b)
 - Designated Marijuana Account Funding
 - Substance Abuse Block Grant
7. Informational Items
 - a. State Budget Update (Attachment 7.a)
 - b. Budget Update (Attachment 7.b)
 - Substance Use Disorder Distribution
 - c. Substance Use Disorder Residential Changes
 - d. Integration
 - Continued Discussion Regarding Full Integration
 - Updates from Other Behavioral Health Organizations
 - Discussion of Planning Process Moving Forward
 - e. Quality Assurance (Attachment 7.e.1, 7.e.2)
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Board Member Check-in
10. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHO	Behavioral Health Organization, replaced the Regional Support Network
CAP	Corrective Action Plan
CMHA	Community Mental Health Agency
CMS	Center for Medicaid & Medicare Services (federal)
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DDA	Developmental Disabilities Administration
DMHP	Designated Mental Health Professional
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FBG	Federal Block Grant (specifically MHBG and SABG)
FIMC	Full Integration of Medicaid Services
FYSPRT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IMD	Institutes for the Mentally Diseased
IS	Information Services
ITA	Involuntary Treatment Act
LOC	Level of Care
MAT	Medical Assisted Treatment
LRA	Least Restrictive Alternative
MCO	Managed Care Organization
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
OST	Opiate Substitution Treatment
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QA, QI	Quality Assurance, Quality Improvement
QUIC	Quality Improvement Committee
QRT	Quality Review Team
RCW	Revised Code Washington
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SAPT	Substance Abuse Prevention Treatment
SBHO	Salish Behavioral Health Organization
SUD	Substance Use Disorder
UM	Utilization Management
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Go to <http://www.kitsapgov.com/hs/sbho/sbholicies.htm> for a full listing of definitions and acronyms

Action Items

a. OPIATE TREATMENT PROGRAM RECOMMENDATION

The organization which responded to the OTP Request for Proposals met with the RFP Committee and staff from the Health Departments in Kitsap and Clallam Counties as well as Lisa Rey Thomas of the Olympic Community of Health and SBHO staff on June 26 to respond to any remaining questions the group had regarding their proposal. The Board is asked to make a recommendation to the Executive Board to contract with BayMark for OTP services in Kitsap And Clallam Counties.

b. ESTABLISH RFP COMMITTEES

- Designated Marijuana Account Funding

In the spring of 2016, the Legislature cut state funding for Substance Use Disorder services, and substituted Designated Marijuana Account (DMA) funds for the former state funding. At the time, BHOs were told that the fund switch was not anything to be concerned about, and the funds were interchangeable. In January 2017, the SBHO received a contract amendment containing language (Attachment 6.b) that makes utilization of the DMA funding very restrictive. The SBHO believes that the best way to utilize these funds at this point is to complete an RFP specifically for this program. The Board is asked to establish a committee to assist.

- Substance Abuse Block Grant (SABG)

The Substance Abuse Block Grant is a separate funding stream which requires community involvement and input from the Advisory Board. The SBHO is setting up a system of developing SABG plans in the fall of the year so that a more thoughtful process can be facilitated in the future. We have extended current SABG contracts by six months, and would like to complete an RFP cycle in time for January contracts. The Board is requested to set up a review committee.

Informational Items

a. STATE BUDGET UPDATE

The Legislature completed work on an operations budget in the nick of time, providing ongoing funding for critical state programs. The Division of Behavioral Health and Recovery (DBHR) has not yet completed the process of analyzing and distributing funding, but it appears that our revenue will be unaffected by the budget. An SBHO developed comparison of this biennium's budget to that of last biennium is attached for the Boards information.

b. BUDGET UPDATE

- Substance Use Disorder Distribution

The lack of a final distribution of funding from the State makes putting together a final annual budget impossible. The significant change in the revenue picture as a result of the Federal change to the IMD (Institutions for Mental Diseases) rule which made approximately half of our residential stays ineligible for Medicaid reimbursement, and the need to back-fill those residential costs with Non-Medicaid funds has created a very complex situation. Staff continues to refine our efforts to distribute non-Medicaid funding to areas of highest need, and we have entered into six month contracts with our providers for both State funds as well as Substance Abuse Block Grant funding (Attachment 7.b). Staff will monitor provider expenditures closely in order to inform January contracts and the SABG RFP process.

c. SUBSTANCE USE DISORDER RESIDENTIAL CHANGES

The change in the Federal IMD rule has resulted in a significant change in how many BHOs approach Residential SUD services as well as how some programs are operated.

Within our BHO, the program at the Kitsap Recovery Center has been modified, and the program physically moved to prepare for the development of a Triage Center by Kitsap Mental Health. The program at the new Recovery Center has been modified to create a non-IMD situation by shrinking the residential program to 16 beds, and increasing the Withdrawal Management program to 16 beds. In Pierce County, Prosperity Wellness has decreased their bed capacity to 16, and increased their outpatient program.

Behavioral Health Organizations have taken different approaches to the new payment paradigm, with some BHOs shortening their authorization period to as little as 12 days. The SBHO has not made any authorization changes, but will be monitoring residential utilization and funding flows carefully to ensure that we remain in compliance with funding restrictions.

d. INTEGRATION

- Continued Discussion Regarding Full Integration
 - Updates from Other Behavioral Health Organizations

At the time of this writing, it is anticipated that Pierce and King Counties may step forward to become mid-adopters of full financial integration of Managed Care. Each of these counties has special unique circumstances that have led to these decisions, which staff will discuss.

- Discussion of Planning Process Moving Forward
- The Board is asked to discuss what role it sees itself filling in informing and making recommendations to the Executive Board regarding the state's

intention to move all Medicaid funding to Managed Care Organizations by January of 2020.

e. QUALITY ASSURANCE

The Quality Assurance staff will present an update on performance measures (Attachment 7.e.1) and EDV results (Attachment 7.e.2).

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**10:00 a.m., Friday, June 2, 2017
City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382**

CALL TO ORDER – Jon Stoup, 2nd Vice Chair, called the meeting to order at 10:04 a.m.

INTRODUCTIONS – Self introductions were conducted around the room.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS – None

****This meeting did not qualify as a quorum based on attendance records, therefore any action taken during the meeting is void.****

APPROVAL OF THE AGENDA

The agenda was adjusted to move item 7.c, Integration to an Action Item (6.B). The order of presentation was changed to begin with Informational Items until a quorum could be reached.

MOTION: Catharine Robinson moved to approve the amended agenda. Lois Hoell seconded. Motion carried.

APPROVAL OF May 5, 2017 MINUTES

MOTION: Freida Fenn moved to approve the minutes of the May 5, 2017 meeting as submitted. Lois Hoell seconded. Motion carried.

ACTION ITEMS

➤ Substance Use Disorder Budget

- Staff presented information on the non-Medicaid funds for SUD services.
- The need to reserve significant non-Medicaid funds to pay for residential services due to the IMD rule change has created the need to modify the distribution of State and Substance Abuse Block Grant funding (SABG).
- The SBHO is proposing to do six month contracts for SABG funding (July 2017 – December 2017) and then do a RFP in the Fall of 2017 to allocate funds for the remaining 6 months (January 2018 – June 2018).
- SBHO staff suggested the board to review how agencies are spending SABG funds in the Fall of 2017 to ensure that the funding isn't lost and to assist with the RFP.
- Most of our agencies are behind with spending SABG funds. Several providers spoke about the struggles their agencies are having with spending SABG funds.
 - Pam Brown spoke for West End Outreach Services (WEOS) and stated that the SABG rates don't match up for the salaries and benefits that WEOS must pay its staff and that they are having to subsidize salaries

and benefit expenses through the hospital. WEOS is still looking for a creative way to use SABG funds.

- Ford Kessler from Safe Harbor/Beacon of Hope stated that his contracts were not finalized until October of 2016 and that they waited to start spending SABG funds until the contracts were finalized. Next year will provide better information with SABG spending for his agency.
- Joe Roszak, Kitsap Mental Health Services, stated that a licensing issue at the state caused a delay in being able to provide SUD services and that a work shortage for SUD providers in our area has made it a challenge.
- The Criminal Justice Treatment Act (CJTA) needs to have a more planned process that includes working with each counties court system to see how they want the CJTA money spent. A better system needs to be created to allocate funds.

➤ **MOTION: Freida Fenn moved to approve the Substance Use Disorder Budget as submitted. Helen Morrison seconded. Motion Carried.**

➤ Integration

- SBHO staff presented on the issue of transitioning to Fully Integrated Managed Care (FIMC) and provided an update on the discussion the Executive Board had at its last meeting.
- The power point presentation that the Health Care Authority created and spoke on at the May 19, 2017 Executive Board meeting was presented and reviewed.
 - SB 6312 passed in 2014 changed how the state purchased mental health and substance use disorder services in the Medicaid program and directed the state to fully integrate mental health and substance use disorder services into managed care by 2020.
 - For over 20 years the HCA/DSHS have tried to make two distinct managed care systems work together to provide care and have provided various types of contract requirements (MOU's between MCO's and RSN's, education, joint meetings) but clients still get caught in the no persons' land without access to care. The end result was poor outcomes.
 - Services that are not included in MCO Contracts include crisis services, state-funded services for non-Medicaid beneficiaries, block grant funded services, criminal justice related services, county funded services for Medicaid and non-Medicaid, and miscellaneous (BH Ombudsman, WISe, CLIP, FYSPRT, BH Advisory Board, writing block grant project plans, and other items).
 - The proposed county role in integration would be to choose a start date for implementation, decide whether the county/counties will retain any of the funding for non-Medicaid Behavioral Health services (crisis system, Federal Block Grant funded services, state funding, local government oversight committees, and Ombudsperson).
 - Some of the benefits of being a mid-adopter are the opportunity to collaborate with HCA to ensure that the program design works for their region, implementing prior to 2020 means the region will have a dedicated window to focus on a successful integration, access to resources and support for implementation, and additional incentive payments under the Medicaid

Demonstration Project, which accrue to the Olympic Community of Health (OCH).

- All regions with implementation dates prior to 2020 will receive incentives to support provider transition. These funds can be used to assist with implementing new billing technology, technical assistance to learn new billing systems, technical assistance in moving to value-based purchasing payment methods, technical assistance in implementing a new EHR, and assistance implementing an integrated clinical model.
- SBHO staff presented handouts on the four options that our region has when it comes to full integration
 - Option 1, Do nothing; without legislative intervention, the SBHO would become fully integrated in January of 2020 and all Behavioral Health funds would transfer to MCO's serving the region.
 - Pros: least amount of work for the BHO, could be used to create public perception that we want to continue to operate, and don't negotiate with plans that will not exist in region. Cons: No early planning for January 2020 takeover, public perception that we are not engaged, OCH does not get incentive funds and continued uncertainty.
 - Option 2, Plan on January 2020 FIMC through establishment of Leadership Table; this engages with MCO's to plan responsibilities under full integration.
 - Pros: Engage with MCO's to work together, take part in system design, appear less intransigent. Cons: Lack of staff time to devote to project, spend time negotiating with two-three plans which will not exist in 2020, gives the appearance that this is what we want.
 - Option 3, Submit letter of intent for FIMC in 2019, the SBHO would cease to exist in January of 2019.
 - Pros: OCH receives incentive payment of \$4.9 million and the SBHO could potentially have the most impact on eventual outcome. Cons: local control is lost a year early, significant funding that currently goes to the provider network would be lost, would take considerable investment of staff time (does not currently exist), and continued uncertainty.
 - Option 4, Attempt legislative change; gives us the possibility that Behavioral Health services could continue to be managed locally.
 - Pros: Local oversight and controls preserved and continued flow of funds unaffected by MCO administrative load. Cons: It is difficult to create change of this magnitude, could be vetoed by the governor if successful, and these efforts would take away from time available to plan for a smooth transition.

MOTION: Freida Fenn moved that we recommend that our region should attempt legislative change while advocating for integration of medical services with behavioral health services that would be managed locally. Lois Hoell seconded. Motion carried.

INFORMATIONAL ITEMS

➤ Funding Issues

State Budget

- Not a lot of information is coming out of the legislature; we are in the dark as to what to expect.
- An update will be provided once we have the final numbers from the state.

➤ SUD Practices

OST RFP

- The RFP Review Committee met on May 18th to evaluate the one response that was received and has asked for the opportunity to meet with the one applicant (BayMark Health Services) to ask follow up questions regarding their proposal. The meeting is tentatively scheduled for June 26.

➤ Quality Assurance (QA)

- QA Staff presented the first draft of the dashboard that has live up to date statistics on unique number of individuals served per month, provider service hours per month, service modality utilization by month, and procedure code utilization for each providing agency.
- The board was very supportive of the dashboard and asked the QA team to continue to work on the project.
- QA staff also presented on the data reports included in the agenda packet.

OPPORTUNITY FOR PUBLIC COMMENT

- Steve Workman (Jefferson County) – Spoke on the subject of MCO's making the decisions that the SBHO Advisory Board is currently making once FIMC occurs and asked for additional clarification on the subject.
- Ellen Epstein (RMH Services) – Voiced concern over the federal government and the potential impact their decisions can have on the FIMC. Ellen also voiced her concern over the AI/AN terminology from the state as it is very confusing and hard for patients/clients to understand.
- Joe Roszak (KMHS) – Offered his appreciation and support to the board for making this decision on integration as it was a bold move and a vote for the people. Joe plans on taking the boards message to the Accountable Communities of Health (ACH) Board meeting as they are about to have a similar vote and are currently sitting on the other side of the fence.
- Ford Kessler (Beacon of Hope) Thank you for the vote and being a voice as we need to stand up for the people to get them the quality of care.
- Rebecca Miller (PBH) Thank you for the vote. It is scary that we might lose control at the local level are area is unique and does not have the same resources that a market like Seattle had.

FOR THE GOOD OF THE ORDER

Attachment 5

- Board Member Check-In: Helen- good meeting and discussion; Catharine-good meeting and thank you to the providers for providing information to assist the board.
- The next meeting is Friday, August 4, 2017 at the City of Sequim Transit Center.

ADJOURNMENT - The meeting adjourned at 12:11 p.m.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<p><u>Present</u> Lois Hoell Freida Fenn Helen Morrison Janet Nickolaus Catharine Robinson Jon Stroup</p> <p><u>Absent/Excused</u> Roberta Charles Anne Dean Jolene George Russell Hartman Jennifer Kreidler-Moss Charles Pridgen Steve Schemerhorn</p>	<p>Darcy Allbee – West Sound Treatment Center Andy Brastad, Clallam County HHS Pam Brown, West End Outreach Services Ellen Epstein, RMH Services John Freeburg, QRT – Dispute Resolution Christine Green, West Sound Treatment Center Ford Kessler, Beacon of Hope Vivian Morey, Ombuds Joe Roszak, Kitsap Mental Health Services Doug Washburn, Kitsap County Human Services Steve Workman, Jefferson County Citizen Rebecca Miller, Peninsula Behavioral Health</p>	<p>Anders Edgerton Alexandra Hardy Richelle Jordan Ileea Nehus</p>

State Contract Amendment B

A new Subsection 4.14 Dedicated Marijuana Account (DMA) to read as follows:

4.14 Dedicated Marijuana Account (DMA).

4.14.1. DMA funds shall be used to fund substance use disorder treatment services for youth living at or below 220% of the federal poverty level, without insurance coverage or who are seeking services independent of their parent/guardian.

4.14.2. DMA funds may be used for development, implementation, maintenance, and evaluation of programs that support intervention, treatment, and recovery support services for middle school and high school aged students.

▶ All new programs services must direct at least eighty-five percent (85%) of funding to evidence-based or research-based programs and practices that produce objectively measurable results, and are expected to be cost beneficial.

▶ Up to fifteen percent (15%) of the funds appropriated for new programs and new services may be used to provide support to proven and tested practices, emerging best practices, or promising practices.

Salish Behavioral Health Organization				
Budget Comparisons				
	2016/17	2018/19	Difference	Percent Change
Mental Health				
Community Services				
State	692,459,000.00	800,565,000.00	108,106,000.00	15.6%
Federal	962,163,000.00	1,021,705,000.00	59,542,000.00	6.2%
Total	1,678,948,000.00	1,847,502,000.00	168,554,000.00	10.0%
Institutional Services				
State	352,121,000.00	564,759,000.00	212,638,000.00	60.4%
Federal	162,866,000.00	148,093,000.00	14,773,000.00	-9.1%
Total	571,656,000.00	765,482,000.00	193,826,000.00	33.9%
SUD				
State	129,660,000.00	150,150,000.00	20,490,000.00	15.8%
Federal	432,441,000.00	575,249,000.00	142,808,000.00	33.0%
Total	631,281,000.00	809,645,000.00	178,364,000.00	28.3%

July 2017 update			
Agency/Fund	State	Criminal Justice Treatment Act	SAPT 6 months
AGAPE			
State	\$ 56,000		
CJTA		\$ 39,000	
SABG			\$ 26,357
BEACON			
State	\$ 126,000		
CJTA		\$ 45,000	
SABG			\$ 34,408
CASCADIA			
State	\$ 10,000		
Cedar Grove			
State	\$ 10,000		
CJTA		\$ 15,000	
KMHS			
State	\$ 40,000		
SAPT			\$ 52,778
KRC			
State	\$ -		
CJTA/Drug		\$ 343,000	
LCS			
SAPT			\$ 7,828
NOHC			
SAPT			\$ 125,000
Thereapeutic childcare (in residential)			\$ 8,000
OLYMPIC PERS GROWTH			
State	\$ 30,000		
CJTA/Drug		\$ -	
SAPT			\$ 34,622
REFLECTIONS			
State	\$ 50,000		
SAPT			\$ 33,924
TRUE STAR			
State	\$ 50,000		
CJTA		\$ 10,000	
WEOS			
State	\$ 2,000		
SAPT			\$ 7,323
West Sound			
State	\$ 20,000		
SAPT			\$ 100,468



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

* Regional Performance Measure ** Core Performance Measure

Definition of Indicator and Measurement Standard

1. Crisis Response Timeliness*

The percentage of crisis event face to face responses that occurred within 2 hours of request.

Formula:

$$\frac{\text{Number of crisis events where face to face response time was } \leq 2 \text{ hours from request during time period}}{\text{Number of crisis events for time period}}$$

Percentage of Crisis Responses within 2 hours of request*
1Q 2016 - 3Q 2017

Entity	Percentage
Region	97%
DBH	98%
KMHS	97%
PBH	98%
WEOS	100%

*Numerator includes crisis events where response time was > 2 hours if denoted as non-emergent and/or pre-arranged

Measurement

	REGION	DBH	KMHS	PBH	WEOS
FY	98.5%	94.3%	98.6%	98.9%	100.0%
1Q 2016	589/598	33/35	281/285	270/273	5/5
2Q 2016	96.3%	97.8%	94.6%	97.7%	100.0%
	647/672	44/45	295/312	300/307	8/8
3Q 2016	97.5%	96.4%	97.4%	97.8%	100.0%
	692/710	53/55	368/378	268/274	3/3
4Q 2016	98.4%	98.9%	97.7%	98.9%	100.0%
	660/670	88/89	302/309	266/269	4/4
1Q 2017	96.3%	100.0%	94.6%	97.5%	100.0%
	517/539	53/53	265/280	197/202	2/2
2Q 2017	96.6%	96.6%	96.2%	97.1%	N/A
	618/640	56/58	330/343	232/239	0/0
3Q 2017	97.5%	97.6%	96.6%	98.1%	100.0%
	585/600	41/42	286/296	253/261	1/1

Target: 95% or above
Source: PIHP Contract

Data Source: ProFiler Report - Crisis Response Time by Agency
Data Notes: Numerator includes crisis events where response time was > 2 hours if they were identified as non-emergent and/or pre-arranged.
Data Valid as of 6/28/17



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

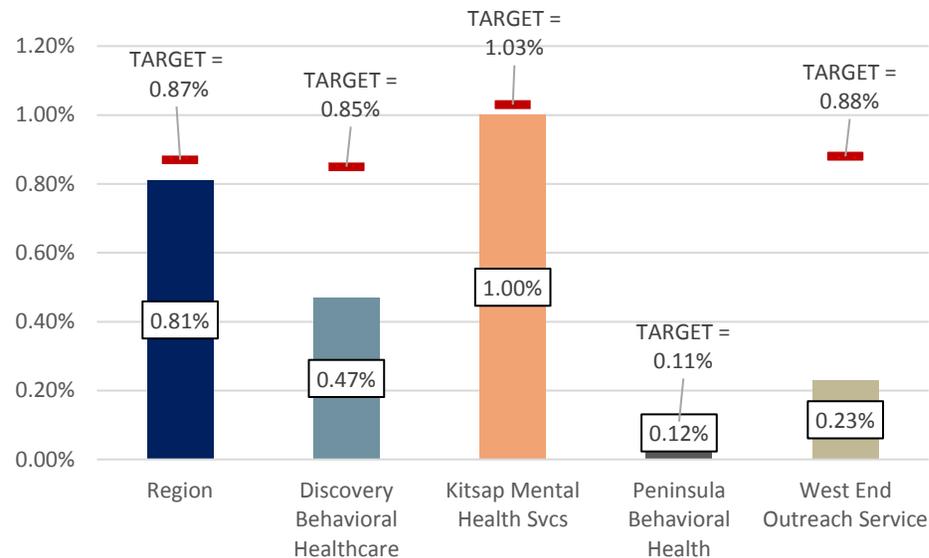
2. Child and Family (C&F) Team Meetings*

Rate of Child & Family team meetings encountered using the HT modifier

Formula:

$$\frac{\text{Number of C\&F team meetings (using HT modifier) that are recorded for children and youth under the age of 21 during time period}}{\text{Number of children and youth services encountered in time period}}$$

Child & Family Team Meetings FY 2017* Average



*FY 2017 Average calculated from Quarters 1, 2, & 3 2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
FY17 TARGET	0.87%	0.85%	1.03%	0.11%	0.88%
FY15 AVG	0.61%	1.02%	0.62%	0.03%	0.70%
FY16 AVG	0.79% 382/48398	0.77% 14/1818	0.94% 349/37321	0.10% 8/7881	0.80% 11/1378
1Q 2016	0.48% 51/10548	0.58% 3/520	0.57% 46/8035	0.12% 2/1726	0.00% 0/267
2Q 2016	1.01% 118/11667	1.22% 6/490	1.18% 105/8866	0.19% 4/2079	1.24% 3/242
3Q 2016	1.05% 138/13106	0.92% 3/325	1.26% 129/10199	0.09% 2/2177	0.99% 4/405
4Q 2016	0.57% 75/13067	0.41% 2/483	0.68% 69/10221	0.00% 0/1899	0.86% 4/464
1Q 2017	0.64% 68/10636	0.37% 2/539	0.80% 65/8149	0.00% 0/1639	0.32% 1/309
2Q 2017	0.91% 110/12052	0.18% 1/543	1.14% 107/9353	0.06% 1/1657	0.20% 1/499
3Q 2017	0.85% 104/12173	0.72% 6/832	1.02% 92/8999	0.27% 5/1847	0.20% 1/495

Target: 10% increase over previous FY average

Source: QUIC designated target

Data Source: ProFiler Report - RSN Encounter Data Validation

Data Notes: HT Modifier indicates Multi-disciplinary team and is recorded by meeting lead only

Parameters: Encounters for children and youth under the age of 21

Data Valid as of 6/28/17



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

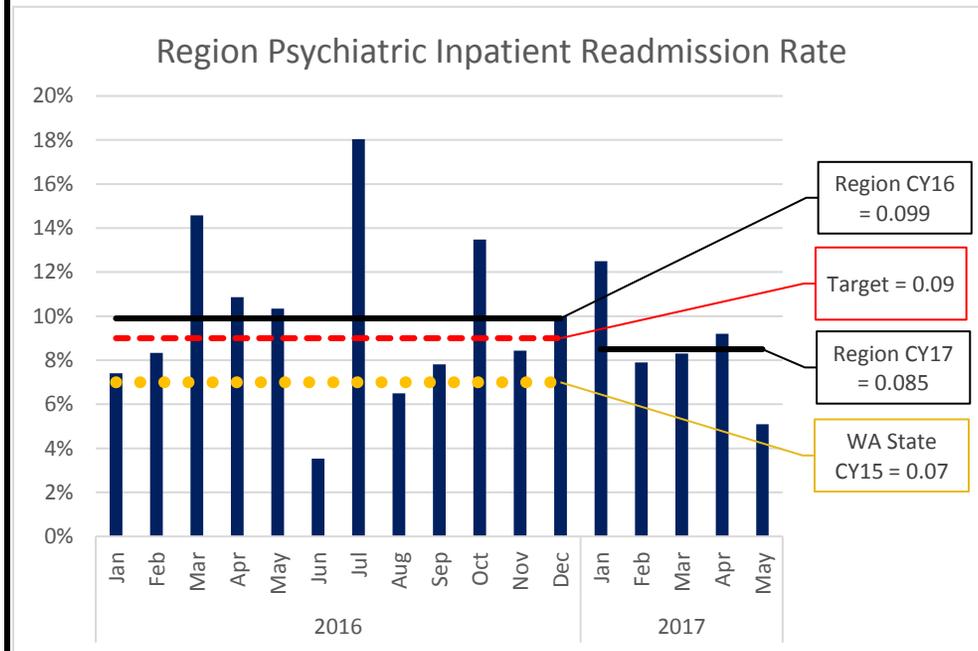
Definition of Indicator and Measurement Standard

3. Inpatient Utilization (Readmission Rate)**

Percent of clients who were discharged from inpatient psychiatric care and were readmitted to inpatient psychiatric care within 30 days of discharge

Formula:

$$\frac{\text{Number of clients readmitted to inpatient psychiatric care within 30 days of discharge within time period}}{\text{Number of clients discharged from inpatient psychiatric care during time period}}$$



Target: Within 2 points of the State's average for previous year

Source: Minimum performance standard

Data Notes: Time period is calculated based on month of discharge from psychiatric inpatient facility. Review of data source pending.

Data Source: CommCare SBHO MH Readmissions Report, CommCare SBHO MH LOS Report, SCOPE.

Data Valid as of: 6/2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
CY 15 TOTAL	9.1% 84/924	7.7% 5/65	9.0% 55/611	10.4% 23/222	3.8% 1/26
CY 16	14.6%	30.0%	15.0%	8.3%	0.0%
MAR	14/96	3/10	9/60	2/24	0/2
APR	10.9% 10/92	20.0% 1/5	7.7% 5/65	20.0% 4/20	0.0% 0/2
MAY	10.3% 9/87	18.2% 2/11	14.0% 7/50	0.0% 0/23	0.0% 0/3
JUN	3.5% 3/85	0.0% 0/11	1.9% 1/54	11.8% 2/17	0.0% 0/3
JUL	18.0% 11/61	25.0% 1/4	19.0% 8/42	7.1% 1/14	100% 1/1
AUG	6.5% 5/77	0.0% 0/8	7.3% 4/55	8.3% 1/12	0.0% 0/2
SEP	7.8% 5/64	0.0% 0/4	9.3% 4/43	6.3% 1/16	0.0% 0/1
OCT	13.5% 12/89	15.4% 2/13	16.1% 9/56	5.9% 1/17	0.0% 0/3
NOV	8.4% 7/83	16.7% 1/6	8.8% 5/57	6.3% 1/16	0.0% 0/4
DEC	10.0% 8/80	22.2% 2/9	8.2% 4/49	9.5% 2/21	0.0% 0/1
CY 17	12.5%	16.7%	16.3%	0.0%	0.0%
JAN	9.7% 9/72	2.1% 2/12	7.7% 7/43	0.0% 0/14	0.0% 0/3
FEB	7.9% 6/79	20.0% 1/5	8.5% 4/47	5.6% 1/18	0.0% 0/6
MAR	8.3% 7/84	0.0% 0/11	11.8% 6/51	4.8% 1/21	0.0% 0/1
APR	9.2% 6/65	0.0% 0/6	11.4% 5/44	7.1% 1/14	0.0% 0/1
MAY	5.1% 4/78	33.3% 1/3	0.0% 0/50	12.5% 3/24	0.0% 0/1



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

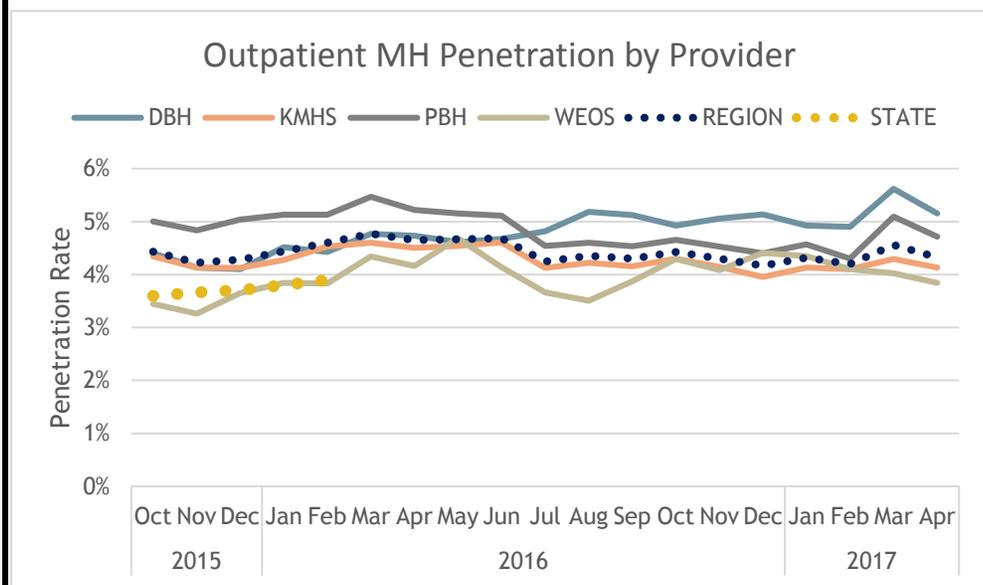
Definition of Indicator and Measurement Standard

4. Access (Outpatient Penetration Rates)**

The proportion of Medicaid enrollees who received non-crisis outpatient MH services

Formula:

$$\frac{\text{Number of Medicaid clients receiving non-crisis outpatient MH services during time period}}{\text{Number of Medicaid eligible individuals during time period}}$$



Target: Not yet available from the State - anticipated Spring 2017

Data Source: Profiler DW - RSNEncounterValid_2, Medicaid Eligible Population, SCOPE

Data Notes: Regional count unduplicates clients completely.

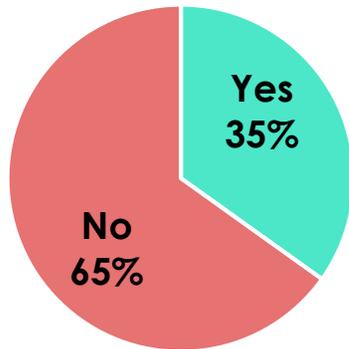
Data Valid as of 6/28/2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
CY 16	4.8%	4.8%	4.6%	5.5%	4.3%
MAR	3745/78493	339/7106	2357/51218	894/16348	166/3821
APR	3662/78736	336/7101	2313/51328	859/16460	160/3847
MAY	3683/78894	331/7174	2331/51365	851/16512	180/3843
JUN	3697/78914	334/7149	2369/51414	843/16486	160/3865
JUL	3348/78822	340/7062	2119/51353	751/16531	142/3876
AUG	3431/78859	367/7079	2168/51340	762/16558	136/3882
SEP	3397/78998	362/7067	2141/51508	750/16551	150/3872
OCT	3503/79187	349/7086	2221/51639	771/16573	167/3889
NOV	3411/79374	358/7081	2148/51824	749/16552	160/3917
DEC	3317/79609	365/7108	2054/51936	732/16620	174/3945
CY 17	4.3%	4.9%	4.1%	4.6%	4.4%
JAN	3422/79222	349/7084	2136/51651	758/16578	170/3909
FEB	3339/79383	349/7084	2105/51651	724/16712	163/3936
MAR	3622/79455	399/7101	2223/51807	846/16618	158/3929
APR	3454/79928	367/7125	2149/52050	792/16800	152/3953

SBHO Encounter Data Validation (EDV) 2017 Summary Results

Substance Use Disorder: Did the Service Note justify the Encounter



Mental Health: Did the Service Note justify the Encounter

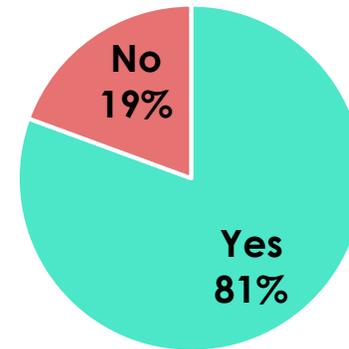


Table Key:

Match	The clinical documentation is consistent with the service description in the SERI, and demonstrates medical necessity
Erroneous	Inappropriate code used: Based on the clinical documentation, a different code (CPT) should have been used. Provide a narrative description explaining the reason for concluding the code use was invalid.
Unsubstantiated	<ol style="list-style-type: none"> 1. Not Encounterable: The documentation of the services indicates that the event did not meet criteria for any allowable services code in SERI. Provide narrative explaining reasoning. 2. Duplicate Service: The documentation of the service indicates the service was reported more than one or occurred at the same time as another service. 3. Missing: The clinical record contains evidence of a s service but is not represented by the encounter record.

SBHO Encounter Data Validation (EDV) 2017 Summary Results

Benchmark Expectation is \geq 95% Match Rate.

Table 1. Substance Use Disorder: Did the Service Note justify the Encounter by Procedure Code

Procedure Code	Procedure Code Description	Match		Erroneous		Unsubstantiated		Total	
		#	%	#	%	#	%	#	%
96153	Health and behavior intervention, group, per 15 minutes	32	23%	0	0%	107	77%	139	100%
96155	Health and behavior intervention, family w/o patient, per 15 minutes	1	100%	0	0%	0	0%	1	100%
H0001	Alcohol and/or drug assessment	4	100%	0	0%	0	0%	4	100%
H0004	Behavioral health counseling/therapy, 15 mins	26	74%	3	9%	6	17%	35	100%
H0047	Alcohol and/or other drug abuse services, not otherwise specified	1	100%	0	0%	0	0%	1	100%
T1016	Case management, each 15 minutes	4	27%	1	7%	10	67%	15	100%
Grand Total		68	35%	4	2%	123	63%	195	100%

Table 2. Mental Health: Did the Service Note justify the Encounter by Procedure Code

6. Procedure Code	6.a Procedure Code Description	Match		Erroneous		Unsubstantiated		Total	
		#	%	#	%	#	%	#	%
90792	Psychiatric diagnostic evaluation w/medical	2	100%	0	0%	0	0%	2	100%

SBHO Encounter Data Validation (EDV) 2017 Summary Results

6. Procedure Code	6.a Procedure Code Description	Match		Erroneous		Unsubstantiated		Total	
		#	%	#	%	#	%	#	%
90832	Psychotherapy, 30 min w/patient, family member	2	67%	1	33%	0	0%	3	100%
90834	Psychotherapy, 45 min w/patient, family member	7	100%	0	0%	0	0%	7	100%
90837	Psychotherapy, 60 min w/patient, family member	53	93%	0	0%	4	7%	57	100%
90846	Family psychotherapy without patient present	1	100%	0	0%	0	0%	1	100%
90847	Family conjoint psychotherapy w/patient present	14	74%	3	16%	2	11%	19	100%
90853	Group psychotherapy other than multiple-family	7	78%	0	0%	2	22%	9	100%
90889	Preparation of patient report for others	2	100%	0	0%	0	0%	2	100%
96372	intramuscular injection	5	100%	0	0%	0	0%	5	100%
99203	E&M office visit, mod-high severity, 30 mins	1	100%	0	0%	0	0%	1	100%
99212	E&M office/outpatient visit, minor, 10 mins	1	50%	0	0%	1	50%	2	100%
99213	E&M office/outpatient visit, low-mod, 15 mins	16	73%	5	23%	1	5%	22	100%
99214	E&M office/outpatient visit, mod-high, 25 mins	20	91%	1	5%	1	5%	22	100%
99215	E&M office/outpatient visit, mod-high, 40 mins	4	80%	0	0%	1	20%	5	100%
H0004	Behavioral health counseling/therapy, 15 mins	3	100%	0	0%	0	0%	3	100%
H0019	Beh health long-term residential, per diem	48	69%	1	1%	21	30%	70	100%

SBHO Encounter Data Validation (EDV) 2017 Summary Results

6. Procedure Code	6.a Procedure Code Description	Match		Erroneous		Unsubstantiated		Total	
		#	%	#	%	#	%	#	%
H0023	Behavioral health outreach service	27	93%	0	0%	2	7%	29	100%
H0031	Mental health assessment, by non-physician	15	100%	0	0%	0	0%	15	100%
H0032	MH service plan development, by non-physician	1	100%	0	0%	0	0%	1	100%
H0033	Oral medication admin, direct observation	20	80%	1	4%	4	16%	25	100%
H0036	Community psych supportive treatment, 15 mins	199	83%	8	3%	34	14%	241	100%
H0038	Self-help/peer services, per 15 minutes	30	71%	1	2%	11	26%	42	100%
H0046	otherwise specified	49	72%	3	4%	16	24%	68	100%
H2011	Crisis intervention service, per 15 minutes	43	84%	3	6%	5	10%	51	100%
H2012	Behavioral health day treatment, per hour	39	76%	0	0%	12	24%	51	100%
H2015	Comprehensive community support svcs, 15 mins	54	78%	3	4%	12	17%	69	100%
S9446	Patient education, not otherwise classified	36	75%	0	0%	12	25%	48	100%
S9484	Crisis Intervention mental health svcs, per hour	9	82%	0	0%	2	18%	11	100%
T1001	Nursing assessment/evaluation	19	90%	2	10%	0	0%	21	100%
Grand Total		727	81%	32	4%	143	16%	902	100%



SALISH BHO

ADVISORY BOARD MEETING

DATE: Friday, September 8, 2017
TIME: 10:00 AM – 12:00 PM
LOCATION: City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382

A G E N D A

<http://www.kitsapgov.com/hs/sbho/sbhoboard.htm>

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of May 5, 2017 and August 4, 2017 Minutes (Attachments 5.a, 5.b)
6. Informational Items
 - a. Funding Update
 - Expenditures and Reserve Balances (Attachment 6.a.1)
 - IMD Update
 - SUD Expenditures FY 18 (Attachment 6.a.2)
 - State Allocation
 - Mental Health Funding
 - b. American Indian/Alaskan Native Exemption Update
 - c. Healthcare Integration (Attachments 6.c.1, 6.c.2)
7. Opportunity for Public Comment (limited to 3 minutes each)
8. Board Member Check-in
9. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHO	Behavioral Health Organization, replaced the Regional Support Network
CAP	Corrective Action Plan
CMHA	Community Mental Health Agency
CMS	Center for Medicaid & Medicare Services (federal)
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DDA	Developmental Disabilities Administration
DMHP	Designated Mental Health Professional
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FBG	Federal Block Grant (specifically MHBG and SABG)
FIMC	Full Integration of Medicaid Services
FYSPRT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IMD	Institutes for the Mentally Diseased
IS	Information Services
ITA	Involuntary Treatment Act
LOC	Level of Care
MAT	Medical Assisted Treatment
LRA	Least Restrictive Alternative
MCO	Managed Care Organization
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
OST	Opiate Substitution Treatment
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QA, QI	Quality Assurance, Quality Improvement
QUIC	Quality Improvement Committee
QRT	Quality Review Team
RCW	Revised Code Washington
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SAPT	Substance Abuse Prevention Treatment
SBHO	Salish Behavioral Health Organization
SUD	Substance Use Disorder
UM	Utilization Management
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Go to <http://www.kitsapgov.com/hs/sbho/sbhopolices.htm> for a full listing of definitions and acronyms

SBHO Advisory Board

Agenda Briefings

September 8, 2017

Informational Items

a. FUNDING UPDATE

Staff will provide an update on a variety of financial issues, including:

- **Expenditures and Reserve Balances**

We have produced a report outlining our expenditures for the April through June 2017 period outlining our expenditures and our reserve balances. Staff will provide a full explanation of the report.

- **IMD Update**

In consideration of the new Federal IMD rules, the SBHO is tracking utilization of the various residential programs very closely, and we are required to submit data to the state by the 10th of each month on specific individuals who were residents of IMDs for more than 15 days in any previous month. Two programs that had been IMDs prior to July 1st closed all but 16 of their beds starting in July, though one has since re-opened their closed beds. Our Residential IMD costs are broken out on the SUD Expenditure Report.

- **SUD Expenditures FY 18**

Attached is an expenditure report specific to SUD subcontractor funding which outlines our expenditures for July of various SUD funding streams for services. Staff will go over the report and explain fully.

- **State Allocation**

The BHO received our official allocation of non-Medicaid funds the week of August 21, and several disturbing realities came to light, including that the state does not have a mechanism currently for letting BHOs know how many of the AI/AN population have opted in to managed care, and how many have not. Another issue is that the state has been paying BHOs a Per Member Per Month (PMPM) payment for the IMD backfill, and only two regions have been able to identify the funds. Staff will be utilizing the new information from the State to update our regional expenditure budget, which should be ready for the October meeting.

- **Mental Health Funding**

The distribution of funds for mental health services appears to be unchanged although staff needs to inquire regarding what funding the State is including in some of their calculations.

b. AMERICAN INDIAN/ ALASKAN NATIVE EXEMPTION UPDATE

There is a distinct lack of information to report on the Exemption. BHOs do not have an easy and transparent way to determine how many individuals have opted in to BHO services, and providers have had significant difficulty getting paid on the new Fee for Service system. Staff will provide details.

C. HEALTHCARE INTEGRATION

The State continues to be intent on moving forward with the full financial integration of healthcare within Managed Care Plans. Though the Legislature failed to pass HB 1388, which would have moved the Division of Behavioral Health from the Department of Social and Health Services into the Health Care Authority, evidently the Governor's office intends to re-introduce the bill in January. There have been two resignations of note from the HealthCare Authority – the Director, Dorothy Teeter, resigned during session, and one of the main architects of the current direction resigned in August. It is unknown at this point if these personnel changes will result in any programmatic changes.

The Authority did release what they call the “preliminary” findings from the first year of full integration, a copy of which is attached. It should be noted that most of the findings are health related and not dependent on any form of integrated funding. The second thing to note is that the State has no intention to ever compare Behavioral Health services under full integration with those in non-integrated regions. In fact, the Managed Care Organizations operating in fully integrated areas are not required to provide the state with the same types and level of data that BHOs are required to provide.

Board members may also be interested in looking at the latest External Review of MCOs which compares the MCO performance with each other and with national averages:

<https://www.hca.wa.gov/assets/program/eqr-comparative-analysis-report-2016.pdf>

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**Friday, May 5, 2017
10:00 a.m.-12:00 p.m.
City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382**

CALL TO ORDER – Russel Hartman, Chair, called the meeting to order at 10:05 a.m.

INTRODUCTIONS – Self introductions were conducted around the room.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS - None

APPROVAL OF THE AGENDA

Agenda was accepted without motion.

APPROVAL OF April 7, 2017 MINUTES

MOTION: Anne Dean moved to approve the minutes of the January 27, 2017 meeting as submitted. Lois Hoell seconded. Motion carried unanimously.

ACTION ITEM

- Medicaid Budget
 - SBHO staff spoke on the most recent Medicaid budget proposals.
 - Our mental health providers have worked hard to build up productivity and expand service delivery (going back to July 2015) to get the SBHO some of the best rates in the state. They are one of the only regions to see significant rate increases.
 - Designated Marijuana Account (DMA) – The DMA has very specific expenditures as written and passed by the state. The DMA has a quarter of a million dollars written into the SBHO budget, but it has not been used as of its specificity (It is designated for youth SUD services who are not Medicaid eligible). The SBHO is analyzing likelihood of preparing an RFP to determine how the funds are to be allocated. The SBHO plans to coordinate with the 1/10 of 1% groups when an RFP goes out as the groups are currently putting a good portion of their funds towards SUD services for youth which fits the specificity of the DMA fund. This can potentially help the 1/10 of 1% groups better leverage their funds.
 - The AI/AN Exemption will likely have a significant impact on West End Outreach Services (WEOS) as those individuals who identify as AI/AN are able to opt in or opt out on a monthly basis. SBHO staff proposed transferring \$300,000 from the Medicaid reserves to assist WEOS through the transition until more data is collected on the impact the exemption will have.
 - SBHO staff asked for the board's approval of the budget based on the preliminary numbers calculated by the division so that contracts can be finalized. The budgets were based on the SBHO receiving the same amount of funding from the state as it did in the previous year. The budget will have to be amended once the state has its final numbers.

MOTION: Lois Hoell moved to approve the proposed preliminary budget. Janet Nikolaus seconded. Motion carried unanimously.

INFORMATIONAL ITEMS

➤ Funding Issues

State Budget

- SBHO staff presented on the data reports.
- IMD's account for 85-90% of SUD services. In the first year of providing SUD services, the SBHO had over 4 million dollars in expenditures. This is an area of concern.
- We are starting with a \$700,000 hole in the state budget as the actuaries inflated the Medicaid side of expenses, but not the state side of expenses. It is being advocated to get the \$700,000 back as the SBHO's costs have significantly gone up. The SBHO will not know until the state budget is finalized.

SUD Practices - OST RFP

- A bidder's conference was held with one bidder showing up, but the SBHO has received other inquiries. Proposals are due on May 11, 2017.
- The SBHO did not include a budget as the costs of running a facility are unknown and we want to see what the bidders propose.
- The Review Committee from the Advisory Board along with Lisa Rey Thomas (OCH), Chris Frank (Clallam County Public Health Officer) and Susan Turner (Kitsap County Public Health Officer) will review the bids for the RFP on May 18, 2017. An update will be provided at the next meeting.

Integration

- In 2014, Bill 6312 was passed to establish BHO's. This also set the framework to move all healthcare dollars, including behavioral healthcare dollars, over to managed care facilities and operations by 2020. The state is very vested in having full integration of funds and treatments.
- The state has been divided into 10 different regional service areas with common insurers. To become a mid-adopter, the county authority must sign a letter of intent to integrate by September 15, 2017. It is now upon our region to decide if they are to become a mid-adopter. County Commissioners will have the final say in what will happen to the BHO in our region.
- For the state, a lot hinges on every region playing this game and working in harmony. The other force is the Section 1115 district waiver, a 1.25-billion-dollar waiver that specifies the state receiving these funds only if full integration of healthcare in the state occurs. The pressure is on the state to make this happen.
- In the states rubric of integrated care, BHO's will go away completely and managed care facilities would contract directly with providers. An amendment to Bill 1388, which is currently in the back of the house, would allow the development of a leadership table in each regional service area. Counties would lead the development of the leadership table with the assistance of managed care facilities and the Health Care Authority.
- The board needs to explore its options before making a decision on integration. What is the risk to us and our communities if we do not go along with mid

enrollment? Would it be worth it to develop a proposal that integrates healthcare into the SBHO? What do the commissioners envision in a fully integrated system? These items will be taken to the Executive Board for further discussion and presented at the next Advisory Board meeting.

➤ Quality Assurance

- SBHO staff presented on the QA data reports.
- The SBHO QA staff are working on creating an internal data system that will provide more detailed and accurate information.

➤ Board Priorities

- The board agreed at the April 7, 2017 meeting that the five priorities the board previously established, should continue to be a focus for this year. These priorities include; funding, SUD practices, integration, QA, and 1/10 of 1% groups in each of the counties. As additional ideas or thoughts come up, please send them to Anders Edgerton and Russ Hartman so that they can be addressed.

OPPORTUNITY FOR PUBLIC COMMENT

- Pam Brown -Thank you for supporting Clallam County and not cutting services for our folks.
- Ellen Epstein -Regarding the AI/AN exemption; if a tribal member wants to receive services from the SBHO, where would the funds go? Tribal members will have the opportunity to opt in or out of SBHO services on a monthly basis.
- Vivian Morey -Would Ombuds services go away if the BHO opted for early integration? Ombuds services would remain in place.

FOR THE GOOD OF THE ORDER

- Board Member Check-In:
 - Russ – We continue to live in very interesting times.
 - Janet - Agreed with Russ; these are interesting times.
 - John – Submitted his letter of resignation as he is on the QRT Board and according to SBHO Bylaws, this is a conflict of interest.

- The next meeting is Friday, June 2, 2017 at the City of Sequim Transit Center.

ADJOURNMENT - The meeting adjourned at 11:59 a.m.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<u>Present</u> Anne Dean John Freeburg Janet Nickolaus Roberta Charles Russ Hartman Lois Hoell Jolene George <u>Absent/Excused</u> Helen Morrison Charles Pridgen Steve Schermerhorn Jon Stroup Catharine Robinson Mike Stringer Jennifer Kreidler-Moss Freida Fenn	Ellen Epstein, RMH Services Lisa Rey Thomas, Olympic Community of Health Vivian Morey, Ombuds Pam Brown, WEOS Vicki Lowe, AIHC/Jamestown Mike Glenn, Jefferson Healthcare Carol Ru Kirk, Discovery Behavioral Healthcare Dunia Faulx, Jefferson Healthcare Wendy Sisk, Peninsula Behavioral Health	Anders Edgerton Alexandra Hardy

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**Friday, August 4, 2017
10:00a.m. – 12:00p.m.
City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382**

CALL TO ORDER – Russ Hartman, Chair, called the meeting to order at 10:00 a.m.

INTRODUCTIONS – Self introductions were conducted around the room.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS - None

APPROVAL OF THE AGENDA

Agenda was accepted without motion.

APPROVAL OF June 2, 2017 MINUTES

The matter of Action Items being taken at the June 2, 2017 meeting when the attendance records detailed the meeting was not a quorum was brought to the attention of the board and discussed. The board requested that the minutes of the June 2, 2017 meeting be amended to reflect that a quorum was not present; therefore, any action item taken at the meeting is void.

MOTION: Catharine Robinson moved to adjust the minutes of the June 2, 2017 meeting to reflect that a quorum was not present at the meeting and any action taken at the meeting is void. Charles Pridgen seconded. Motion carried unanimously.

MOTION: Catharine Robinson moved to approve the amended minutes of the June 2, 2017 meeting. Charles Pridgen seconded. Motion carried unanimously.

AGENDA

The subject of amending the agenda for the meeting was discussed by the board due to three Action Items (Substance Use Disorder Budget, May 5, 2017 Meeting Minutes, and Integration) being void from the June 2, 2017 meeting. After the board discussed the topic, the following decisions were made:

- **Substance Use Disorder Budget:** The Substance Use Disorder budget has already changed and is currently being updated. The item will be added as an Action Item at a future meeting.
- **May 5, 2017 Minutes:** The May 5, 2017 meeting minutes will be added as an Action Item to the September 8, 2017 meeting.
- **Integration:** The board decided to revisit the discussion of Integration at the meeting as an Informational Item, but not to revote on the subject as the Executive Board has already made its decision on the subject.

ACTION ITEMS➤ Opiate Treatment Program Recommendation

- The organization which responded to the OTP Request for Proposals met with the RFP Committee and staff from the Health Departments in Kitsap and Clallam Counties as well as Lisa Rey Thomas of the Olympic Community of Health and SBHO staff on June 26 to respond to any remaining questions the group had regarding their proposal.
- The board held a discussion on Baymark's proposal to decide if the SBHO should enter into a contract with them to provide opiate treatment in Kitsap and Clallam Counties.
- The consensus is that Baymark will integrate into the community well by choosing a proper location, keeping the appearance of the building well maintained, and holding open houses for the communities they move into.
- The board was concerned with the data that will be collected by Baymark. The board requested to include a section in the contract on data collection to ensure the SBHO receives the information on our region to track success rates.
- Baymark is primarily known to prescribe Methadone which will complement our region's needs. Baymark will also prescribe Vivitrol and Suboxone as the RFP requires. The board also requested that verbiage is included in the contract to ensure Baymark prescribes all three opiate treatment drugs.
- The board suggested leaving the contract length up to SBHO staff to decide what would be best.

MOTION: Jennifer Kreidler-Moss moved to approve continuing working on a contract with Baymark for Opiate treatment in our region. Helen Morison seconded. Motion Carried unanimously.

- It was suggested that the SBHO develop a sub-committee to work with Baymark to monitor the integration process with other treatment providers and to ensure the people seeking services are receiving the best treatment plan for them.
- Jolene George, Jennifer Kreidler- Moss, Catharine Robinson, and Charles Pridgen volunteered to participate on the Opiate Sub-Committee.

MOTION: Jennifer Kreidler-Moss moved to create a sub-committee to monitor the integration Freida Fenn seconded. Motion Carried unanimously.

➤ RFP Committees▪ **Designated Marijuana Account Funding**

In the Spring of 2016, the Legislature cut state funding for Substance Use Disorder services and substituted Designated Marijuana Account (DMA) funds for the former state funding. At the time, BHO's were told that the fund switch was not anything to be concerned about, and the funds were interchangeable.

In January 2017, the SBHO received a contract amendment containing language that makes utilization of the DMA funding very restrictive. The SBHO believes the best way to utilize these funds at this time is to appoint an RFP specific to this program.

▪ **Substance Abuse Block Grant**

Attachment 5.b

The Substance Abuse Block Grant is a separate funding stream which requires community involvement and input from the Advisory Board. The SBHO is setting up a system of developing SABG plans in the fall of the year so that a more thoughtful process can be facilitated in the future. The SBHO has extended current SABG contracts by six months and would like to complete an RFP cycle in time for January contracts.

- The board decided that it would be best to combine the two items and have one RFP sub- committee.
- Helen Morrison, Russ Hartman, and Jon Stroup volunteered for the committee.

INFORMATIONAL ITEMS

➤ State Budget

- The Legislature completed work on an operations budget in the nick of time, providing ongoing funding for critical state programs. The Division of Behavioral Health and Recovery (DBHR) has not yet completed the process of analyzing and distributing funding, but it appears that our revenue will be unaffected by the budget.
- State hospitals received a 34% increase in funding; this is a historical rise as they are typically flat in funding. The state budget officer said that even with the increase in budget, the state hospitals are already in a deficit.
- We don't know how the state will distribute funding to the different BHO's.
- SBHO staff will provide an update once information is received from the state.

➤ Budget Update

Substance Use Disorder Distribution

- The lack of a final distribution of funding from the State makes putting together a final annual budget impossible. The significant change in the revenue picture as a result of the Federal change to the IMD rule which made approximately half of our residential stays ineligible for Medicaid reimbursement, and the need to backfill those residential costs with Non- Medicaid funds has created a very complex situation.
- FY 2016, the SBHO received \$1.5 million for the first twelve months of the SABG contract. FY 2017, we were given \$1.2 million. However, we were given a 3-month extension to spend money on the previous year's contract and additionally asked for more money which we were given for a total of \$1.9 million.
- SABG RFP will go out in the fall for January 2018 – December 2018 contracts.
- The vast majority of funding is going towards residential care because of the IMD rule change.

Substance Use Disorder Residential Changes

- The change in the Federal IMD rule has resulted in a significant change in how many BHO's approach Residential SUD services as well as how some programs are operated.
- Within our BHO, the program at Kitsap Recovery Center has been modified, and the program physically moved to prepare for the development of a Triage Center by Kitsap Mental Health. The program at the new center has been modified to create a non-IMD situation by shrinking the residential program to 16 beds and increasing the Withdrawal Management program to 16 beds. In Pierce County, Prosperity Wellness has decreased their bed capacity to 16 (from 33) and increased their outpatient program. The decrease to 16 beds makes these programs eligible for Medicaid services.

- Behavioral Health Organizations have taken different approaches to the new payment paradigm; with some BHO's shortening their authorization period to as little as 12 days. The SBHO has not made any authorization changes, but will be monitoring residential utilization and funding flows carefully to ensure that we remain in compliance with funding restrictions.
- Some states have a waiver that allows them to use Medicaid funding for IMD's. Washington State is planning on submitting an identical waiver to the other states that have been successful. The waiver is believed to take effect in July of next year.
- Quality Assurance (QA)
 - QA Staff presented on the performance measures and the Encounter Data Validation (EDV) results.
 - The board was concerned about the agencies having ramifications for not meeting criteria and requested to review the SBHO's Policies and Procedures on the subject at the next meeting.
 - The QA team was requested to include performance measures for a longer period of time and to present more data on peer services at future meetings.
 - The board also requested the QA team to include footnotes and narratives on the data to better explain the information being presented.
 - The SBHO is issuing Corrective Action Plans (CAPS) to agencies not meeting standards on the EDV reports for clinical chart notes.
 - The board discussed their concerns with the results of the EDV and how they would like to ensure this problem is fixed and how to prevent the reoccurrence of the problem in the future.

OPPORTUNITY FOR PUBLIC COMMENT

- Steve Workman (Jefferson County) – Thank you for the discussion and brainstorming during this difficult era. Steve raised his concerns that the board failing to mention law enforcement and the role it plays in the discussions that were held today. Steve was also concerned that inmates being released from jail services in Jefferson County will not have anywhere close by to go for opiate treatment as the RFP only included Clallam and Kitsap Counties. Steve was also concerned that the board was focusing more on funding and not the quality of care when it comes to the subject of integration.
- Pam Brown (Director of West End Outreach Services) –The board failed to mention one good thing about the crisis response and the timeliness of the entire system when looking at the QA performance measures and EDV results; the focus of the meeting was on all the red. It is hard to cram behavioral health into a few qualitative measures and it isn't fair to take funding away based on these measures.

FOR THE GOOD OF THE ORDER

- Board Member Check-In:
 - Catharine – Good meeting, thank you to the public.
 - Freida – Would like us to focus on the good and not just the red in future meetings.
 - Helen – The board should make it a goal to focus on supporting the agencies getting better outcomes going forward.
 - Jolene - We need to continue this discussion on the EDV and have the agencies focus on correcting the issues.
 - Roberta – enjoyed the discussion.

- Russ – Stated that we live in interesting times and offered compliments to the board for the discussions. Russ brought up that at the next meeting, the board needs to elect a nominating committee to select the Chair and Vice Chairs for the year starting in January 2018.
-
- Charles – Thank you to Anders and Alex for making the arrangements for him and his wife to attend the state convention in Vancouver.
- Janet – beginning to catch on.
- Jennifer – Is struggling a bit as she is seeing data that shows that we are not superior and is seeing budgets that show we are not cost effective. Jennifer is wondering why we would want to retain a system that is not functioning at where it should be?
- Sandy – Mentioned that she is the new kid on the block and that she has a lot to learn, but from her background, she would like to focus on children services and families.

ADJOURNMENT - The meeting adjourned at 12:01 p.m.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<p><u>Present</u> Lois Hoell Freida Fenn Helen Morrison Janet Nickolaus Catharine Robinson Roberta Charles Anne Dean Jolene George Russell Hartman Jennifer Kreidler-Moss Charles Pridgen Sandy Goodwick</p> <p><u>Absent/Excused</u> Jon Stroup Jennifer Risinger</p>	<p>Andy Brastad, Clallam County HHS Pam Brown, West End Outreach Services Ellen Epstein, RMH Services Vivian Morey, Ombuds Steve Workman, Jefferson County Citizen Rebecca Miller, Peninsula Behavioral Health Lisa Rey Thomas, Olympic Community of Health Kathy Stevens, Peninsula Behavior Health</p>	<p>Anders Edgerton Alexandra Hardy Richelle Jordan Ileea Nehus</p>

Salish Behavioral Health Organization
Expenditures and Reserves
April - June 2017

Revenue	
Medicaid	\$ 10,769,998
State	\$ 1,743,047
Misc	\$ 612,453
Total	\$ 13,125,498

Expenditures					
	Mental Health	Substance Use Disorder	BHO Support *	Administration**	Total
Medicaid	\$ 7,711,608	\$ 2,373,438	\$ 526,693	\$ 379,293	\$ 10,991,032
State	\$ 1,450,531	\$ 155,866	\$ 70,114	\$ 56,385	\$ 1,732,896
Misc	\$ 195,498	\$ 294,775			\$ 490,273
Total	\$ 9,357,637	\$ 2,824,079	\$ 596,807	\$ 435,678	\$ 13,214,201

Reserves		
	Medicaid	State
Required		
Risk and Inpatient***	\$ 6,050,750	\$ 192,150
Reserved for Encumbrances		\$ 1,352,817
Optional		
Operating Reserve	\$ 1,115,663	\$ 326,691
Unreserved Fund Balance		

*Includes Information Services, Quality Assurance, and Ombuds costs

**Costs of general SBHO staffing

***Minimum of \$3,300,000 required for Medicaid - \$6,375,000 allowed

SUD Expenditure Report

Month: August

Through billing month: July

Line Item	Budget	July	LTD	Percent	Balance	Expected
Medicaid						
Outpatient	\$ 8,050,000.00	\$ 311,604.21	\$ 311,604.21	3.87%	\$ 7,738,395.79	
Residential	\$ 2,000,000.00	\$ 217,080.54	\$ 217,080.54	10.85%	\$ 1,782,919.46	
Withdrawal Management	\$ 660,000.00	\$ 43,146.64	\$ 43,146.64	6.54%	\$ 616,853.36	
Substance Abuse Block Grant						
Outpatient	\$ 962,438.00	\$ 18,006.44	\$ 18,006.44	1.87%	\$ 944,431.56	
Residential	\$ 700,000.00	\$ 174,704.12	\$ 174,704.12	24.96%	\$ 525,295.88	
Nurse Care Manager	\$ 248,743.00	\$ 6,395.66	\$ 6,395.66	2.57%	\$ 242,347.34	
Criminal Justice Treatment Act						
Outpatient	\$ 226,000.00	\$ 583.84	\$ 583.84	0.26%	\$ 225,416.16	
Residential	\$ 226,000.00	\$ -	\$ -	0.00%	\$ 226,000.00	
IMD Backfill						
Residential (billed to SABG)	\$ 821,000.00	\$ -	\$ -	0.00%	\$ 821,000.00	
State						
Outpatient	\$ 389,000.00	\$ -	\$ -		\$ 389,000.00	
Residential	\$ 300,000.00	\$ -	\$ -	0.00%	\$ 300,000.00	
Withdrawal Management	\$ 40,000.00	\$ -	\$ -	0.00%	\$ 40,000.00	
SABG Child Care/PPW						
		\$ 5,284.00	\$ 5,284.00			
Residential						
IMD		\$ 217,080.54				
Non-IMD		\$ 174,704.12				
Total	\$ 14,623,181	\$ 776,805	\$ 776,805	5.31%		

From: Lindeblad, MaryAnne (HCA) [maryanne.lindeblad@hca.wa.gov]
Sent: Thursday, August 10, 2017 11:27 AM
To: Joe Valentine; Anders Edgerton; tcardwell-burns@ncwbh.org; MBollinger@greatriversbho.org;
Barada, Christine; Freedman, Mark; brad.finegood@kingcounty.gov; Roughton, Ken (Greater Columbia
RSN); bea.dixon@optum.com; Ann Christian
Subject: Preliminary data: integrated care in Southwest Washington | BHOs

Hello,

I'm reaching out today to let you know of some preliminary data showing positive results in the first year of fully integrated managed care in Southwest Washington.

The Research and Data Analysis (RDA) Division of the Department of Social & Health Services has been tracking and compiling data on key measures in order to analyze the effectiveness of integrated managed care on Washington State's Medicaid population. The data covers the first nine months of beneficiary experience under the FIMC model.

The attached document shows that the Southwest Washington region is performing significantly better in 10 measures, no significant difference in 8 measures, and a relative decline in one measure. For the measure that shows negative performance (ED utilization per 1,000 member months), the performance level in Southwest Washington was second-highest among all ACH regions. In other words, Southwest Washington is a high performer in this measure already, which contributes to the data showing a relative decline.

RDA plans to share more detailed data with Southwest Washington ACH later this month, and I will be sure to keep you updated on the findings.

Please feel free to reach out to me if you have any questions.

Sincerely,

MaryAnne Lindeblad, BSN, MPH
Medicaid Director
office: 360-725-1863
maryanne.lindeblad@hca.wa.gov



Preliminary First Year Findings from the Evaluation of Fully Integrated Managed Care in Southwest Washington

David Mancuso, PhD

Background

The Fully Integrated Managed Care (FIMC) approach to delivering Medicaid-funded physical and behavioral health care was implemented in the Southwest Washington region (Clark and Skamania counties) in April 2016. The FIMC model integrates purchasing of Medicaid physical and behavioral health services within a single accountable managed care organization (MCO), in contrast to the presence of separate medical MCOs and behavioral health organizations (BHOs) operating in the balance of the state. The Health Care Authority has contracted with the DSHS Research and Data Analysis Division to partner with the University of Washington in the evaluation of the FIMC model. This document summarizes preliminary first year evaluation findings based on outcome data through CY 2016, including nine months of beneficiary experience under the FIMC model.

Evaluation Approach

The evaluation of the FIMC payment model tests whether the integrated purchasing of physical and behavioral health care:

- Improves access to and engagement in needed behavioral health services;
- Improves coordination and quality of physical and behavioral health care;
- Reduces potentially avoidable use of emergency department (ED), inpatient, and crisis services;
- Improves beneficiary level of functioning and quality of life, as indicated by improved labor market outcomes, increased housing stability, and reduced criminal justice involvement; and
- Reduces disparities in access, quality, utilization, and social outcomes between Medicaid beneficiaries with behavioral health treatment needs, relative to other Medicaid beneficiaries.

Preliminary findings are based on statistical tests of the relative change from CY 2015 to CY 2016 in 19 outcome metrics for adult Medicaid beneficiaries in Southwest Washington, relative to the experience of Medicaid beneficiaries in the balance of the state. Final evaluation analyses will use a regression-based difference-of-difference approach.

Summary of Preliminary Findings

- Of the 19 outcome measures analyzed:
 - 10 showed statistically significant relative improvement for Medicaid beneficiaries residing in the FIMC region,
 - 8 showed no significant difference between the FIMC region and balance of state, and
 - 1 showed a statistically significant relative decline in the FIMC region.

- For the one metric where the relative change in performance in the FIMC region was negative and statistically significant (ED utilization per 1,000 member months), the performance level in the FIMC region in CY 2016 was second best among all ACH regions.
- Subgroup analyses focused on the experience of Medicaid beneficiaries with serious mental illness or co-occurring mental illness and substance use disorder showed a similar pattern of improvement in outcomes from CY 2015 to CY 2016 for persons residing in the FIMC region, relative to the experience in the balance of the state.

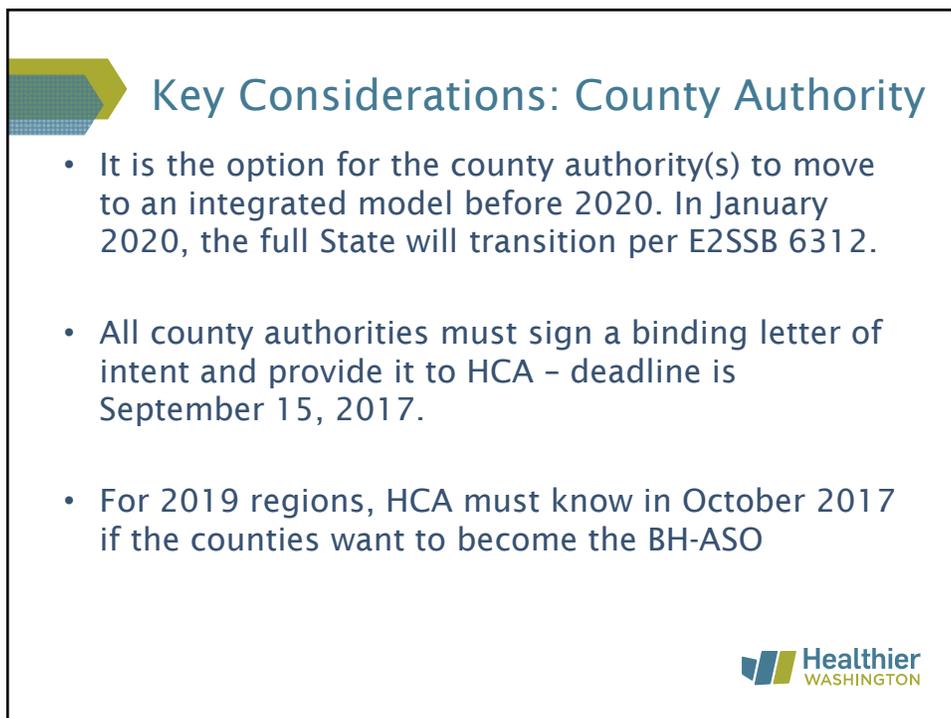
Summary of Changes in Outcome Metrics in the FIMC Region Relative to the Balance of State, CY 2015 to CY 2016

- Metrics showing statistically significant improvement for adult Medicaid beneficiaries residing in the FIMC region, relative to the balance of state:
 - Adults' Access to Preventive/Ambulatory Health Services
 - Cervical Cancer Screening
 - Chlamydia Screening in Women
 - Comprehensive Diabetes Care - Hemoglobin A1c Testing
 - Antidepressant Medication Management - Continuation Phase Treatment
 - Follow-up after ED Visit for AOD Dependence-Within 7 Days
 - Follow-up after ED Visit for AOD Dependence-Within 30 Days
 - Percent Homeless - Narrow Definition
 - Percent Homeless - Broad Definition
 - Percent Arrested
- Metrics showing no significant difference between the FIMC region and balance of state:
 - Breast Cancer Screening
 - All-Cause 30-Day Readmission
 - Antidepressant Medication Management - Acute Phase Treatment
 - Adherence to Antipsychotics for Persons with Schizophrenia
 - Diabetes Screening for People With Schizophrenia or Bipolar Disorder
 - Inpatient Utilization per 1000 Coverage Months
 - Balance of Home and Community-Based Services and Nursing Facility Utilization
 - Percent Employed
- Metrics showing statistically significant decline in the FIMC region, relative to the balance of state:
 - Outpatient ED Utilization per 1000 Coverage Months



Integrated Managed Care

MaryAnne Lindeblad
Health Care Authority
August 10, 2017



Key Considerations: County Authority

- It is the option for the county authority(s) to move to an integrated model before 2020. In January 2020, the full State will transition per E2SSB 6312.
- All county authorities must sign a binding letter of intent and provide it to HCA – deadline is September 15, 2017.
- For 2019 regions, HCA must know in October 2017 if the counties want to become the BH-ASO





Key Considerations: Procurement

- HCA will release a statewide procurement in February 2018 that will determine the MCOs for the rest of the state, and have two effective dates:
 - January 2019 and January 2020
- MCOs will be selected approx. May 2018
- Mid-adopter regions will be able to work with HCA to create a regional addendum to the procurement that will allow the region to set forth priorities and ask region-specific questions
- Mid-adopter regions can nominate scorers for the RFP
- Mid-adopter RFP process is the strongest opportunity to set expectations for MCOs and drive commitments




Key Considerations: Incentive Funds

- All regions with implementation dates prior to 2020 will receive incentives to support provider transition:
 - First incentive on receipt of binding letter: after receipt by September 15, 2017
 - Second incentive on implementation date: after implementation on January 1, 2019
- These funds will be dispersed to providers and community organizations to assist in the transition to full integration



Full Integration – 3 Options

Full Integration on January 2019

- On Jan. 1, 2019 MCOs assume all risk and responsibility for Medicaid behavioral health services – no delegation
- On Jan. 1, 2019 BH-ASO assumes responsibility for crisis system and other non-Medicaid functions

Transition Year Beginning 2019 – Full Integration by January 1, 2020

- MCOs assume risk for Medicaid services, subcontract an agreed upon set of services and/or functions to the BHO for 1 year
- BHO maintains non-Medicaid BH Contracts for 1 year – can continue as BH-ASO in 2020 if desired
- Region must meet readiness review milestones during 2019
- Full integration complete by January 1, 2020

No Transition Year – Full Integration by January 1, 2020

- On Jan 1, 2020 MCOs assume all risk and responsibility for Medicaid BH services – no delegation
- On Jan 1, 2020 BH-ASO assumes responsibility for crisis system and other non-Medicaid functions

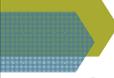


Transition year – HCA’s parameters

Transition year – HCA’s parameters

1. BHO PIHP contract will terminate, funding and contractual authority for Medicaid services will transition to MCOs on January 2019
2. BHO Non-Medicaid contracts could remain in 2019
3. BHO must agree to maintain crisis system and all other functions of “ASO” during the transition year; option to stay as the BH-ASO in 2020
4. Access to Care Standards must be eliminated January 2019
5. 2017–2018 is the planning year: interlocal group will be led to determine details of transition year, including specifics of delegation to BHO and 2019 milestones that will be achieved
6. HCA will conduct readiness review on a quarterly basis in 2019 to evaluate progress to meeting full integration in January 2020
7. HCA expects delegated functions to transition to MCOs during 2019, with integration fully achieved by 2020





Transition year contract info

Definition: 1.84 Essential Behavioral Health Administrative Functions

- “Essential Behavioral Health Administrative Functions” means utilization management, Grievance and appeals, network development and management, provider relations, quality management, data management and reporting, and claims and financial management.

Subcontracts 9.7 Behavioral Benefit Administration with Subcontractors and Subsidiaries

- 9.7.1 Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this Contract, except Behavioral Health Administrative Functions. Essential Behavioral Health Administrative Functions may be subcontracted for a period of time as determined by HCA and the Contractor. The Contractor shall achieve full integration of Essential Behavioral Health Administrative Functions according to a timeline agreed upon with HCA. No Subcontractor shall terminate the Contractor’s legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any Subcontractor.




County role & risk

- RCW 71.24 places BHO at risk for the administration of RCW 71.05, 71.34 and 70.96A, including the provision of crisis services and involuntary treatment
- In the absence of a BHO, this risk falls to the State
- HCA delegates the risk for administration of RCW 71.05, 71.34 and 70.96A to the BH-ASO
- HCA requires the BH-ASO to carry out the provisions of RCWs 71.05, 71.34 and 70.96A, including delivery to of all crisis services in the community
- The BH-ASO is held to managed care fiscal requirements that assure fiscal solvency, including a \$1 million surety bond and RCW 48.44.055





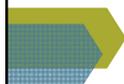
BHO reserves

- Per BHO contracts, all remaining reserves at the close of the PIHP and BH State Only Contracts must be returned to the State
 - Redirection of unspent funds requires legislative action
- BHOs must submit a spend-down plan to detail how reserves will be spent in Contract term, and amount reserved for claims runout
- Details of encumbered reserves should be further discussed with the State



Questions?

Federal Notice: The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.



Resources

HCA Contacts

Isabel Jones

360-725-0862

Isabel.Jones@hca.wa.gov

Alice Lind

360-725-2053

Alice.Lind@hca.wa.gov





SALISH BHO

ADVISORY BOARD MEETING

DATE: Friday, October 6, 2017
TIME: 10:00 AM – 12:00 PM
LOCATION: City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382

A G E N D A

<http://www.kitsapgov.com/hs/sbho/sbhoboard.htm>

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of May 5, 2017, August 4, 2017 and September 8, 2017 Minutes (Attachments 5.a, 5.b, 5.c)
6. Action Items
7. Informational Items
 - a. Healthcare Integration (Attachments 7.a.1, 7.a.2)
 - b. Quality Assurance (Attachments 7.b.1, 7.b.2, 7.b.3, 7.b.4)
 - c. Funding Update
 - SUD Expenditures FY 18 (Attachment 7.c.1)
 - Number of Medicaid Enrollees (Attachment 7.c.2)
 - American Indian/Alaskan Native Exemption
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Board Member Check-in
10. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHO	Behavioral Health Organization, replaced the Regional Support Network
CAP	Corrective Action Plan
CMHA	Community Mental Health Agency
CMS	Center for Medicaid & Medicare Services (federal)
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DDA	Developmental Disabilities Administration
DMHP	Designated Mental Health Professional
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FBG	Federal Block Grant (specifically MHBG and SABG)
FIMC	Full Integration of Medicaid Services
FYSPT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IMD	Institutes for the Mentally Diseased
IS	Information Services
ITA	Involuntary Treatment Act
LOC	Level of Care
MAT	Medical Assisted Treatment
LRA	Least Restrictive Alternative
MCO	Managed Care Organization
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
OST	Opiate Substitution Treatment
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QA, QI	Quality Assurance, Quality Improvement
QUIC	Quality Improvement Committee
QRT	Quality Review Team
RCW	Revised Code Washington
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SAPT	Substance Abuse Prevention Treatment
SBHO	Salish Behavioral Health Organization
SUD	Substance Use Disorder
UM	Utilization Management
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Go to <http://www.kitsapgov.com/hs/sbho/sbholicies.htm> for a full listing of definitions and acronyms

Action Items

None

Informational Items

a. HEALTHCARE INTEGRATION

The state Health Care Authority has put significant pressure on the larger BHOs to become mid-adopter regions, and King County has apparently submitted a letter of intent, but has negotiated significant modifications to make their participation possible. Staff will provide a full explanation of the modifications negotiated by King County.

Attached are two additional documents, from North Sound and Spokane, with questions from those BHOs and answers from the Health Care Authority related to full integration.

Staff will update the board with the latest news from around the state.

b. QUALITY ASSURANCE

The Quality Assurance staff will present an update on performance measures.

c. FUNDING UPDATE

Staff will provide an update on a variety of financial issues, including:

- SUD Expenditures FY 18

Attached is an expenditure report specific to SUD subcontractor funding which outlines our expenditures through August of various SUD funding streams for services. Staff will go over the report and explain fully.

- Number of Medicaid Enrollees

The state has increased the speed and depth of its review of Medicaid eligibility this year, resulting in an actual decrease in the number of Medicaid enrollees for the first time in twenty-five years. This directly results in a decrease in revenue for the SBHO and our mental health contractors, as revenue is directly tied to the number of individuals receiving Medicaid in a given month. An explanation from the State is attached.

- American Indian/Alaskan Native Exemption

The state has produced the first reports related to the number of American Indian/Alaskan Native individuals who have been exempted from behavioral health managed care and those who have opted in. The numbers for the SBHO are very skewed, with only 39 out of 5,700 individuals opting in for behavioral health services for the month of August. The statewide rate was expected to be approximately fifty percent based on the state's experience with health care managed care.

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**Friday, May 5, 2017
10:00 a.m.-12:00 p.m.
City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382**

CALL TO ORDER – Russel Hartman, Chair, called the meeting to order at 10:05 a.m.

INTRODUCTIONS – Self introductions were conducted around the room.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS - None

APPROVAL OF THE AGENDA

Agenda was accepted without motion.

APPROVAL OF April 7, 2017 MINUTES

MOTION: Anne Dean moved to approve the minutes of the January 27, 2017 meeting as submitted. Lois Hoell seconded. Motion carried unanimously.

ACTION ITEM

- Medicaid Budget
 - SBHO staff spoke on the most recent Medicaid budget proposals.
 - Our mental health providers have worked hard to build up productivity and expand service delivery (going back to July 2015) to get the SBHO some of the best rates in the state. They are one of the only regions to see significant rate increases.
 - Designated Marijuana Account (DMA) – The DMA has very specific expenditures as written and passed by the state. The DMA has a quarter of a million dollars written into the SBHO budget, but it has not been used as of its specificity (It is designated for youth SUD services who are not Medicaid eligible). The SBHO is analyzing likelihood of preparing an RFP to determine how the funds are to be allocated. The SBHO plans to coordinate with the 1/10 of 1% groups when an RFP goes out as the groups are currently putting a good portion of their funds towards SUD services for youth which fits the specificity of the DMA fund. This can potentially help the 1/10 of 1% groups better leverage their funds.
 - The AI/AN Exemption will likely have a significant impact on West End Outreach Services (WEOS) as those individuals who identify as AI/AN are able to opt in or opt out on a monthly basis. SBHO staff proposed transferring \$300,000 from the Medicaid reserves to assist WEOS through the transition until more data is collected on the impact the exemption will have.
 - SBHO staff asked for the board's approval of the budget based on the preliminary numbers calculated by the division so that contracts can be finalized. The budgets were based on the SBHO receiving the same amount of funding from the state as it did in the previous year. The budget will have to be amended once the state has its final numbers.

MOTION: Lois Hoell moved to approve the proposed preliminary budget. Janet Nikolaus seconded. Motion carried unanimously.

INFORMATIONAL ITEMS

➤ Funding Issues

State Budget

- SBHO staff presented on the data reports.
- IMD's account for 85-90% of SUD services. In the first year of providing SUD services, the SBHO had over 4 million dollars in expenditures. This is an area of concern.
- We are starting with a \$700,000 hole in the state budget as the actuaries inflated the Medicaid side of expenses, but not the state side of expenses. It is being advocated to get the \$700,000 back as the SBHO's costs have significantly gone up. The SBHO will not know until the state budget is finalized.

SUD Practices - OST RFP

- A bidder's conference was held with one bidder showing up, but the SBHO has received other inquiries. Proposals are due on May 11, 2017.
- The SBHO did not include a budget as the costs of running a facility are unknown and we want to see what the bidders propose.
- The Review Committee from the Advisory Board along with Lisa Rey Thomas (OCH), Chris Frank (Clallam County Public Health Officer) and Susan Turner (Kitsap County Public Health Officer) will review the bids for the RFP on May 18, 2017. An update will be provided at the next meeting.

Integration

- In 2014, Bill 6312 was passed to establish BHO's. This also set the framework to move all healthcare dollars, including behavioral healthcare dollars, over to managed care facilities and operations by 2020. The state is very vested in having full integration of funds and treatments.
- The state has been divided into 10 different regional service areas with common insurers. To become a mid-adopter, the county authority must sign a letter of intent to integrate by September 15, 2017. It is now upon our region to decide if they are to become a mid-adopter. County Commissioners will have the final say in what will happen to the BHO in our region.
- For the state, a lot hinges on every region playing this game and working in harmony. The other force is the Section 1115 district waiver, a 1.25-billion-dollar waiver that specifies the state receiving these funds only if full integration of healthcare in the state occurs. The pressure is on the state to make this happen.
- In the states rubric of integrated care, BHO's will go away completely and managed care facilities would contract directly with providers. An amendment to Bill 1388, which is currently in the back of the house, would allow the development of a leadership table in each regional service area. Counties would lead the development of the leadership table with the assistance of managed care facilities and the Health Care Authority.
- The board needs to explore its options before making a decision on integration. What is the risk to us and our communities if we do not go along with mid

enrollment? Would it be worth it to develop a proposal that integrates healthcare into the SBHO? What do the commissioners envision in a fully integrated system? These items will be taken to the Executive Board for further discussion and presented at the next Advisory Board meeting.

➤ Quality Assurance

- SBHO staff presented on the QA data reports.
- The SBHO QA staff are working on creating an internal data system that will provide more detailed and accurate information.

➤ Board Priorities

- The board agreed at the April 7, 2017 meeting that the five priorities the board previously established, should continue to be a focus for this year. These priorities include; funding, SUD practices, integration, QA, and 1/10 of 1% groups in each of the counties. As additional ideas or thoughts come up, please send them to Anders Edgerton and Russ Hartman so that they can be addressed.

OPPORTUNITY FOR PUBLIC COMMENT

- Pam Brown -Thank you for supporting Clallam County and not cutting services for our folks.
- Ellen Epstein -Regarding the AI/AN exemption; if a tribal member wants to receive services from the SBHO, where would the funds go? Tribal members will have the opportunity to opt in or out of SBHO services on a monthly basis.
- Vivian Morey -Would Ombuds services go away if the BHO opted for early integration? Ombuds services would remain in place.

FOR THE GOOD OF THE ORDER

- Board Member Check-In:
 - Russ – We continue to live in very interesting times.
 - Janet - Agreed with Russ; these are interesting times.
 - John – Submitted his letter of resignation as he is on the QRT Board and according to SBHO Bylaws, this is a conflict of interest.

- The next meeting is Friday, June 2, 2017 at the City of Sequim Transit Center.

ADJOURNMENT - The meeting adjourned at 11:59 a.m.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<u>Present</u> Anne Dean John Freeburg Janet Nickolaus Roberta Charles Russ Hartman Lois Hoell Jolene George <u>Absent/Excused</u> Helen Morrison Charles Pridgen Steve Schermerhorn Jon Stroup Catharine Robinson Mike Stringer Jennifer Kreidler-Moss Freida Fenn	Ellen Epstein, RMH Services Lisa Rey Thomas, Olympic Community of Health Vivian Morey, Ombuds Pam Brown, WEOS Vicki Lowe, AIHC/Jamestown Mike Glenn, Jefferson Healthcare Carol Ru Kirk, Discovery Behavioral Healthcare Dunia Faulx, Jefferson Healthcare Wendy Sisk, Peninsula Behavioral Health	Anders Edgerton Alexandra Hardy

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**Friday, August 4, 2017
10:00a.m. – 12:00p.m.
City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382**

CALL TO ORDER – Russ Hartman, Chair, called the meeting to order at 10:00 a.m.

INTRODUCTIONS – Self introductions were conducted around the room.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS - None

APPROVAL OF THE AGENDA

Agenda was accepted without motion.

APPROVAL OF June 2, 2017 MINUTES

The matter of Action Items being taken at the June 2, 2017 meeting when the attendance records detailed the meeting was not a quorum was brought to the attention of the board and discussed. The board requested that the minutes of the June 2, 2017 meeting be amended to reflect that a quorum was not present; therefore, any action item taken at the meeting is void.

MOTION: Catharine Robinson moved to adjust the minutes of the June 2, 2017 meeting to reflect that a quorum was not present at the meeting and any action taken at the meeting is void. Charles Pridgen seconded. Motion carried unanimously.

MOTION: Catharine Robinson moved to approve the amended minutes of the June 2, 2017 meeting. Charles Pridgen seconded. Motion carried unanimously.

AGENDA

The subject of amending the agenda for the meeting was discussed by the board due to three Action Items (Substance Use Disorder Budget, May 5, 2017 Meeting Minutes, and Integration) being void from the June 2, 2017 meeting. After the board discussed the topic, the following decisions were made:

- **Substance Use Disorder Budget:** The Substance Use Disorder budget has already changed and is currently being updated. The item will be added as an Action Item at a future meeting.
- **May 5, 2017 Minutes:** The May 5, 2017 meeting minutes will be added as an Action Item to the September 8, 2017 meeting.
- **Integration:** The board decided to revisit the discussion of Integration at the meeting as an Informational Item, but not to revote on the subject as the Executive Board has already made its decision on the subject.

ACTION ITEMS➤ Opiate Treatment Program Recommendation

- The organization which responded to the OTP Request for Proposals met with the RFP Committee and staff from the Health Departments in Kitsap and Clallam Counties as well as Lisa Rey Thomas of the Olympic Community of Health and SBHO staff on June 26 to respond to any remaining questions the group had regarding their proposal.
- The board held a discussion on Baymark's proposal to decide if the SBHO should enter into a contract with them to provide opiate treatment in Kitsap and Clallam Counties.
- The consensus is that Baymark will integrate into the community well by choosing a proper location, keeping the appearance of the building well maintained, and holding open houses for the communities they move into.
- The board was concerned with the data that will be collected by Baymark. The board requested to include a section in the contract on data collection to ensure the SBHO receives the information on our region to track success rates.
- Baymark is primarily known to prescribe Methadone which will complement our region's needs. Baymark will also prescribe Vivitrol and Suboxone as the RFP requires. The board also requested that verbiage is included in the contract to ensure Baymark prescribes all three opiate treatment drugs.
- The board suggested leaving the contract length up to SBHO staff to decide what would be best.

MOTION: Jennifer Kreidler-Moss moved to approve continuing working on a contract with Baymark for Opiate treatment in our region. Helen Morison seconded. Motion Carried unanimously.

- It was suggested that the SBHO develop a sub-committee to work with Baymark to monitor the integration process with other treatment providers and to ensure the people seeking services are receiving the best treatment plan for them.
- Jolene George, Jennifer Kreidler- Moss, Catharine Robinson, and Charles Pridgen volunteered to participate on the Opiate Sub-Committee.

MOTION: Jennifer Kreidler-Moss moved to create a sub-committee to monitor the integration Freida Fenn seconded. Motion Carried unanimously.

➤ RFP Committees▪ **Designated Marijuana Account Funding**

In the Spring of 2016, the Legislature cut state funding for Substance Use Disorder services and substituted Designated Marijuana Account (DMA) funds for the former state funding. At the time, BHO's were told that the fund switch was not anything to be concerned about, and the funds were interchangeable.

In January 2017, the SBHO received a contract amendment containing language that makes utilization of the DMA funding very restrictive. The SBHO believes the best way to utilize these funds at this time is to appoint an RFP specific to this program.

▪ **Substance Abuse Block Grant**

The Substance Abuse Block Grant is a separate funding stream which requires community involvement and input from the Advisory Board. The SBHO is setting up a system of developing SABG plans in the fall of the year so that a more thoughtful process can be facilitated in the future. The SBHO has extended current SABG contracts by six months and would like to complete an RFP cycle in time for January contracts.

- The board decided that it would be best to combine the two items and have one RFP sub- committee.
- Helen Morrison, Russ Hartman, and Jon Stroup volunteered for the committee.

INFORMATIONAL ITEMS

➤ State Budget

- The Legislature completed work on an operations budget in the nick of time, providing ongoing funding for critical state programs. The Division of Behavioral Health and Recovery (DBHR) has not yet completed the process of analyzing and distributing funding, but it appears that our revenue will be unaffected by the budget.
- State hospitals received a 34% increase in funding; this is a historical rise as they are typically flat in funding. The state budget officer said that even with the increase in budget, the state hospitals are already in a deficit.
- We don't know how the state will distribute funding to the different BHO's.
- SBHO staff will provide an update once information is received from the state.

➤ Budget Update

Substance Use Disorder Distribution

- The lack of a final distribution of funding from the State makes putting together a final annual budget impossible. The significant change in the revenue picture as a result of the Federal change to the IMD rule which made approximately half of our residential stays ineligible for Medicaid reimbursement, and the need to backfill those residential costs with Non- Medicaid funds has created a very complex situation.
- FY 2016, the SBHO received \$1.5 million for the first twelve months of the SABG contract. FY 2017, we were given \$1.2 million. However, we were given a 3-month extension to spend money on the previous year's contract and additionally asked for more money which we were given for a total of \$1.9 million.
- SABG RFP will go out in the fall for January 2018 – December 2018 contracts.
- The vast majority of funding is going towards residential care because of the IMD rule change.

Substance Use Disorder Residential Changes

- The change in the Federal IMD rule has resulted in a significant change in how many BHO's approach Residential SUD services as well as how some programs are operated.
- Within our BHO, the program at Kitsap Recovery Center has been modified, and the program physically moved to prepare for the development of a Triage Center by Kitsap Mental Health. The program at the new center has been modified to create a non-IMD situation by shrinking the residential program to 16 beds and increasing the Withdrawal Management program to 16 beds. In Pierce County, Prosperity Wellness has decreased their bed capacity to 16 (from 33) and increased their outpatient program. The decrease to 16 beds makes these programs eligible for Medicaid

services.

- Behavioral Health Organizations have taken different approaches to the new payment paradigm; with some BHO's shortening their authorization period to as little as 12 days. The SBHO has not made any authorization changes, but will be monitoring residential utilization and funding flows carefully to ensure that we remain in compliance with funding restrictions.
- Some states have a waiver that allows them to use Medicaid funding for IMD's. Washington State is planning on submitting an identical waiver to the other states that have been successful. The waiver is believed to take effect in July of next year.

➤ Quality Assurance (QA)

- QA Staff presented on the performance measures and the Encounter Data Validation (EDV) results.
- The board was concerned about the agencies having ramifications for not meeting criteria and requested to review the SBHO's Policies and Procedures on the subject at the next meeting.
- The QA team was requested to include performance measures for a longer period of time and to present more data on peer services at future meetings.
- The board also requested the QA team to include footnotes and narratives on the data to better explain the information being presented.
- The SBHO is issuing Corrective Action Plans (CAPS) to agencies not meeting standards on the EDV reports for clinical chart notes.
- The board discussed their concerns with the results of the EDV and how they would like to ensure this problem is fixed and how to prevent the reoccurrence of the problem in the future.

OPPORTUNITY FOR PUBLIC COMMENT

- Steve Workman (Jefferson County) – Thank you for the discussion and brainstorming during this difficult era. Steve raised his concerns that the board failing to mention law enforcement and the role it plays in the discussions that were held today. Steve was also concerned that inmates being released from jail services in Jefferson County will not have anywhere close by to go for opiate treatment as the RFP only included Clallam and Kitsap Counties. Steve was also concerned that the board was focusing more on funding and not the quality of care when it comes to the subject of integration.
- Pam Brown (Director of West End Outreach Services) –The board failed to mention one good thing about the crisis response and the timeliness of the entire system when looking at the QA performance measures and EDV results; the focus of the meeting was on all the red. It is hard to cram behavioral health into a few qualitative measures and it isn't fair to take funding away based on these measures.

FOR THE GOOD OF THE ORDER

- Board Member Check-In:
 - Catharine – Good meeting, thank you to the public.
 - Freida – Would like us to focus on the good and not just the red in future meetings.
 - Helen – The board should make it a goal to focus on supporting the agencies getting better outcomes going forward.
 - Jolene - We need to continue this discussion on the EDV and have the agencies focus on correcting the issues.
 - Roberta – enjoyed the discussion.

- Russ – Stated that we live in interesting times and offered compliments to the board for the discussions. Russ brought up that at the next meeting, the board needs to elect a nominating committee to select the Chair and Vice Chairs for the year starting in January 2018.
-
- Charles – Thank you to Anders and Alex for making the arrangements for him and his wife to attend the state convention in Vancouver.
- Janet – beginning to catch on.
- Jennifer – Is struggling a bit as she is seeing data that shows that we are not superior and is seeing budgets that show we are not cost effective. Jennifer is wondering why we would want to retain a system that is not functioning at where it should be?
- Sandy – Mentioned that she is the new kid on the block and that she has a lot to learn, but from her background, she would like to focus on children services and families.

ADJOURNMENT - The meeting adjourned at 12:01 p.m.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<p><u>Present</u> Lois Hoell Freida Fenn Helen Morrison Janet Nickolaus Catharine Robinson Roberta Charles Anne Dean Jolene George Russell Hartman Jennifer Kreidler-Moss Charles Pridgen Sandy Goodwick</p> <p><u>Absent/Excused</u> Jon Stroup Jennifer Risinger</p>	<p>Andy Brastad, Clallam County HHS Pam Brown, West End Outreach Services Ellen Epstein, RMH Services Vivian Morey, Ombuds Steve Workman, Jefferson County Citizen Rebecca Miller, Peninsula Behavioral Health Lisa Rey Thomas, Olympic Community of Health Kathy Stevens, Peninsula Behavior Health</p>	<p>Anders Edgerton Alexandra Hardy Richelle Jordan Ileea Nehus</p>

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**10:00 a.m., Friday, September 8, 2017
City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382**

CALL TO ORDER – Russ Hartman, Chair, called the meeting to order at 10:10 a.m.

INTRODUCTIONS – Self introductions were conducted around the room.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS - None

APPROVAL OF THE AGENDA

SBHO staff requested that the agenda be amended to include Opiate Treatment Program, RFP's, and the Citizens Advisory 1/10th of 1% Committees as Informational Items.

Revised agenda was approved without motion.

APPROVAL OF MAY 5, 2017 and AUGUST 4, 2017 MINUTES

The approval of minutes was tabled for a future meeting as the board did not meet requirements for a quorum.

INFORMATIONAL ITEMS

➤ Funding Update
Expenditures

- SBHO staff presented a report outlining revenue and expenditures for the April through June 2017 period.
- This report is part of the quarterly report that the SBHO provides to the state. SBHO staff will start presenting this report quarterly to the board.
- The SBHO is focusing on spending the money it has in reserve accounts down as the integration date gets closer to ensure that the funds are spent in our region. The reserve accounts need to be an agenda topic in the boards conversations on integration.

SUD Expenditures FY 2018

- SBHO staff are tracking SUD expenditures closely (Monthly) as it is very easy to go into the red with the IMD rule change.
- SUD services are paid on a case rate per person system for outpatient services and daily rate for residential services. Residential services can be paid with Non-Medicaid funds and Medicaid funds depending on the size of the facility and the length of stay.
- The SBHO is spending more money on residential care than outpatient care.
- Studies show that the longer an individual is in care for substance abuse disorders, the better the outcomes. It does not seem like a wise expenditure to spend most of our money on residential treatment as it tends to be a short-term result. We need to examine the cultural practice of residential treatment.
- The lack of housing in the area also complicates the SUD system as a lot of

times residential treatment provides housing that is otherwise not available.

IMD Update

- The SBHO is tracking utilization of the various residential programs very closely, and the SBHO is required to submit data to the state by the 10th of each month on specific individuals who were residents of IMDs for more than 15 days in any previous month.
- The SBHO has not seen a mental health IMD reports yet, but should be the end of the month. Staff will continue to provide updates.

State Allocation

- The BHOs received official allocation of non-Medicaid funds the week of August 21.
- The funding was unchanged from what has previously been presented to the board.
- SBHO is concerned as the state does not have a mechanism currently for letting BHOs know how many of the AI/AN population have opted in to managed care and how many have not.
- The other issue is the state has been paying BHOs a Per Member Per Month payment for the IMD backfill, and only two regions have been able to identify those funds.

Mental Health Funding

- The distribution of funds for mental health services appears to be unchanged although staff needs to inquire regarding what funding the State is including in some of their calculations.

➤ Opiate Treatment Program

- The Executive Board voted to go ahead with the SBHO finalizing a contract with BayMark for the OTPs in Clallam County and Kitsap County. The SBHO is working on finalizing the contract with BayMark and will continue to provide updates.
- The SBHO will host a public forum in each of the communities to introduce and educate the public on Opiate Treatment Programs (OTP).
- A document has been created to assist with the education process and can be found on the SBHO website.
http://www.kitsapgov.com/hs/sbho/documents/MAT_FAQ_90517.pdf
- The Advisory Board had a very active sub-committee for the OTP RFP; it was proposed that the Advisory Board discuss at a future meeting the possibility of the sub-committee continuing to assist with the integration of BayMark into our region.

➤ RFP UPDATES

- The RFP for the Designated Marijuana Account is about to be released.
- The SABG RFP will most likely come out in November.
- Staff will continue to provide updates.

➤ Citizens Advisory 1/10th of 1% Committees

- There is a move to have a summit with all three county Citizens Advisory 1/10th of 1% Committees and the SBHO Advisory Board.

- The primary purpose of the summit would be to maximize funding in our communities and to discuss programs and funding post integration.

➤ Integration

- The state continues to be intent on moving forward with the full financial integration of healthcare within Managed Care Plans.
- The SBHO Advisory Board discussed the transition to integration and developed a list of questions and areas to focus future discussions on.

	Question	SBHO Response/ Follow Up
1.	What do communities envision for behavioral health services after integration occurs? What do our communities value? Do we want one place that treats everything or do we want to provide options and variety to our communities?	This needs to be a topic in the boards discussions on integration.
2.	What focus should the SBHO take with the transition to integration?	The SBHO needs to take a dual track, prepare for integration, but also fight integration.
3.	Are MCOs just insurance companies? How will the geographical boundaries be set up for MCOs?	MCOs will only act as insurance companies. The MCO regions will be arranged by the geographical areas of the BHOs; an RFP is going out in February for the MCOs to bid on regions.
4.	Does the SBHO have a list of services that the SBHO currently covers, but will not be included in the MCO contract post integration? Can the list include possible funding sources for the services post integration?	SBHO staff will work on developing a list to help ensure services will continued to be offered post integration.
5.	What is the Olympic Community of Health's (OCH) role now? What role with the OCH have post integration?	The OCH was established to distribute the demonstration 1115 waiver money for our region. The waiver money runs for five years; at this point we do not know if funding will continue after the five-year mark. A discussion with the OCH over their visions for integration would be useful to the board.
6.	What is the OCH applying the demonstration 1115 funds too?	The funds are to support the OCH in the development of a value based payment system and the transition to integration for our region.
7.	How is the SBHO going to spend reserve accounts down prior to integration?	This needs to be a topic in the boards discussions on integration.
8.	How can the board encourage more dialogue with the various providers in the area? How can we get the providers to attend the SBHO meetings?	This needs to be a topic in the boards discussions on integration.
9.	What will happen to BayMark when integration occurs?	This needs to be a topic in the boards discussions on integration.
10.	How can the SBHO assist the agencies in our region with building a stronger foundation and strengthen our current system?	This needs to be a topic in the boards discussions on integration.
11.	Would our region benefit from an all-day retreat to focus on the transition to integration?	This needs to be a topic in the boards discussions on integration.

OPPORTUNITY FOR PUBLIC COMMENT

- Ru Kirk (Discovery Behavioral Health) – Going to the OCH meetings, getting on their mailing lists, and looking at their website would be helpful in providing ideas and a

reference points on the OCH and their role in integration.

- Anna McEnergy (Jefferson County Public Health) having a summit with the 1/10th of 1% Communities and the Advisory Boards would be beneficial and helpful as she is interested in learning more about the transition to integration and maximizing funds.
- Rebecca Miller (Peninsula Behavioral Health) – It is a scramble every day; most providers are over worked and under paid. Do we want people to have just one option for care or multiple options for individuals to decide where to go to get the best care?
- Sally O’Callaghan (Kitsap County Citizen) - Who are we integrating with on the medical side; How does integration work from a client component?

FOR THE GOOD OF THE ORDER

- Board Member Check-In:
 - Russ Hartman– The board needs to appoint a Nominating Committee for the selection of board officers for the next year. Charles Pridgen, Jennifer Kreidler-Moss, and Helen Morrison were appointed to continue as the Nominating Committee.
 - Roberta Charles– Thank you for all the questions and answers.
 - SBHO Staff – Look at page 19 of the Agenda Packet to view the preliminary outcomes from integration in Southwest Washington. There will never be a comparison of behavioral health services in an integrated region verses a non-integrated region.

ADJOURNMENT - The meeting adjourned at 12:08 p.m.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<u>Present</u> Helen Morrison Janet Nickolaus Roberta Charles Russell Hartman Charles Pridgen Sandy Goodwick	Ellen Epstein, RMH Services Vivian Morey, Ombuds Rebecca Miller, Peninsula Behavioral Health Kathy Stevens, Peninsula Behavior Health Anna McEnergy, Jefferson County Public Health	Anders Edgerton Alexandra Hardy
<u>Absent/Excused</u> Jon Stroup Jennifer Risinger Jennifer Kreidler-Moss Anne Dean Jolene George Lois Hoell Freida Fenn Catharine Robinson		

**Follow Up Questions for Health Care Authority
Regarding Mid-Adopter Integration
North Sound BHO County Authorities Executive Committee
DRAFT for discussion September 7, 2017**

Assumptions regarding the BHO transition to a BH-ASO, with clarification	
1. Starting in 2019 [or 2020 if no mid-adopter], all Medicaid funds would be contracted to the MCOs	Correct
2. During the 2019 transition period for mid-adopters, the MCOs could choose to contract with and/or delegate certain Medicaid funded services or functions.	Yes, and this would be a focus of the Interlocal Leadership Group.
3. Starting in 2020, no behavioral health administrative essential functions can be delegated to the BH-ASO.	If there is a function that is widely agreed to be a value-add or most effective when delegated to the BH-ASO, this could be discussed.
4. The current BHOs must return all unspent Medicaid and non-Medicaid dollars to the state, except for an agreed upon portion to pay all remaining bills.	Yes, and the State will work with the BHO to develop an approved spend down plan to maximize spend down of reserve funds prior to the BHO closeout. BHOs should begin proactively planning for spend down now. For further details on reserves, please review the draft reserve Q&A.
5. There is no provision to provide “start-up” funds to the new BH-ASOs. This means that a BHO who wishes to transition to a BH-ASO would be required to determine how it will obtain the necessary operating funds to carry out its functions.	HCA is exploring possibilities and will keep Counties informed as we work through a resolution.

	Issue	Question	BHO Notes	HCA Response
1.	CONTINUUM OF CARE AND COUNTY SERVICES	What will the new integrated structure look like for counties? How will dollars the BHO uses to support the counties in their stabilization and continuum of care programs flow? How will the administrative costs of running stabilization/human service programs be paid?	The North Sound BHO currently delegates and funds certain allied coordination activities to the county human service departments.	<p>If the county is also a service provider, the county provider agency would be eligible to contract with the MCOs and/or BH-ASO to continue providing treatment services, just as any other behavioral health provider agency in the region. This is the case in Skamania and Grant counties already.</p> <p>If the county provides allowable delegated functions or coordination functions on behalf of the BHO, and would like to continue providing those functions in the future, the MCO/BH-ASO could choose to continue that arrangement. If these functions are paid for by county dollars, those dollars stay with the county and are used at the discretion of the county.</p>
2.	CONTINUUM OF CARE AND COUNTY SERVICES	Where are current county staff (providing care coordination and mental health outreach services) going to work? What about public health staff who work on prevention programs? Is the role of health and human services at the county level being eliminated or simply changing? What (specifically) does it look like in an integrated model?	All North Sound counties use the 1/10 of 1% sales tax to help fund prevention and other related behavioral health service activities.	<p>Any county staff or functions that are funded by local funds, such as 1/10th of 1%, will not be affected at all by this transition. Counties maintain full control over local funds and 1/10th 1% funds. The prevention programs funded through DBHR/Substance Abuse block grant will continue to be funded through counties unless the county chooses not to maintain this role.</p> <p>Care Coordination and outreach would become a responsibility of the MCOs. However, that does not prevent the counties from continuing some/all of those functions through contracting with the MCOs or ASO.</p>
3.	CONTINUUM OF CARE AND COUNTY SERVICES	What assurances do local jurisdictions have that this is not a cost shift or unfunded mandate? What assurances do we have that		HCA will be requiring the same services to be provided through contracted MCOs and ASOs. HCA will monitor utilization to ensure that services will not be negatively affected. The interlocal team

	Issue	Question	BHO Notes	HCA Response
		service levels will not be negatively impacted?		has an opportunity to provide input on the monitoring activities, early warning system, and performance measures.
4.	RURAL HEALTH AND BEHAVIORAL HEALTH CARE	What is the significance of a critical access hospital , or in the case of San Juan County, having no significant healthcare system in place? How will the integrated model look in counties (or rural areas of counties) if there is an unwillingness, or inability, of the primary healthcare system to deliver service? What happens if they are prohibited from delivering certain services because of their hospital designation? How will that gap be filled? How will those patients be diverted to another system and who will pay for that diversion?		This transition will most significantly impact the BHO-contracted providers and behavioral health services paid for by the BHO. This transition should not result in any significant changes to the critical access hospitals or primary care providers that already operate in the medical system. The Managed Care Plans will continue to be held to network adequacy requirements that require them to maintain a network of medical providers (including primary care, hospital, specialty, etc.) that meet time and distance standards, etc. If providers are unwilling or unable to contract with managed care plans, or choose not to serve Medicaid patients, the managed care plans must find new providers to contract with, otherwise they will be out of compliance with network adequacy which will result in an enrollment stoppage, or additional corrective actions.
5.	RURAL HEALTH AND BEHAVIORAL HEALTH CARE	What tools does the integrated model have to improve access (notably in rural areas) that the current system does not have? What happens if providers refuse to improve access (for whatever reason)? What are the MCOs commitment to the local communities, especially small rural ones, in funding for full integration?		As noted in prior questions, if behavioral health services are delivered in new settings then this will lead to increase penetration rates and access. While not the same as BHO standards, the MCOs are required to adhere to access standards in rural areas, and also have care coordination requirements specific to rural and frontier regions. Through network adequacy standards, time and distance standards will also be required for BH services. We would be happy to discuss better

	Issue	Question	BHO Notes	HCA Response
				<p>aligning standards through the Inter-local leadership.</p> <p>Rural and frontier providers will play a critical role for MCOs in their ability to meet these network standards. Commitment to supporting these communities will be critical to these efforts. This is also why HCA does not plan to have less than 3 plans in any region.</p>
6.	BLENDED FUNDING SERVICES	How will the funds for Crisis Services be “braided” after integration? Will MCOs be contractually required to provide Medicaid funds to partially support Crisis Services moving forward? What requirements will there be for MCOs to help maintain other services that require blended funding.	This includes the full “continuum” of crisis services: ITA, mobile outreach, Triage Centers, Crisis Line, etc.	<p>The MCOs are required in Contract with HCA, to establish a contract with the BH-ASO to pay for Medicaid-covered crisis services for their members. This includes mobile crisis outreach and the crisis hotline and any short term crisis stabilization activity that might occur during a mobile outreach visit, etc.</p> <p>If as a result of their encounter with the crisis system, a Medicaid client is committed to treatment, such as being committed to an E&T by a DMHP, the MCO’s are contractually required to pay for that treatment service (the MCO pays the E&T directly). They are not able to do prior authorization or deny a service that has been court ordered.</p> <p>The BH-ASO <i>also</i> has a contract with HCA funded by non-Medicaid funding sources. This covers the non-Medicaid crisis related costs, such as crisis services delivered to non-Medicaid individuals or court reimbursements for any individual who is involuntarily committed or the cost of a DMHP ITA investigation.</p>

	Issue	Question	BHO Notes	HCA Response
				<p>The braiding of funding really happens at the BH-ASO level, just as it does right now at the BHO level. The actual crisis providers should expect to be paid by the BH-ASO similar to the way they are today by a BHO. Providers will directly negotiate with the MCOs and ASO a payment method that works best for them.</p>
7.	<p>MAINTAINING AND EXPANDING TREATMENT CAPACITY</p>	<p>How will residential treatment be paid for, and what assurances are there that systems the counties are investing in will be utilized</p>		<p>Residential treatment beds are paid for by the MCO, or for non-Medicaid clients, by the BH-ASO. The MCOs will have a portion of state-only funds that will allow them to pay the non-Medicaid room/board cost, just as the BHO's do today. Residential treatment services are Medicaid covered and therefore are paid for by the MCO's using Medicaid funds.</p> <p>As the BHOs currently do, the MCOs will be required to provide medically necessary services, including treatment in IMDs that extends beyond 15 days.</p> <p>If an individual is involuntarily committed to residential treatment or is otherwise authorized for residential treatment by the BH-ASO, the BH-ASO would pay for that out of non-Medicaid funds (state funds, block grant, proviso, CJTA - - as allowable/available).</p> <p>In terms of assurances to the county regarding whether the beds will be contracted; there is a shortage of beds in the State of Washington. As Essential Behavioral Health Providers, the MCOs</p>

	Issue	Question	BHO Notes	HCA Response
				will need as many providers as are available. MCOs are responsible for the full spectrum of services, it behooves them to serve clients in the least restrictive manner possible, where clients are likely to succeed. This would include maintaining relationships with the communities in which the person resides.
8.	MAINTAINING AND EXPANDING TREATMENT CAPACITY	If the North Sound is successful with its request for new capital dollars to build new crisis centers and residential treatment facilities, it's not likely all of these will be completed by 2019. What requirements will there be for MCOs to partner with the counties in maintaining and expanding the capacity of treatment facilities?	The BHO contracted for population modeling that shows there is currently a gap of over 100 treatment beds and this will grow over the coming years.	Depending on how this is currently operates or is funded, HCA will work with the region during the lead-up to integration to ensure capacity building continues.
9.	MAINTAINING AND EXPANDING TREATMENT CAPACITY	What is the logistical process for bringing on more providers and increasing consumer access to services? What happens if the limitation for increased access is workforce? How will capacity be developed in order to keep people stable and out of crisis?		<p>As noted in prior questions, the MCOs are held to network adequacy requirements that require them to have an adequate network of providers to meet the access needs of the population. If the limitation is workforce, the MCOs have flexibility and discretion to increase provider rates for certain types of hard-to-access services. Additionally, in SWWA HCA is working on a capacity building process with the MCOs, BH-ASO, ACH and counties to collectively work towards increasing provider capacity in the region.</p> <p>One of the benefits of this model is that the access to care standards and silos are removed, which allows new providers such as medical systems to obtain licensure for BH services (if desired) and offer additional services or clinically integrated models that they have not previously delivered. If</p>

	Issue	Question	BHO Notes	HCA Response
				<p>this occurs over time, it will improve access to services.</p>
10.	COORDINATION WITH PUBLIC SAFETY SYSTEMS	<p>Who is responsible for coordination with jails to ensure diversion services are working? What will counties do if they are not, who is responsible for coordination with courts to ensure timely access to assessments and funding support and treatment access for Drug Court. How will the CJTA money be distributed?</p>		<p>The MCOs and BH-ASO all must coordinate with the criminal justice system and treatment providers to assure their members are engaged in treatment and diverted from jail whenever possible. The region should expect that the MCOs and ASO hire jail liaisons and are actively engaged in jail diversion activities.</p> <p>In SWWA and NC, the BH-ASO receives the “jail transition” proviso funds and contracts those funds to the providers who have been providing jail transition services in the region.</p> <p>The BH-ASO also receives the CJTA funds and contracts those to providers, primarily to support the non-Medicaid justice-involved population that is eligible for CJTA funded treatment. Many of the treatment services funded via CJTA are also Medicaid-covered and thus covered by the MCOs for their clients.</p> <p>The use of CJTA funds is directed locally, by each region’s CJTA panel. This does not change -- the BH-ASO simply contracts the funds out in accordance with the priorities and parameters that are determined by the local CJTA panel.</p> <p>Depending on how the Drug Court currently operates or is funded, HCA will work with the</p>

	Issue	Question	BHO Notes	HCA Response
				region during the lead-up to integration to ensure Drug Court continues.
11.	WORKFORCE	Who will do advocacy for workforce needs and training? Who will identify future local needs and how will those needs be addressed?	North Sound BHO currently provides significant funding support for on-line and classroom training.	This should be a topic for the interlocal group as implementation progresses.
12.	COORDINATION OF REGIONAL PLANNING	Who is responsible for regional planning on programs and services that need to be coordinated	If this function is assigned to the BH-ASO then there needs to be an adequate level of administrative funding carry it out. The BHO currently depends heavily on its Medicaid administrative funds to plan and coordinate a network of services across the five county region.	HCA would further discuss with the regional stakeholders and selected MCOs/BH-ASO how they would like this to look in their region, and how they think it can be most effective. This should be a topic for the interlocal group as implementation progresses.
13.	COORDINATION OF REGIONAL PLANNING	With county involvement (BHO/ASO) how will the above coordinating services be funded? What is the protection for counties that the system we are involved with will be adequately compensated and not require backfill with local county funds?		HCA would need more specific information on the type of coordinating services this question refers to. HCA has no ability to require the counties to “backfill” the cost of services in the Medicaid program. Strategies for ensuring the system of care within the region remains intact, could be a task for the inter-local group.

	Issue	Question	BHO Notes	HCA Response
14.	COORDINATION OF REGIONAL PLANNING	The transition period will require additional demands on our local staff as well as additional staffing to do reporting and maintain Level of Services [LOS], how can this be funded?		<p>SIM-funded TA dollars to assist mid-adopter counties in the transition to 2019 are available, up to \$200K per region. These funds should be used to support planning and implementation that will need to occur at the local level.</p> <p>Also, the ACH has the ability to provide integration incentive funding to the counties to support implementation costs.</p>
15.	CLIENT RIGHTS	What does a County do if a MCO or the local health care provider “fires” a client for things like “no-show,” “behavioral issues,” or simply not following medical advice? What happens if the client has a barrier to accessing care? Who is their advocate?	BHO contacted providers are not allowed to refuse services to someone except in exceptional circumstances and only with BHO approval.	<p>HCA MCO contracts include requirements regarding “involuntary disenrollment”, including, e.g. 4.12.6.3 “HCA will not terminate enrollment and the Contractor may not request disenrollment of an Enrollee solely due to a request based on an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or behavioral health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b) (2)).”</p> <p>MCOs are required to provide access to care for clients, and provide assistance to them when providers terminate services. MCOs are required to provide information on grievances and appeals to clients. Additionally, the Ombuds function will continue within the region and can assist the client, should they feel they have been wrongly terminated or denied services.</p>
16.	PREPARING PROVIDERS	Which partners need to be ready if the region decides to be a mid-adopter? Who is		The initial change means that BH providers currently contracted with the BHO will need to

Issue	Question	BHO Notes	HCA Response
		<p>responsible for knowing if they can be ready in time? Who is responsible for ensuring that our healthcare systems are ready to take on behavioral health patients; and or that they have enough capacity to provide preventative care to the expanded population?</p>	<p>contract with the MCOs/ ASO and be paid using more standard insurance payment/billing methods. Additionally, allied systems that coordinate closely with the BHO will need to transition to working with and partnering with the MCOs/ASO. The MCOs/ASO are required to develop an allied system coordination plan that clearly outlines these partnership agreements, including with MOUs where appropriate. Best approaches for ensuring ongoing relationships with allied system partners could be discussed and developed further through the inter-local leadership. We think it could be a creative approach for this work to be delegated to the BH-ASO, as a single coordinating entity.</p> <p>HCA has learned lessons from SWWA, and has been working to develop tools that will assist with assessing provider readiness. This includes a survey tool to assess providers billing and IT capacity, that the Department of Health contracted practice coaches will be trained to use.</p> <p>Additionally, DOH, through its Transformation Hub, is responsible for developing a full toolkit and “roadmap” that will complement the survey tool, to clearly define the MCO billing expectations for providers and provide guidance and clear timelines on what they need to do to be ready for implementation.</p> <p>These tools should ideally be paired with hands-on technical assistance. For example, in North Central</p>

	Issue	Question	BHO Notes	HCA Response
				<p>and SW, HCA has devoted SIM grant dollars to bringing on consultants to provide hands-on TA to providers to configure their billing systems, implement new EHRs, and test billing/claims submission with MCOs. HCA is invested in finding solutions to assist providers with readiness. In mid-adopter regions we believe this type of work should be a priority use of Medicaid Transformation Demonstration incentive funds via the ACH.</p> <p>Assessing “readiness” of providers is something that will require a very high degree of collaboration between HCA, the BHO, the selected MCOs and the ACH. It is not something one entity will be solely responsible for. We should discuss what you mean by “expanded population”, since from our view the only new population for MCOs is the BH Services Only group.</p>
17.	PREPARING PROVIDERS	Who will pay the providers to upgrade their computer software/systems to meet the new data demands? Who will do the training on how to use the systems? Who will do compliance monitoring? Who will advocate for the providers so that they have the resources they need to succeed in providing care?	The BHO has provided significant financial and technical support to both MH and SUD providers to upgrade their systems to meet managed care requirements.	<p>HCA would expect that ACH Demonstration incentive funds would be used to support provider IT infrastructure building. Additionally it would be an allowable use of BHO funds to support providers’ transition to the MCO delivery system. As noted in prior sections, HCA would strongly encourage the provision of TA on IT/billing changes, which could be a good use of ACH integration incentive funds. The MCOs will also be very involved in the provider readiness.</p> <p>Providers can also advocate for themselves and should. A best practice from SWWA is the</p>

	Issue	Question	BHO Notes	HCA Response
				formation of a BH Provider Alliance, which the providers use to advocate for their needs.
18.	INTEGRATION INCENTIVE DOLLARS	Could the mid-adopter incentive dollars be used to help providers make the necessary changes to their electronic record systems so that they can meet the new MCO requirements for data reporting and billing?		Absolutely and we would strongly support this as a priority.
19.	INTEGRATION INCENTIVE DOLLARS	Assuming we become mid-adopters, for small counties, what assurances do we have that the ACH will utilize the incentive dollars to make the investments needed in rural areas to ensure adequate capacity in our healthcare system?		The ACHS are expected to use those incentive dollars for providers for be better prepared for integration, for example, developing infrastructure that supports clinical integration, etc. In order to maintain adequate networks within rural areas, the MCOs have a vested interest in ensuring that providers have the resources they need to continue providing services.
20.	INTEGRATION INCENTIVE DOLLARS	Does agreement to use 2019 as a transition year with some Medicaid services still contracted back to the BHO-ASO still qualify the region to receive incentive dollars?		Yes.
21.	REINVESTMENT OF BHO RESERVES	When specifically will we know what spend-down is eligible for our reserves? Will we know early enough to spend the money down in the region? How much flexibility will we be given as a region to plug identified holes or prepare the system for full-integration?		<p>The BHO can spend the PIHP and BH State Contract inpatient reserves to the minimum, and this amount is defined in contract.</p> <p>The BHO can spend the PIHP and State Contract operating reserves to 0.</p> <p>The State is limited in the “flexibility” we can allow because Medicaid (PIHP) reserves must be spent in accordance with the BHO Medicaid contract, and BH State reserves must be spent in accordance with the BH State Contract (which is already fairly flexible).</p>

	Issue	Question	BHO Notes	HCA Response
				<p>In the process of approving the BHO spend-down plan the State can work with you further on this.</p> <p>Please see reserves Q&A for additional details.</p>
22.	REINVESTMENT OF BHO RESERVES	Can any unspent dollars remaining at the end of 2018 be “redirected” with legislative approval to continue capacity building efforts that were begun before 2019, e.g., development of crisis and residential treatment facilities?		This would require legislative action and is something that will require additional discussion
23.	BH-ASO	Does the BH-ASO contract with HCA or is it a sub-contract with the MCOs?	It is our understanding that the “ASO” contract is with HCA, but that the MCOs can also contract with the ASO for delegated Medicaid functions. However, for blended funding services, such as the various types of crisis services, will there be multiple contracts with HCA and the MCOs?	<p>Both. The BH-ASO has a contract with HCA that is funded by multiple non-Medicaid funding sources (State General Fund, SAMHSA Block Grant, proviso, CJTA, etc.).</p> <p>Additionally, the MCOs are REQUIRED to contract with the BH-ASO to reimburse for Medicaid covered crisis services. HCA has encouraged the MCOs to contract on a capitated basis with the BH-ASO. They are essentially passing through the portion of the PMPM that is for crisis services, and delegating the administration to the BH-ASO.</p>
24.	BH-ASO	What is the role of the BH-ASO? Can you provide examples of activities/programs?	Will the contracted ASO functions be the same as it is for SW Washington and North Central?	<p>Please see ASO contract for further details. The primary role is:</p> <ul style="list-style-type: none"> • Manage the crisis system regionally including mobile outreach, ITA investigations, DMHPs, crisis hotline, etc.

	Issue	Question	BHO Notes	HCA Response
				<p>BH-ASO contracts with existing crisis providers to do this, and then will work overtime to expand services if desired by the community.</p> <ul style="list-style-type: none"> • Pay for BH services for non-Medicaid clients, including services if a client is involuntarily committed, or other BH services as funding allows. • Manage the FYSPRT, BHAB, block grant project plan writing process, and any other regional committee or convening structures focused on planning or coordination efforts. • Administer CJTA funds and other non-Medicaid funding sources in accordance with CJTA Panel Plan and locally developed block grant project plan • Employ the regional BH ombuds • Manage discharge planning for non-Medicaid clients out of the state hospital • Other centralized functions as agreed upon by BH-ASO/MCOs, etc.
25.	BH-ASO	Can certain delegated functions continue beyond 2019 if the MCOs and BHO develop a plan for limited delegation of functions? See attached diagram of possible functions for a BH-ASO. Delegation to ASO?		Potentially – yes. If you choose to use the 2019 transition year, delegation would be allowed. This role identified in the attached document is similar to the existing BH-ASO role, with some additional services such a PACT being fully managed by the BH-ASO. HCA is open to working on this model further with the region. Beyond 2020, delegation is limited by contract language

	Issue	Question	BHO Notes	HCA Response
26.	BH-ASO	If the Medicaid money is going to the MCOs, what is the funding mechanism for the BH-ASO? How will it work for a smooth transition? What is the best way to guarantee adequate funding for a BH-ASO?		See attached funding grid. MCOs are required to sub-contract a portion of Medicaid funds to the BH-ASO for crisis services to Medicaid Clients. Additionally, a large portion of GFS dollars also go to the BH-ASO and other grant and proviso funds.
27.	BH-ASO	What is the nature of the “risk” that will be assumed by the ASO? Will there be a financial risk to counties if they assume the ASO role using their BHO structure?		See risk document.
28.	TRANSPORTATION AND OTHER NON-MEDICAID SUPPORT SERVICES	Some of the support services to persons receiving Medicaid funded treatment are paid for entirely with non-Medicaid funds, e.g., transportation from SUD residential treatment facilities and “flex” funds for outpatient providers. How will transportation issues and costs in general be addressed if services are regionalized and who will be responsible for connecting patients with the network of providers?	<p>Because persons in SUD residential treatment may be returning from facilities out of the region, the BHO uses non-Medicaid funds to reimburse the cost of their transportation back to their community from out of county facilities.</p> <p>The BHO also provides an allocation of state general funds to outpatient providers for flex funds to pay for incidental services that support the treatment plan.</p>	<p>For transportation, if the client is being transported to a Medicaid-covered treatment service, the providers can access HCA’s transportation broker service to obtain Medicaid-covered transportation. This applies regardless of whether the treatment provider is in the region or out of the region. If there is concern with access or timeliness of access to the broker services, please notify Health Care Authority and we will work with you to resolve this issue.</p> <p>The flex funds proposal is a very interesting idea for transportation costs not covered by Medicaid. We would expect the MCO’s/Beacon to replicate at least initially in their provider contracts, and assuming it is something that continues to be viewed as a value-add, it’s likely that type of contracting arrangement could continue, as agreed upon by providers & payers. The MCOs are provided some GF-S dollars to support this type of wraparound supports.</p>

	Issue	Question	BHO Notes	HCA Response
29.	MCO PROCUREMENT	How many MCOs will there be for a given region? The HCA presentation suggested only one but this is confusing.		Clients will have a choice of at least two health plans. Most regions will have three to five health plans.

DRAFT

Spokane County Community Services, Housing, and Community Development Department



COMMUNITY SERVICES, HOUSING, AND COMMUNITY DEVELOPMENT DEPARTMENT
Christine Barada, Director

Spokane County and Regional Area

Fully Integrated Managed Care (FIMC) Questions:

1. Do we understand correctly that Okanogan County has a vote in Spokane Regional Area's decision to become a Mid-Adopter (immediate or transitional approach) or Later-Adopter region? We have been told by HCA that in a multi-county regional service area, the county authorities for all counties in the region must sign the binding letter of intent and that any change to this language would require a legislative change in the statute.
 - a. If Okanogan County does have a vote in Spokane Regional Area's decision, please confirm Okanogan County could vote for the region to be a Late-Adopter and all other counties in the Spokane Regional Area could vote to be a Mid-Adopter, and the decision would be Spokane Regional Area would be a Later-Adopter region based on this vote?

The Spokane Region can make the decision on mid-adopter without the inclusion of Okanogan County. Okanogan County cannot veto the decision.

Okanogan County can also make a decision independent of the Spokane region.

If the Spokane region chooses to become a mid-adopter, Okanogan County would need to transition to North Central on January 1, 2019 and HCA would need to obtain a letter of intent from Okanogan County to facilitate this.

2. If Okanogan County decides to join the North Central Regional Area's FIMC model prior to Spokane Regional Area implementing the FIMC model, how does that work? We have heard it might require a bridge contract between Okanogan County and Spokane County Regional BHO, such as from 7/1/2018- 12/31/2018.

There is no bridge contract. In this scenario, Spokane BHO would be responsible for Okanogan County until 12/31/2018 and on January 1, 2019 the managed care contracts would go into effect and the managed care plans would assume coverage for Okanogan county residents. HCA and DBHR would work with Spokane BHO to spend-down Okanogan County reserves, and modify rates to account for the removal of Okanogan County from the BHO's service area effective 1/1/19.

3. Where is the oversight on the state dollars from the local level in the FIMC model, regardless of timing?

Final authority and oversight of state dollars is with the Health Care Authority, as the entity that

Spokane County Community Services, Housing, and Community Development Department

contracts those funds to the MCOs and BH-ASO. The Health Care Authority is accountable to the legislature. Through an Interlocal Leadership Structure, or another Regional Advisory Structure as desired by the region, local communities can provide a strong advisory role and can also work with the State and MCOs/ASO to obtain information about how the state funds are being expended.

4. Can you please explain what it means in the North Central Regional Area's RFP by the fact that health plans are only required to have the capacity to serve 80% or more of all eligible clients, when the BHOs are required to serve 100% of all eligible clients (see excerpt below)?

3.4.2 Medical/Mental Health:

1. *The Bidder must show that it will have the capacity to serve 80% or more of all eligible clients within a given service area for the following providers: Hospitals, Pharmacy, PCPs, Specialists, SNFs, and community mental health agencies.*
2. *The Bidder's network must provide reasonable access to all program enrollees without unnecessary travel time or wait times for appointments with the following: Cardiologists, Oncologists, Ophthalmologists, Orthopedic Surgeons, General Surgery, Gastroenterologists, Pulmonologists, Neurologists, Otolaryngologists, Obstetrics, Mental Health Providers and Specialists in Physical Medicine, and Rehabilitation services*

a. In the excerpt above, what is HCA's measurable criteria for reasonable access to all program enrollees?

b. In the excerpt above, what is HCA's measurable criteria for unnecessary travel time?

c. In the excerpt above, what is HCA's measurable criteria for unnecessary wait times for appointments?

5. What is HCA doing to prevent health plans from developing more comprehensive networks in population centers, including specialty services, and leaving those residents living outside of the population centers to rely on Medicaid Transport (inadequate), public transportation (often non-existent), their own vehicle (if they have no vehicle and/or no money), or natural supports which are all barriers to serving high needs individuals?

In order for a plan to be awarded a Contract with HCA, the plan must demonstrate their network has the capacity to serve 80 percent of the Medicaid eligible population in a given service area. No single plan will have 100% of the Medicaid population like the BHO does today because coverage for the population is distributed amongst multiple MCOs. However each plan must achieve at least 80% network coverage. This means if you have between 3-5 plans with 80% network coverage, the region will have coverage for much more than 100% of the Medicaid population.

Network adequacy is calculated not only by number of providers within the service area but also by proximity of the providers to the possible enrollee. This means that all eligible proximity locations within a service area are taken into consideration when calculating the capacity of a plan to deliver services to all eligibles including those outside of the population centers. This measurement is completed

Spokane County Community Services, Housing, and Community Development Department

through Geocoding.

In other words, network adequacy is measured in both urban and rural settings and is monitored using Geocoding. MCOs would not be able to meet network adequacy without meeting distance standards, which prevents MCOs from concentrating their networks only in urban areas.

6. Will HCA require all the health plans and the BH-ASO to contract with all the behavioral health service providers that are contracted with Spokane County Regional Behavioral Health Organization at the time of the implementation (1/2019 - Mid-Adopter immediate and transitional, 1/2020 - Late-Adopter)?

It is HCA's expectation that during the RFP process the MCOS will offer contracts to all the existing BHO-contracted providers. It is the decision of a provider whether or not they want to negotiate a contract with an MCO. HCA cannot compel providers to contract with payers.

During the RFP network review and again during the readiness review process, HCA closely reviews network submissions, which includes signed contracts with providers. During these reviews, HCA monitors to determine if all BHO-contracted providers are in-network and if not, HCA would work closely with the health plan to attempt to resolve the issue so a provider can be brought in-network. However, as stated above, HCA cannot compel a provider to contract with a health plan.

The goal is to replicate the existing behavioral health network 100% and then begin to add new providers and expand the network over time. This goal was achieved in Southwest Washington and in North Central. 100% of the previously contracted providers have been brought into the MCOs networks, and all crisis providers and other applicable BH-ASO providers are contracted with Beacon Health Options.

7. Is it true that HCA expects providers and provider agencies to get loans from banks for opening new sites as part of the FIMC implementation (if they don't have sufficient reserves for doing so), and in subsequent years, to participate in the FIMC model?

No.

8. What specific decisions should be made by a Regional Service Area if they would like to remove all risk to the counties as part of the Mid-Adopter or Late-Adopter decision?

The counties will have no financial risk for behavioral health service if they **do not** choose to become the BH-ASO, and instead opt for a procured BH-ASO.

9. If Spokane County does not want to become the BH-ASO for the region, but another county in the region does, can that county become the BH-ASO for the region? Are there any new or different BH-ASO requirements for that county? Can more than one county become the BH-ASO within the same region, such as if multiple counties want to be the BH-ASO for their county only?

The counties can organize the BH-ASO management any way they want, but all counties must agree to have a county-based BH-ASO for the region. If all counties do not agree, the State will procure a BH-ASO, like has been the case in Southwest and North Central.

Spokane County Community Services, Housing, and Community Development Department

10. If Spokane Regional Area decides they want to be the BH-ASO, does the BH-ASO obtain the non-Medicaid reserves remaining from the BHO?
- a. If the BH-ASO does not obtain the BHO's non-Medicaid reserves, what legal authority does HCA have to take non-Medicaid reserves, if the BH-ASO still has the burden of risk?

As stated in the BHO contract that is signed by the Spokane BHO, the unspent reserves must be returned to the State at the termination of the BHO contract.

If the BHO opts to transition into a BH-ASO, it would establish an entirely new contract and would become a new organization.

HCA is currently exploring options related to reserves. Options currently include whether as part of the BHO reserve spend-down process, the BHO could use non-Medicaid reserves to purchase a surety bond or be used to assist with transition costs in becoming the BH-ASO. Another option that would require legislative direction, could be to direct back a portion of the reserve funds to the BH-ASO after they have been returned to the State.

11. If Spokane Regional Area decides they want to be the BH-ASO, is the BH-ASO required to obtain a surety bond?
12. If Spokane Regional Area decides they want to be the BH-ASO, can they use non-Medicaid state funding reserves from the BHO to pay for a surety bond to cover the BH-ASO risk?
13. If Spokane Regional Area decides they want to be the BH-ASO and they cannot use non-Medicaid state funding reserves from the BHO to pay for a surety bond, will HCA provide funding to the region's BH-ASO to pay for the surety bond to cover the risk?
- a. If HCA won't fund the surety bond, what options are available to a region to pay for the surety bond?

We recognize this is an issue and we are looking at options to assist. This includes looking at actuarial ways to reduce the reserve minimums or exploring legislative options to allow certain reserves to fund these types of transition-related expenses.

14. Non-Medicaid reserves are critical for the BHO currently and will be critical if the BHO decide to become the BH-ASO of their region in the future, or if the region decides on becoming a Mid-Adopter transitional region. Please provide the direct citation that allows HCA/DSHS to bankrupt the BHO and take back all their non-Medicaid reserves at the time of transition and FIMC adoption.
15. Does HCA/DSHS have statutory authority to take back a BHO's Medicaid and non-Medicaid reserves? Please provide the statutory citation that allows HCA/DSHS to take back all of a BHO's reserves.

Spokane County Community Services, Housing, and Community Development Department

16. Which state agency is the recipient of the BHO's non-Medicaid reserves and how will they be used in the future?

17. Who is the recipient of the BHO's Medicaid reserves and how will they be used in the future?

18. When the state says that all BHO reserves will be taken back, is this all BHO reserves in all categories?

19. What happens if when the BHO must give reserves back to the state, there are not enough BHO reserves to cover all outstanding costs, such as community hospital inpatient claims and Eastern State Hospital (ESH) penalties?

a. What entity is legally liable for these outstanding claims and costs?

b. Do the counties of that region have any liability for these outstanding claims and costs?

20. What is the timing of reserve fund relinquishment under the Mid-Adopter transitional option, Mid-Adopter immediate approach option, and Late Adopter option? Specifically provide detail on the following options:

a. If the Spokane Regional Area decided to become a Mid-Adopter with the transitional one year option, what is the timing and when would HCA take back both the BHO's Medicaid and non-Medicaid reserves?

b. If the Spokane Regional Area decided to become a Mid-Adopter and did not want to opt for the transitional one year option, what is the timing and when would HCA take back both the BHO's Medicaid and non-Medicaid reserves?

21. Is HCA planning to take back reserves from BHO contracted service providers as part of their FIMC plan? We understood Jessica Diaz and Rick Weaver to say this would not be done by HCA/DSHS during our August 31, 2017 meeting with them, please confirm our understanding.

No, reserves that are subject to re-couplement are unspent BHO reserves.

22. Can counties make recommendations regarding contracting between HCA and the health plans, and health plans and the service providers?

Counties can make recommendations about the RFP, including how many plans would be appropriate for the region and question or considerations to include in the RFP to make sure it's localized. The counties do not get to determine which plans are selected, this occurs through the RFP scoring process.

23. What entities are involved in the contracting between HCA and health plans?

HCA and the health plans are the entities that are involved in the contracting, and the contract is held

Spokane County Community Services, Housing, and Community Development Department

between HCA and the health plan. HCA also works with DSHS on contractual requirements and is happy to consider any suggested changes from stakeholders.

24. What entities are involved in the contracting between health plans and service providers?

Contracts between providers and payers are proprietary and are negotiated between the health plan and the provider.

25. What ability do the locally elected officials have to influence contract negotiations in the Mid-Adopter (immediate and transitional approach) and Late-Adopter options, as it relates to health plans and service providers?

Contracts between health plans and providers are proprietary. Providers negotiate the terms of the contract and rates for services directly with the health plan.

26. Can HCA explain their vision of how transitional Mid-Adopter integration will work in as much detail as possible?

HCA has provided significant detail on the vision for mid-adopter in this document. If additional questions remain, please let us know.

Spokane County Community Services, Housing, and Community Development Department

27. In the Alice Lind, HCA, August 25, 2017 slide presentation, on page 10, regarding the Mid-Adopter transitional approach option, it states that the “MCOs assume risk for Medicaid services, subcontract an agreed upon set of service and or functions to the BHO for 1 year.” What are the “agreed upon set of services?”
- a. If the Spokane Regional Area decided to become a Mid-Adopter with the transitional one year option, what are all the functions that HCA allows the health plans to contract back to the BHO, beyond the BHO-ASO functions?
 - b. We understood from Rick Weaver in a meeting on August 31, 2017 that King County Regional Area is negotiating to have all BHO functions contracted back to them during the one year transition period, is this an opportunity for all regional areas considering this Mid-Adopter option?

This is not what was said at the meeting on August 31, 2017. There was a discussion that King is working to negotiate with the MCOs what is delegated during the transition year. This will be a negotiation between the BHO and MCOs, and HCA will also participate and approve delegation agreements. HCA expects this will be a strong focus of the Interlocal Leadership Group during 2018.

28. If the Spokane Regional Area decided to become a Mid-Adopter with the transitional one year option and decides after the one year transition period to become the BH-ASO for the region, what is the timing HCA requires of the non BHO-ASO functions moving from the BHO to the health plans and how would this transition work?

As has been stated in prior meetings, mid-adopter regions (transition year or no transition year) should plan to decide shortly after the mid-adopter decision whether they want to be a county-based ASO, or whether they want HCA to procure an ASO.

In the scenario described above, the “non-BH-ASO functions” will transition to the health plans by January 1, 2020 when the transition year ends.

The exact details of what is delegated to the BHO by the MCOs during the 2019 transition year will be established during 2018, including clear milestones for when and how those functions/services transition to the health plans by January 2020. HCA intends to do a rolling readiness review process during 2019 to ensure that the functions are transitioning and milestones are being met in preparation for the transition year to end on January 1, 2020.

The details of this transition year and milestones will be a strong focus of the Interlocal Leadership Group.

29. If the Spokane Regional Area decided to become a Mid-Adopter with the transitional one year option, and after the one year transition period, the region decides not to become the BH-ASO for the region, what is the timing HCA requires of the BHO-ASO functions moving from the BHO to a BH-ASO health plan?

Spokane County Community Services, Housing, and Community Development Department

HCA would like this decision to be made in 2017, after a region makes the mid-adopter decision. If not, or if a region changes its decision, HCA must know 9 months prior to January 1, 2020. In that event, the Contractor that will be selected as a result of the upcoming BH-ASO procurement will expand its service area to include the Spokane region, and that entity will need approximately 9 months to transition and establish contracts with providers, etc. HCA intends to structure the upcoming procurement to allow for this type of service area expansion if-needed.

- a. Is there any penalty to Spokane Regional Area's counties for deciding to not become the region's BH-ASO after the transition year?

No.

30. In the fully integrated managed model, where does the funding come from and who pays for the court system costs related to E&T facilities?

The funding comes from the state-only funding contracted to the BH-ASO, and the BH-ASO funds the ITA court costs.

31. In the fully integrated managed model, who pays the E&T costs and how is this determined?

Like any other provider, the E&T negotiates a contract with the appropriate payers, which will include the MCOs as well as the BH-ASO for non-Medicaid individuals. The details of provider and payer contracts are proprietary and negotiated between the provider and payer.

32. In the FIMC model, who pays the ESH penalties for the region? What criteria is used to determine which health plan and/or BH-ASO is required to pay for ESH penalties due to over utilization of allocated beds?

In the FIMC model, the region's ESH bed allocation is distributed to the health plans and the BH-ASO. Based on historical utilization of beds, the BH-ASO is assigned a bed allocation for the non-Medicaid population. The remaining beds are distributed between the MCOs based on their proportion of the region's Medicaid enrollees. When a non-Medicaid client enters the hospital, they are "assigned" to the BH-ASO. When one of the health plans members enters ESH, they are assigned to the appropriate MCO. The MCO's and BH-ASO each employ a hospital liaison who is responsible for managing their census and coordinating discharge/placement, etc. for their assigned clients at ESH.

Under the current methodology, if the entire region remains under its regional allocation, no bed overage fees are assessed and none of the entities (MCOs/ASO) are penalized. If the region goes over its allocation, the bed overage fee (as assessed and calculated by DBHR on a regional basis) is distributed amongst the MCO/ASO entities based on their utilization of beds relative to their target allocation. This means that the entities who utilize more beds or go above their own allocation will be assessed the bed overage fee while those that remain under their allocation will not be assessed a bed overage fee. The utilization of beds at the individual MCO/ASO level is calculated by HCA as a quarterly average of the daily census.

HCA is considering some minor adjustments to this methodology in the future and can share more information when finalized. HCA is always open to input on how these processes and policies can be improved.

33. Please explain in detail how the ESH penalties for beds will work for regions as they are moving forward

Spokane County Community Services, Housing, and Community Development Department

with FIMC as it relates to the BH-ASO and health plans. Please include both separate and combination scenarios in how they will impact the BH-ASO and health plans.

See question 32.

34. How does the ACH fit into the scenarios of Mid-Adopter immediate, Mid-Adopter transitional, and Late-Adopter integration?
35. HCA has stated that in January 2019, all regions must eliminate the Access to Care Standards, what does this mean and what would it look like for a region that is a Mid-Adopter immediate, a Mid-Adopter transition, and a Late-Adopter?
36. When will Spokane Regional Area have Southwest Washington's detail data on their performance results for the past contract year (e.g. jail recidivism, ESH census, ESH recidivism, community hospital census, community hospital recidivism)?
37. When will the raw data from the Southwest Washington region be available for review? When will the final Southwest Washington region report be available from HCA? We urgently all the Southwest Washington data and information be available to our region as soon as possible.
38. When will Spokane Regional Area have Southwest Washington's detail data on their early warning system results for the past contract year?

HCA released a 90 day report on the Southwest Early Warning System, accessible here:
<https://www.hca.wa.gov/assets/program/early-adopter-report.pdf>

While HCA has continued internally monitoring certain early warning system indicators after 90 days, we have not released a public report and we will not be able to do so prior to the decision deadline. We can tell you that the early warning system indicators showed a stable system with no significant change in any direction.

HCA would also direct the region to a letter written by the Southwest Washington Behavioral Health Provider Alliance, which states: “ the change to integrated managed care in Southwest Washington has been a success...access has been significantly improved and administrative processes have been greatly reduced and provider feedback has been a foundational component of the entire process.”

Additionally, in August, 2017, the Research and Data Analysis section of DSHS released an independent report, concluding that the Southwest Washington region had achieved statistically significant improvements in 10 categories of measurement as compared to the balance of the State. On 8 measures, they were measured as equal, and on one measure they were trending negatively. This measure (ED utilization) is mitigated by the

Spokane County Community Services, Housing, and Community Development Department

fact that the region was already the second lowest in ED utilization, and while the region has decreased its ED utilization, it has not decreased as much as other regions.

39. What happens on January 1, 2020 for the Late-Adopters -- is it actually a one-day transition from BHO to health plans as a FIMC model with contracts between HCA and health plans, and health plans and service providers to follow? How are individuals served and providers paid during the time period contracts are being negotiated and executed?

For all regions regardless of mid-adopter status there is a cut-over day. The actual transition and implementation leading up to the cut-over day is a significant operation that will be worked on for months before the cut-over occurs to ensure it is smooth.

On the cut-over day, the BHO contract will end and the MCO/ASO contracts begin. Providers will have negotiated their contracts with the MCOs and ASO months before, and those contracts will be executed with an effective date of January 1, 2019 or January 1, 2020. Providers negotiate contracts with the MCOs/ASO during the RFP process (approx... 6 months before go-live) and HCA checks that those contracts are in place again during readiness review (3-4 months before go-live). For all services rendered prior to the cut-over day, those are billed to the BHO. For all services rendered after the cut-over day, those are billed to the MCOs/ASO.

There will be significant work that will occur between the providers and MCOs to ensure that the providers are able to bill MCOs starting on the cut-over day, with claims testing occurring in the months before go-live. Providers should be able to begin billing MCOs on the cut-over day.

There is no time in which a provider does not have a contract for services rendered – they will maintain the BHO contract until the cut-over date.

Enrollees will also transition to having MCO coverage for BH services on the cut-over day. Their enrollment is processed in the system approximately 6 weeks prior and becomes effective on the cut-over day. They will receive notices and a communications plan is deployed so that clients are fully aware of the change. They will receive new benefits booklets and insurance plan cards, etc. in advance of the cut-over day. The transition is intended to be seamless for clients, they should be able to continue to see their provider with 0 interruption of services.

In Southwest Washington our experience was that the transition for clients was very seamless and there were no reported access issues for clients – clients maintained full continuity of care.

40. What leadership is involved in the transition on January 1, 2020 for the Late-Adopters -- does it include county, BHO, HCA, provider agencies, and health plans?
41. Spokane Regional BHO currently pays a higher capitated rate to some of their contract providers to cover additional risk, how will this work in Value Based Payment arrangements? Are service providers paid per individual served? How is the expected savings achieved by service providers?
42. Does HCA require the health plans to fund all contracted service providers at the same level they were funded by the BHO the first year? If not, what are HCA's funding requirements of the health plans to the service providers during the first year of FIMC? Are there any HCA funding requirements for the health

Spokane County Community Services, Housing, and Community Development Department

plans in the subsequent years with the service providers?

43. How does HCA see Value based Payments working for behavioral health providers?
44. How will “Value Based Payments” compare to the “capitated contracts” some behavioral health providers receive now or the “per patient” contracts providers have had in the past?
45. Will or can the RFP for the health plans and BH-ASO specify how Value Based Payments will work or how that will be addressed in the future?
- a. If not, how does HCA plan to implement and monitor progress in the future on value based payments and integrated services on both the patients and the provider’s ability to deliver adequate services?
46. How do Critical Area Designated Hospitals (CADH) fit into the FIMC model and what changes for them? For instance, currently when a CADH bills Medicaid patients and the hospital loses money in the end, the federal regulators make the hospital whole if there is a loss, will this still continue in the FIMC model?
47. With mental health and chemical dependency being part of supply services co-located and integrated, how does healthcare integration affect our CADHs, clinics and other facilities as it pertains to the “true-up” of expenses?
48. How do Federally Qualified Health Centers (FQHCs) fit into the FIMC model and what changes for them?
49. HCA sets rates for the hospitals, how will this work in the FIMC model? Will HCA require that the funding needed to pay psychiatric inpatient hospital stays come from the behavioral health crisis service, behavioral health outpatient, and substance use disorder residential funding?
50. Is there any legislation that requires counties to supply Mental Health, Chemical Dependency (SUD), and Crisis services? If so, please provide all statutory citations.
51. It is our understanding that counties currently have statutory responsibility to provide Mental Health, Chemical Dependency (SUD), and Crisis services and in the FIMC model will have risk without control. If this is correct, is HCA planning in the upcoming legislative session to work with the legislature on getting this statute changed so the counties do not have this responsibility?

Spokane County Community Services, Housing, and Community Development Department

52. We understood Rick Weaver to say in a meeting with our region's commissioners on August 31, 2017 that only Mid-Adopters will be given the first right of refusal to becoming their region's BH-ASO, and that Late-Adopters would not be given this first right of refusal opportunity. We interpret this to mean that Late-Adopters will not have the option to be their region's BH-ASO, is this understanding correct?
- a. If this is correct, what is HCA's reasoning behind not allowing Late-Adopters to be their region's BH-ASO?

Yes, the 2020 regions will still have the first right of refusal if they want to become the BH-ASO.

53. Can our region be provided with a list of what HCA allows and doesn't allow FIMC health plans to delegate as of January 1, 2020?
54. We understood Rick Weaver to say in a meeting with our region's commissioners on August 31, 2017 that only Mid-Adopters will be allowed to participate in "Leadership Councils" with HCA and the health plans, and have input into the measures that will be included in the Early Warning Systems and the statewide RFP's on questions/scenarios. Why can't Late-Adopters also be included in these "Leadership Councils" or invited into these activities to allow for their input?
55. How can the Mid-Adopter incentive funds be used by an ACH or by BHT in our region?
56. What is BHT's funding allocation per county for the Mid-Adopter incentive funds?
57. HCA has stated that Mid-Adopter incentive funds provided to ACH's will be provided to community organizations and providers is a very broad definition. Will HCA provide any guidance or requirements to ACH's regarding these community organizations and providers being behavioral health service providers, or at least a % of them or the funding being appropriated to behavioral health providers?
58. Please clarify the definition of "Providers" who would be eligible for Mid-Adopter incentive funds (the ~\$8.7 million for our region) if we opt to become a Mid-Adopter region (immediate or transitional).

All incentive funds under the Medicaid Transformation demonstration, including funds earned for integration milestones, are paid to the ACH and held by the Financial Executor. The ACH will determine funds distribution to partnering providers. There is no set definition of partnering providers, but these providers can include providers traditionally reimbursed by Medicaid (e.g. primary care providers, oral health providers, mental health providers, hospitals and health systems, nursing facilities), providers not traditionally reimbursed by Medicaid (e.g. counties, community-based and social organizations, corrections facilities, Area Agencies on Aging), tribes/ITUs, and other organizations identified as critical partners to fulfill objectives of the demonstration. Guidance to ACHs has emphasized intended use to assist providers and the region with the process of transitioning to integrated managed care

Spokane County Community Services, Housing, and Community Development Department

- a. Does HCA have a mechanism to ensure the Mid-Adopter incentive funds provided to a region's ACH are NOT used for unintended purposes/providers? If so, what is that mechanism?

The ACH will report certain information to the Financial Executor in order to distribute funds. While the final details for what information will be required is still under development, the ACH is responsible for providing projected budget information through project plan submissions.

Partnering providers who are eligible to receive incentive funds must register with the Financial Executor through the web portal. In doing so, the providers will also sign a standard partnership agreement to participate in the demonstration. The following list indicates the type of information needed from the partnering providers to register with the Financial Executor:

- Entities tax identification number
- Attestation that entity is not an excluded entity
- Acknowledgement that DSRIP funds are being paid based on achievement of a DSRIP objective
- Acknowledgement that the State and Federal government have a right to audit DSRIP activities and to take back any funds that were improperly paid.
- General Terms and Conditions similar to those included in the contract between ACH and HCA.

59. We understood Rick Weaver to say in a meeting with our region's commissioners on August 31, 2017 that BHO's will not only lose their reserves, but will also lose all encumbered dollars as of January 1, 2019 (Mid-Adopters) or January 1, 2020 (Late Adopters), is this understanding correct? If so, why is this?

Encumbered dollars are dollars that have been identified by the BHO and encumbered for a specific and approved expense. If encumbered dollars and not expended, they would revert to "reserves" which would be subject to recoupment at the end of the contract period.

60. What is the process for regions to spend down their BHO reserves?

61. When will HCA provide regions with reserve plan requirements and criteria so they can begin developing these spend down plans, both for Mid-Adopters and late adopters?

62. Do all proviso dollars go to the BH-ASO, like a region's jail and E&T proviso dollars?

- a. If so, and the region is not the BH-ASO, will counties have any input on how the BH-ASO allocates those dollars within the region?

63. Does HCA's plan with the health plans, allow or require FIMC health plans to contract with county behavioral health agencies?

The services county agencies provide qualify them as "essential behavioral health provider types"

Spokane County Community Services, Housing, and Community Development Department

meaning they must be included in the MCO network.

County behavioral health agencies are treated the same way as any other licensed behavioral health agency. County behavioral health agencies are able to negotiate contracts with the MCOs and/or ASO.

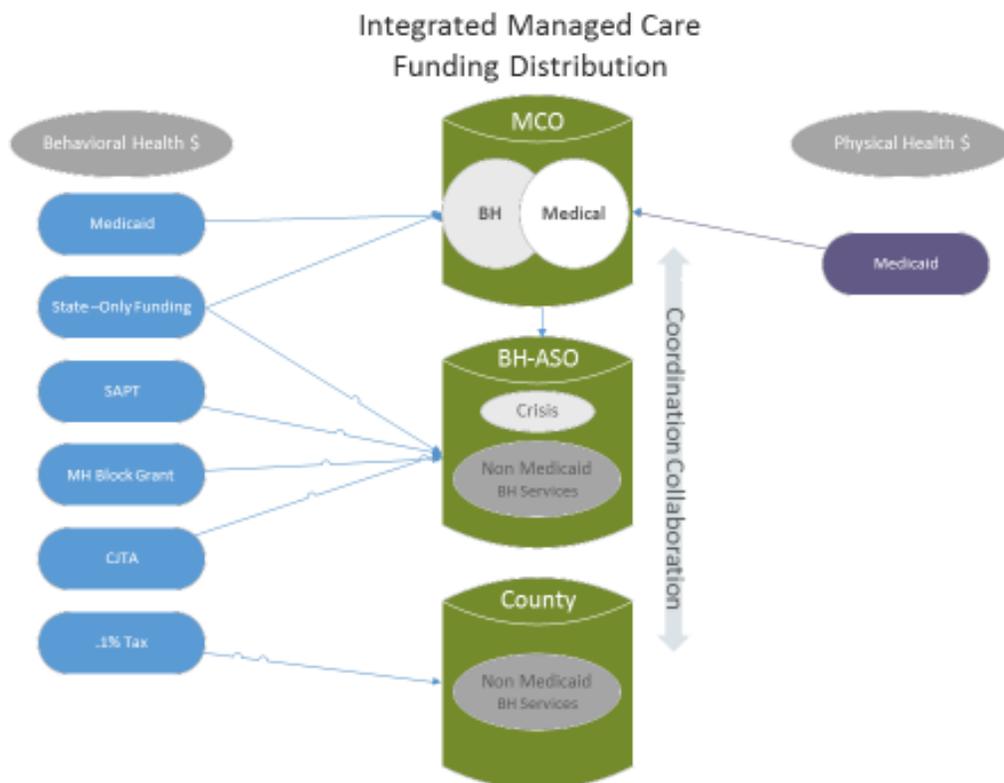
In Southwest Washington, both Clark and Skamania counties operate licensed behavioral health agencies that have contracted with the MCOs and/or ASO. In North Central, Grant County operates a behavioral health agency that is contracted with the MCOs and the ASO.

64. Is the BH-ASO responsible for the costs and services for non-Medicaid individuals from their region that are treated in E&Ts, crisis stabilization facilities and community hospitals outside their region?

Generally speaking, yes, although there are sometimes exceptional or complicated cases.

The BH-ASO is expected to establish contracts with a provider network to serve the non-medicaid population, which could include providers inside or outside the region. In some cases the BH-ASO may also need or desire to pay out-of-network providers using a single case agreement.

65. What is the funding model and how does it work between the state and the BH-ASO, and between the health plans and the BH-ASO?



66. Does any of HCA’s FIMC model affect counties’ Developmental Disabilities programs, contracts, or the

Spokane County Community Services, Housing, and Community Development Department

 Division of Vocational Rehabilitation?

HCA does not anticipate this change will impact a count DD program or Division of Vocational Rehabilitation. If the BHO is funding any county employees in the DD program or the Division of Vocational Rehabilitation, let us know.

67. It is our understanding that Mid-Adopter regions (immediate and transitional) are able to select the number of health plans and have input on the selection of the health plans for their region during the RFP process, is our understanding correct?

Mid-adopter regions can provide input to HCA on how many health plans are recommended for the region. HCA will make the final decision on the number of health plans. There must be at least 2 due to CMS regulations, and there will not be more than 5.

68. We understand that in the Southwest Washington region, the Behavioral Health Providers' funding was "held harmless" during the first year of FIMC. Will the funding of the current Spokane BHO-contracted Behavioral Health providers be held harmless during 2019 if our region opts to become a transitional Mid-Adopter region? If not, what would the Behavioral Health providers funding model look like?

The Southwest Washington providers negotiated to keep their contract terms virtually the same during the first year, as well as to keep their payment rates the same. This included keeping their payment methodology (cost reimbursement, fee-for-service, capitated, etc.) the same for the first year. This was negotiated by the providers and the plans and is what the providers wanted for the first year.

The behavioral health providers funding model is ultimately up to the provider and payer, and is negotiated between them.

69. Who will "Designate" the "Designated Crisis Response Specialist?" Will this be the BH-ASO, the counties, or some other entity?
70. The BH advisory committee function is very important. Does HCA/DSHS provide funds to continue this important function during and after the integration period?
- a. If so, what entity is provided these funds by HCA/DSHS (county, BH-ASO, health plans), and does it vary depending on whether a region is a Mid-Adopter (immediate or transitional) or Late Adopter?
71. What types of things is the HCA going to monitor as we move toward FIMC adoption, both directly with the health plans and expect the health plans and BH-ASO to monitor with the service providers?

Spokane County Community Services, Housing, and Community Development Department

-
- a. Does it vary depending on whether a region chooses Mid-Adopter immediate, Mid-Adopter transitional, or Late Adopter? If so, in what ways?

72. Can County Commissioners influence HCA's monitoring parameters as we move forward?

There are many different monitoring systems for the FIMC managed care plans. Some systems are governed by federal and state statute, and as such have minimal room for input or variation.

There are two main avenues for influencing the monitoring parameters: 1) through requesting that certain measures be added to the early warning system, which will begin at implementation and continue for at least one year; and 2) by establishing an Interlocal Leadership Council, composed of elected officials, and described in the proposed amendment to HB 1388 in last year's legislative session. Through that body, monitoring parameters could be requested and reported.

73. Does any part of the 1/10 of 1% sales tax or the Mental Health/Chemical Dependency property tax collected by counties get dedicated or required to be used as part of the Medicaid funding for integration?

The 1/10th of 1% sales tax is a county funding source. It is 100% under the jurisdiction of the counties and it is the decision of the county how to expend county tax dollars. The State cannot place any requirements on local funds.

74. Does the HCA/DSHS have long range plans to integrate non-Medicaid services into this plan? Please elaborate if so.

Non-Medicaid funds & services are already integrated into the FIMC model. Please see funding flow exhibit included in question 65.

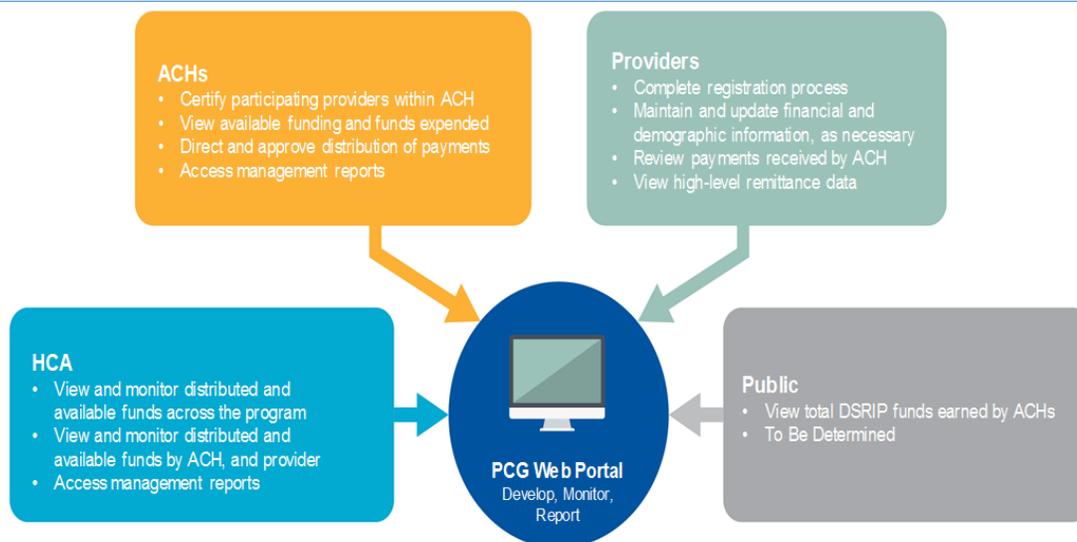
75. How often does the HCA plan to meet with a region that decides to become a Mid-Adopter region? Does it vary whether the region chooses the Mid-Adopter immediate or transitional option? If so, in what ways?

76. What role does the ACH (Better Health Together/BHT for our region) play in the Mid-Adopter transitional integration option?

ACHs are in a regional convening and coordination role and are ready to support and explore opportunities to ensure providers are supported, regardless of the option selected. Specifically, BHT/ACH is responsible for making decisions about allocating integration incentive funds for the region, regardless of the option selected. In addition, each ACH is required to design and implement an integrated physical and behavioral health project as part of the Medicaid Transformation demonstration. This project provides additional opportunities to consider the needs of providers during the transition to integrated managed care.

It's very important that the counties and BHO participate in the ACH and we strongly encourage you to do so. This is the primary avenue to influence decision-making regarding the mid-adopter incentive funds, and BHO/county input should be a critical component of that decision-making.

77. How does the ACH (BHT) get the Mid-Adopter incentive funds for our region?



79. What role does the ACH (Better Health Together/BHT for our region) play in the Mid-Adopter immediate integration option?

The ACH role remains the same regardless of whether the region chooses to pursue a transition year or not, as noted in question 76.

We expect that the focus of the mid-adopter incentive funds should be to build the capacity of the behavioral health providers as they transition to working with managed care organizations. The BHO and Counties should be participating in the ACH and should have a voice to advocate for how funding should be distributed.

80. Does release of the Mid-Adopter incentive funds require CMS and legislative approval?

- a. Has this approval already been given for our region to receive the Mid-Adopter incentive funds if we decide to be a Mid-Adopter region?

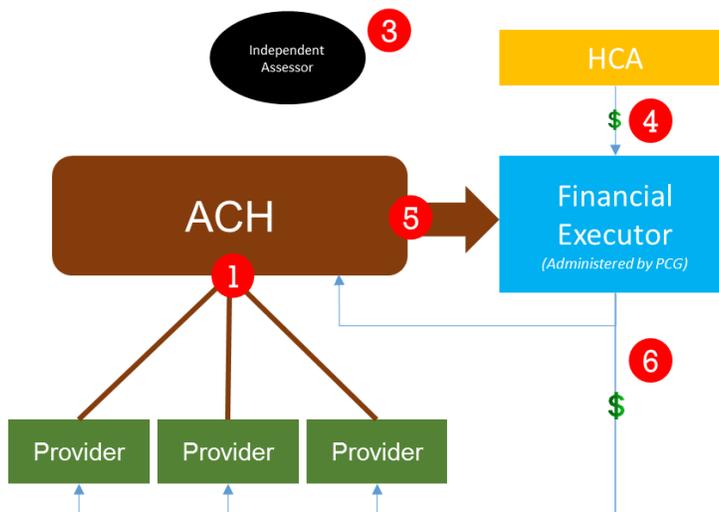
The 2017-2019 biennium budget proviso gives the Health Care Authority legislative approval for the DSRIP incentives, which includes the integration incentive funds. Additionally, CMS has granted approval for the integration incentives through their approval of the Special Terms and Conditions (STCs) and the DSRIP Funding and Mechanics.

- b. What date will the first installment of the mid-adopter incentive funds be released to our region's ACH (BHT)?

Integration funds for submitting a binding letter(s) of intent will be available in early 2018. These funds will be released to the Financial Executor at the same time as incentive funds earned for approval of transformation project plans.

The following graphic provides an overview of the steps to flow incentives, including integration funds, from HCA/CMS to ACHs and partnering providers:

#	Steps
1	ACH's will develop relationships with partner providers, to accomplish the goals of specific projects
2	At the ACH's direction (from the application), providers will be asked to register in the FE's portal, providing banking and other necessary information.
3	The Independent Assessor determines how much DSRIP funding each ACH earns, and informs the FE
4	Per the IA's findings, HCA transfers the appropriate amount of money to the FE's accounts.
5	ACH's will log into the FE's portal and determine the amount of DSRIP money each entities should receive as part of their participation in the projects
6	Based on the ACH's payment distribution, the FE will distribute payments to the appropriate entities.



81. Please explain how HCA plans to improve the physical and behavioral health of non-Medicaid individuals (e.g. income level at or below the 220% federal poverty level, not Medicaid eligible, or uninsured) within the context of implementing the FIMC model throughout Washington state, like HCA is expecting for the Medicaid eligible individuals. This is particularly important to regions' decisions about becoming the BH-ASO since this is the target population served.

SALISH BHO ENCOUNTER DATA VALIDATION (EDV)

October 6, 2017

Attachment 7.b.1

OVERVIEW

Background and Description

Encounter data validation (EDV) is a contractually-required process used to validate encounter data submitted by the Salish Behavioral Health Organization (SBHO) to the State. Encounter data are electronic records of the services provided to Medicaid enrollees by providers under contract with the SBHO. Encounter data are used by BHOs and the State to assess and improve the quality of care and to monitor program integrity. Additionally, the State uses encounter data to determine capitation rates paid to the BHOs.

Every year an EDV is conducted by the SBHO's Quality Assurance Department at the agency level. Prior to 2016, when the Peninsula Regional Support Network (PRSN) became the SBHO with the integration of Substance Use Disorder (SUD) agencies, there were four agencies that were reviewed. According to our contract with the state, over 411 encounters were to be reviewed. With the expansion to the SBHO, the new requirement was for a minimum of 822 encounters for those BHOs who had between 11-20 contracted agencies. In 2017, 1097 encounters were reviewed from both mental health (MH) and SUD agencies who had submitted data. These encounters represent 866 individual client charts (meaning some charts had more than one encounter reviewed from it). The results from the 2016-2017 EDV were sent to the state as a contract deliverable. Individual summary reports were also created for each agency involved in the EDV, summarizing their results and informing them the CAP process will be initiated. See Table 1. below for aggregate results of all data elements reviewed by provider.

In addition to the agency-level EDV conducted by the SBHO, there is another EDV conducted by the State's Medicaid external quality review organization (EQRO). The current EQRO is Qualis Health. Prior to Qualis Health's start in 2015, the EQRO was Acumentra Health. This is of importance to note given the striking difference in results from Acumentra to Qualis (see chart 1. below). According to Qualis Health they perform three activities supporting a complete encounter data validation for the SBHO: a review of the procedures and results of the SBHO's internal EDV required under the SBHO's contract with the State; state-level validation of all encounter data received by the State from the SBHO during the review period; and an independent validation of State encounter data matched against provider-level clinical record documentation to confirm the findings of the SBHO's internal EDV.

Table 1. Aggregated results for each data element per contract

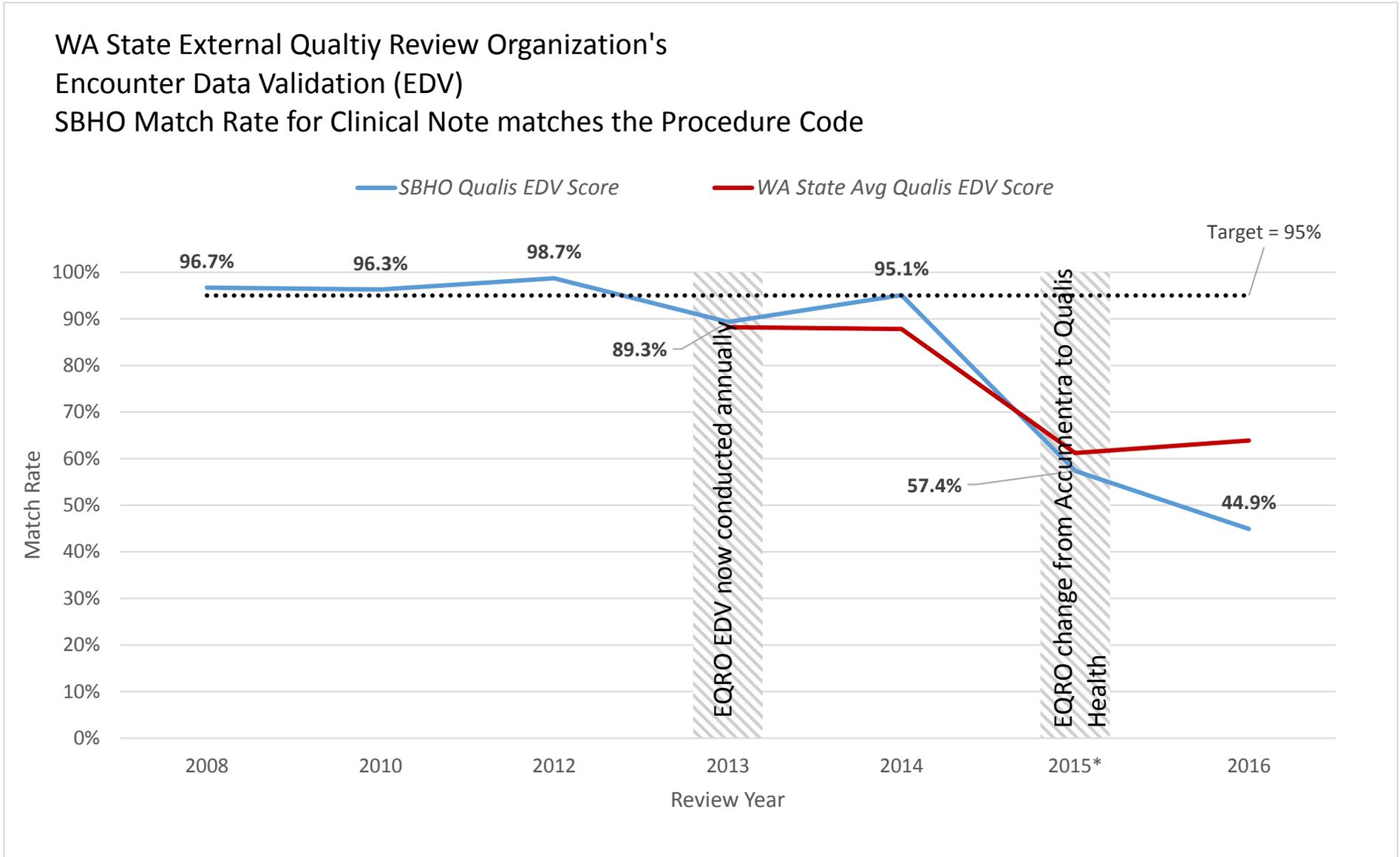
Data Element	Agape Unlimited		Beacon of Hope		Cascadia		Cedar Grove		Jefferson Mental Health		Kitsap Mental Health Svcs		Olympic Personal Growth Center		Peninsula Behavioral Health		Reflections Counseling		True Star		West End Outreach Services		Grand Total			
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%		
Date																										
Erroneous	0	0%	0	0%	0	0%	0	0%	0	0%	1	0%	1	5%	1	1%	0	0%	0	0%	0	0%	0	0%	3	0%
Match	64	100%	26	100%	16	94%	15	100%	74	100%	612	100%	19	95%	175	99%	29	100%	8	100%	55	100%	1093	100%		
Unsubstantiated	0	0%	0	0%	1	6%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	0%
<i>Grand Total</i>	64		26		17		15		74		613		20		176		29		8		55		1097			
Service Provider*																										
Erroneous	0	0%	0	0%	0	0%	0	0%	20	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	208	19%
Match	64	100%	26	100%	16	94%	15	100%	0	0%	613	100%	20	100%	63	100%	29	100%	8	100%	14	100%	888	81%		
Unsubstantiated	0	0%	0	0%	1	6%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	0%
<i>Grand Total</i>	64		26		17		15		20		613		20		63		29		8		14		1097			
Location																										
Erroneous	0	0%	0	0%	0	0%	0	0%	1	1%	4	1%	0	0%	1	1%	0	0%	0	0%	0	0%	1	2%	7	1%
Match	64	100%	26	100%	16	94%	15	100%	73	99%	609	99%	20	100%	175	99%	29	100%	8	100%	54	98%	1089	99%		
Unsubstantiated	0	0%	0	0%	1	6%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	0%
<i>Grand Total</i>	64		26		17		15		74		613		20		176		29		8		55		1097			
Duration																										
Erroneous	3	5%	3	12%	0	0%	0	0%	1	1%	4	1%	0	0%	1	1%	0	0%	1	13%	2	4%	15	1%		
Match	59	92%	23	88%	16	94%	15	100%	73	99%	609	99%	20	100%	175	99%	29	100%	4	50%	53	96%	1076	98%		
Unsubstantiated	2	3%	0	0%	1	6%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	3	38%	0	0%	6	1%		
<i>Grand Total</i>	64		26		17		15		74		613		20		176		29		8		55		1097			
Provider Type																										
Erroneous	9	14%	0	0%	0	0%	2	13%	1	1%	5	1%	7	35%	5	3%	0	0%	0	0%	0	0%	0	0%	29	3%
Match	55	86%	20	77%	5	29%	13	87%	73	99%	605	99%	13	65%	171	97%	29	100%	6	75%	55	100%	1045	95%		
Unsubstantiated	0	0%	6	23%	12	71%	0	0%	0	0%	3	1%	0	0%	0	0%	0	0%	2	25%	0	0%	23	2%		
<i>Grand Total</i>	64		26		17		15		74		613		20		176		29		8		55		1097			
Code																										
Erroneous	0	0%	0	0%	0	0%	0	0%	0	0%	1	0%	0	0%	2	1%	0	0%	0	0%	0	0%	0	0%	3	0%

	Agape Unlimited		Beacon of Hope		Cascadia		Cedar Grove		Jefferson Mental Health		Kitsap Mental Health Svcs		Olympic Personal Growth Center		Peninsula Behavioral Health		Reflections Counseling		True Star		West End Outreach Services		Grand Total	
Data Element	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Match	62	97%	26	100%	16	94%	15	100%	74	100%	611	100%	20	100%	174	99%	29	100%	8	100%	55	100%	1090	99%
Unsubstantiated	2	3%	0	0%	1	6%	0	0%	0	0%	1	0%	0	0%	0	0%	0	0%	0	0%	0	0%	4	0%
Grand Total	64		26		17		15		74		613		20		176		29		8		55		1097	
Mod 1																								
Erroneous	0	0%	0	0%	0	0%	4	27%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Match	62	97%	26	100%	16	94%	15	100%	2	100%	95	100%	16	100%	5	100%	29	100%	8	100%	6	86%	280	99%
Missing	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	14%	1	0%
Unsubstantiated	2	3%	0	0%	1	6%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	3	1%
Grand Total	64		26		17		15		2		95		16		5		29		8		7		284	
Mod 2																								
Match	32	100%	7	100%	3	75%	9	90%									24	100%	3	100%			78	98%
Missing	0	0%	0	0%	0	0%	1	10%									0	0%	0	0%			1	1%
Unsubstantiated	0	0%	0	0%	1	25%	0	0%									0	0%	0	0%			1	1%
Grand Total	32		7		4		10										24		3				80	
Mod 3																								
Match	8	100%			1	100%	2	100%									14	100%					25	100%
Grand Total	8				1		2										14						25	
Mod 4																								
Match	1	100%															1	100%					2	100%
Grand Total	1																1						2	
Code Agrees w/Treatment																								
Erroneous	3	5%	0	0%	1	6%	0	0%	3	4%	24	4%	0	0%	5	3%	0	0%	0	0%	0	0%	36	3%
Match	7	11%	8	31%	2	12%	11	73%	58	78%	497	81%	8	40%	143	81%	15	52%	4	50%	42	76%	795	73%
Unsubstantiated	54	84%	18	69%	14	82%	4	27%	13	18%	92	15%	12	60%	28	16%	14	48%	4	50%	13	24%	266	24%
Grand Total	64		26		17		15		74		613		20		176		29		8		55		1097	
Code Does NOT Agree /Treatment																								
Erroneous/Inappropriate Code Used	3	5%	0	0%	1	0%	0	0%	3	25%	24	21%	0	0%	5	15%	0	0%	0	0%	0	0%	36	12%
Unsubstantiated/Duplicate Service	1	2%	0	0%	1	0%	0	0%	0	0%	1	1%	0	0%	2	6%	0	0%	0	0%	1	8%	6	2%
Unsubstantiated/Not Encounterable	53	93%	18	100%	13	2%	4	100%	13	75%	91	78%	12	100%	26	79%	14	100%	4	14%	12	92%	260	86%

Grand Total	57	18	15	4	16	116	12	33	14	4	13	302
-------------	----	----	----	---	----	-----	----	----	----	---	----	-----

*Due to known attribution error of Service Provider, excluded errors attributed to Discovery Behavioral Health, Peninsula Behavioral Health, and West End Outreach Services for this measure.

Chart 1. Historical EDV Results





SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Guide to Interpretation

- ➔ All measures reviewed are based upon SBHO funded services only. It is not meant to be interpreted as all-inclusive of behavioral health service delivery
- ➔ When interpreting these measures there could be a variety of uncontrolled factors contributing to results including but not limited to:
- The impact of client characteristics and behaviors
 - Factors affecting the need for services, such as variation in regional economic conditions
 - Random variation
 - The degree of stability of a measure: for those measures that are based on a small sample size, the measure is inherently less stable and more prone to variability.

Legend Key:

FY	Fiscal Year - This timeframe runs from July 1 - June 30
CY	Calendar Year - This timeframe runs from January 1 - December 31
<i>Crisis Response Timeliness</i>	This measure is designed to monitor compliance with SBHO PIHP Contract Requirements that response time to crisis requests occur within 2 hours.
<i>C&F Team Meeting</i>	This measure is designed monitor service utilization to youth for a modality that promotes collaborative treatment planning.
<i>Inpatient Psychiatric Readmission</i>	This measure is designed to monitor hospital readmissions as this is a widely accepted outcome measurement for assessing performance of healthcare systems
<i>Mental Health Access (Penetration Rate)</i>	This measure is designed to monitor the rate of service penetration of Mental Health Services for our population as a measure of ensuring adequate access to services



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

* Regional Performance Measure ** Core Performance Measure

Definition of Indicator and Measurement Standard

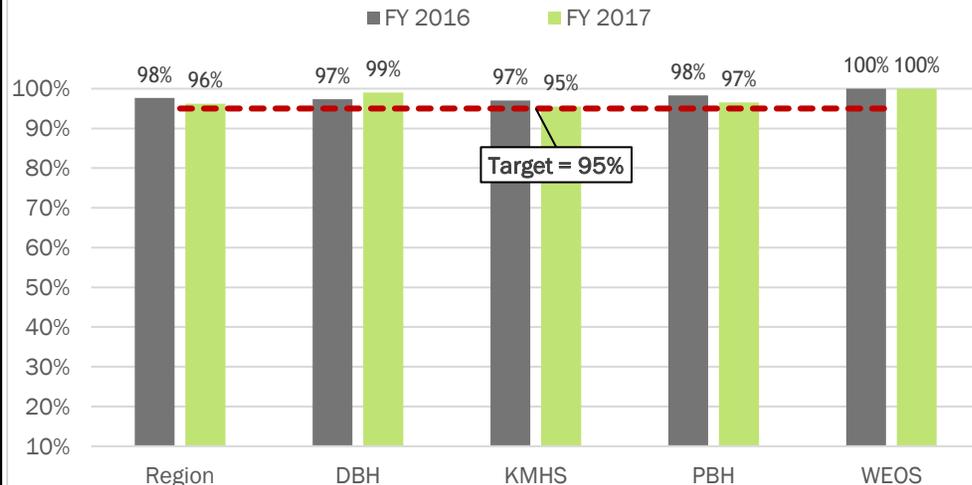
1. Crisis Response Timeliness*

The percentage of crisis event face to face responses that occurred within 2 hours of request.

Formula:

$$\frac{\text{Number of crisis events where face to face response time was } \leq 2 \text{ hours from request during time period}}{\text{Number of crisis events for time period}}$$

Percentage of Crisis Responses within 2 hours of request* by Year Comparison



*Numerator includes crisis events where response time was > 2 hours if denoted as non-emergent and/or pre-arranged

Measurement

	REGION	DBH	KMHS	PBH	WEOS
FY 1Q 2016	98.5% 589/598	94.3% 33/35	98.6% 281/285	98.9% 270/273	100.0% 5/5
2Q 2016	96.3% 647/672	97.8% 44/45	94.6% 295/312	97.7% 300/307	100.0% 8/8
3Q 2016	97.5% 692/710	96.4% 53/55	97.4% 368/378	97.8% 268/274	100.0% 3/3
4Q 2016	98.4% 660/670	98.9% 88/89	97.7% 302/309	98.9% 266/269	100.0% 4/4
1Q 2017	96.3% 517/539	100.0% 53/53	94.6% 265/280	97.5% 197/202	100.0% 2/2
2Q 2017	96.6% 618/640	96.6% 56/58	96.2% 330/343	97.1% 232/239	N/A 0/0
3Q 2017	97.5% 585/600	100.0% 42/42	96.6% 286/296	98.1% 256/261	100.0% 1/1
4Q 2017	94.5% 571/604	100.0% 47/47	94.1% 254/270	94.1% 270/287	N/A 0/0

Target: 95% or above
Source: PIHP Contract

Data Source: ProFiler Report - Crisis Response Time by Agency
Data Notes: Numerator includes crisis events where response time was > 2 hours if they were identified as non-emergent and/or pre-arranged.
Data Valid as of 9/25/17



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

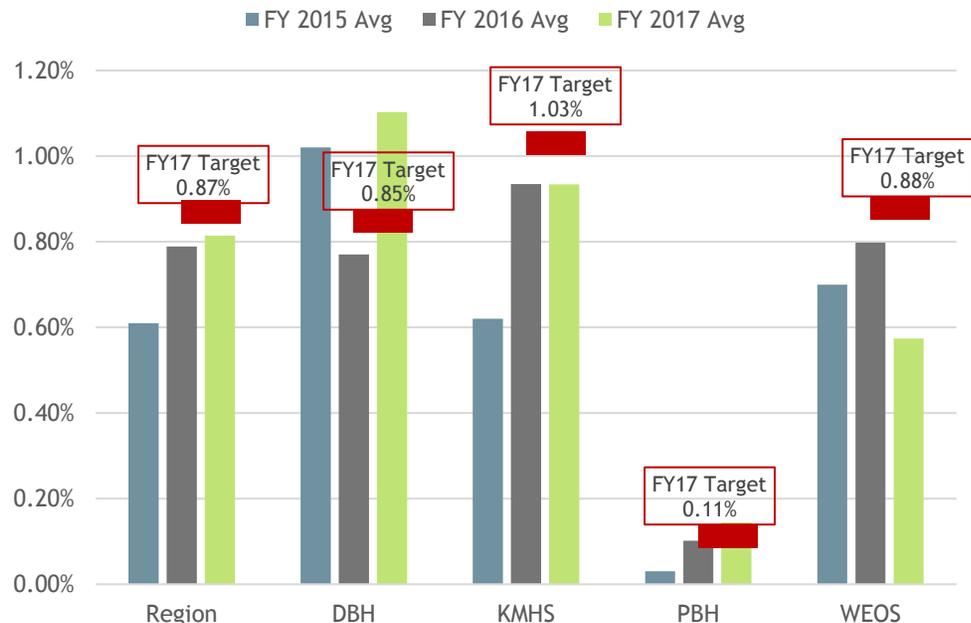
2. Child and Family (C&F) Team Meetings*

Rate of Child & Family team meetings encountered using the HT modifier

Formula:

$$\frac{\text{Number of C\&F team meetings (using HT modifier) that are recorded for children and youth under the age of 21 during time period}}{\text{Number of children and youth services encountered in time period}}$$

Average Child & Family Team Meetings by Year Comparison



Measurement

	REGION	DBH	KMHS	PBH	WEOS
FY17 TARGET	0.87%	0.85%	1.03%	0.11%	0.88%
FY15 AVG	0.61%	1.02%	0.62%	0.03%	0.70%
FY16 AVG	0.79% 382/48398	0.77% 14/1818	0.94% 349/37321	0.10% 8/7881	0.80% 11/1378
1Q 2016	0.48% 51/10548	0.58% 3/520	0.57% 46/8035	0.12% 2/1726	0.00% 0/267
2Q 2016	1.01% 118/11667	1.22% 6/490	1.18% 105/8866	0.19% 4/2079	1.24% 3/242
3Q 2016	1.05% 138/13106	0.92% 3/325	1.26% 129/10199	0.09% 2/2177	0.99% 4/405
4Q 2016	0.57% 75/13067	0.41% 2/483	0.68% 69/10221	0.00% 0/1899	0.86% 4/464
1Q 2017	0.64% 68/10636	0.37% 2/539	0.80% 65/8149	0.00% 0/1639	0.32% 1/309
2Q 2017	0.91% 110/12052	0.18% 1/543	1.14% 107/9353	0.06% 1/1657	0.20% 1/499
3Q 2017	0.85% 104/12173	0.72% 6/832	1.02% 92/8999	0.27% 5/1847	0.20% 1/495
4Q 2017	0.83% 99/11935	2.33% 23/987	0.75% 65/8713	0.22% 4/1795	1.59% 7/440

Target: 10% increase over previous FY average
Source: QUIC designated target
Data Source: ProFiler Report - RSN Encounter Data Validation
Data Notes: HT Modifier indicates Multi-disciplinary team and is recorded by meeting lead only
Parameters: Encounters for children and youth under the age of 21
Data Valid as of 9/25/17



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

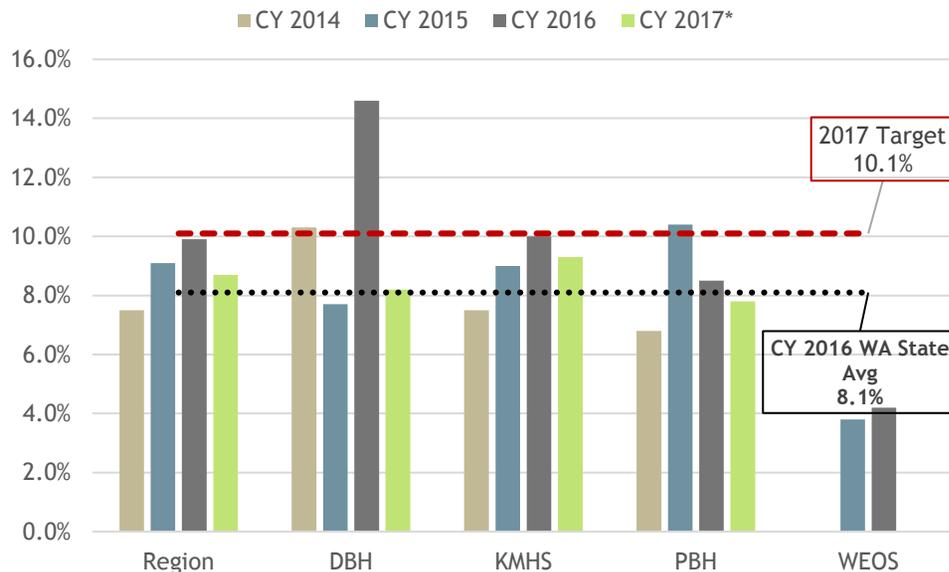
3. Inpatient Utilization (Readmission Rate)**

Percent of clients who were discharged from inpatient psychiatric care and were readmitted to inpatient psychiatric care within 30 days of discharge

Formula:

$$\frac{\text{Number of clients readmitted to inpatient psychiatric care within 30 days of discharge within time period}}{\text{Number of clients discharged from inpatient psychiatric care during time period}}$$

Psychiatric Readmission Rate by Year Comparison



*2017 average calculated through August 2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
CY 15 TOTAL	9.1% 84/924	7.7% 5/65	9.0% 55/611	10.4% 23/222	3.8% 1/26
CY 16 Total	9.9% 96/967	14.6% 13/89	10.0% 63/631	8.5% 19/223	4.2% 1/24
CY 17 JAN	12.5% 9/72	16.7% 2/12	16.3% 7/43	0.0% 0/14	0.0% 0/3
FEB	7.9% 6/79	20.0% 1/5	8.5% 4/47	5.6% 1/18	0.0% 0/6
MAR	8.3% 7/84	0.0% 0/11	11.8% 6/51	4.8% 1/21	0.0% 0/1
APR	9.2% 6/65	0.0% 0/6	11.4% 5/44	7.1% 1/14	0.0% 0/1
MAY	5.1% 4/78	33.3% 1/3	0.0% 0/50	12.5% 3/24	0.0% 0/1
JUN	7.4% 6/81	0.0% 0/5	7.8% 5/64	9.1% 1/11	0.0% 0/1
JUL	10.7% 6/56	0.0% 0/3	9.8% 4/41	16.7% 2/12	0.0% 0/0
AUG	9.1% 6/66	0.0% 0/4	10.9% 5/46	7.1% 1/14	0.0% 0/2

Target: Within 2 points of the State's average for previous year

Source: Minimum performance standard

Data Notes: Time period is calculated based on month of discharge from psychiatric inpatient facility.

Data Source: CommCare SBHO MH Readmissions Report, CommCare SBHO MH LOS Report, DBHR SCOPE.

Data Valid as of: 9/2017



SALISH BEHAVIORAL HEALTH ORGANIZATION: MENTAL HEALTH QUALITY INDICATORS FY 16/17

Definition of Indicator and Measurement Standard

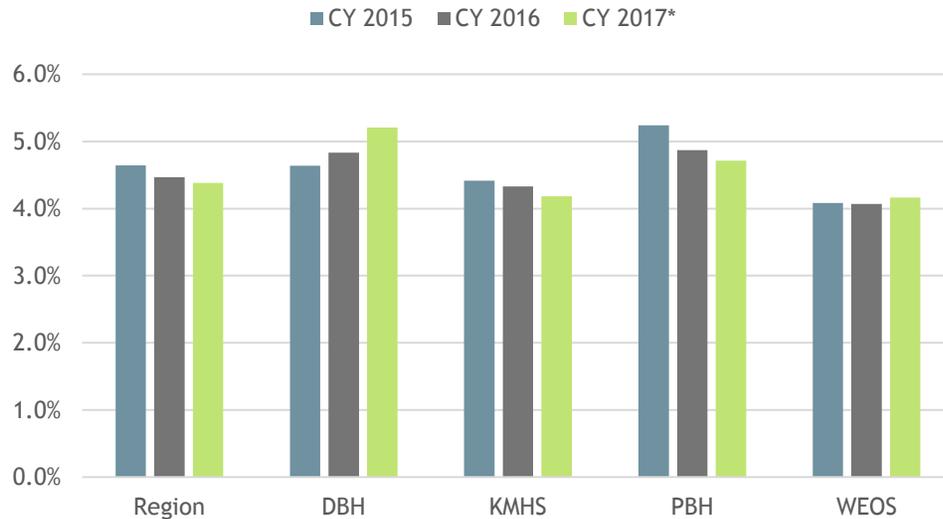
4. Access (Outpatient Penetration Rates)**

The proportion of Medicaid enrollees who received non-crisis outpatient MH services

Formula:

$$\frac{\text{Number of Medicaid clients receiving non-crisis outpatient MH services during time period}}{\text{Number of Medicaid eligible individuals during time period}}$$

Outpatient Mental Health Penetration Rate by Year Comparison



*2017 rate calculated through June 2017

Target: Not yet available from the State - anticipated Spring 2017

Data Source: Profiler DW - RSNEncounterValid_2, Medicaid Eligible Population, SCOPE

Data Notes: Regional count unduplicates clients completely.

Data Valid as of 9/25/2017

Measurement

	REGION	DBH	KMHS	PBH	WEOS
CY 16	4.7%	4.6%	4.5%	5.2%	4.7%
MAY	3683/78894	331/7174	2331/51365	851/16512	180/3843
JUN	4.7%	4.7%	4.6%	5.1%	4.1%
	3697/78914	334/7149	2369/51414	843/16486	160/3865
JUL	4.2%	4.8%	4.1%	4.5%	3.7%
	3348/78822	340/7062	2119/51353	751/16531	142/3876
AUG	4.4%	5.2%	4.2%	4.6%	3.5%
	3431/78859	367/7079	2168/51340	762/16558	136/3882
SEP	4.3%	5.1%	4.2%	4.5%	3.9%
	3397/78998	362/7067	2141/51508	750/16551	150/3872
OCT	4.4%	4.9%	4.3%	4.7%	4.3%
	3503/79187	349/7086	2221/51639	771/16573	167/3889
NOV	4.3%	5.1%	4.1%	4.5%	4.1%
	3411/79374	358/7081	2148/51824	749/16552	160/3917
DEC	4.2%	5.1%	4.0%	4.4%	4.4%
	3317/79609	365/7108	2054/51936	732/16620	174/3945
CY 17	4.3%	4.9%	4.1%	4.6%	4.4%
JAN	3422/79222	349/7084	2136/51651	758/16578	170/3909
FEB	4.2%	4.9%	4.1%	4.3%	4.1%
	3339/79383	349/7084	2105/51651	724/16712	163/3936
MAR	4.6%	5.6%	4.3%	5.1%	4.0%
	3622/79455	399/7101	2223/51807	846/16618	158/3929
APR	4.3%	5.2%	4.1%	4.7%	3.8%
	3454/79928	367/7125	2149/52050	792/16800	152/3953
MAY	4.5%	5.3%	4.3%	4.8%	4.2%
	3572/79750	381/7133	2222/51923	813/16766	165/3928
JUN	4.4%	5.3%	4.2%	4.7%	4.4%
	3512/79587	375/7115	2173/51801	794/16754	174/3917

2016 COMMUNITY CHECKUP REPORT

Improving Health Care in Washington State

www.WACommunityCheckup.org



Introduction



This version of the Community Checkup report is the tenth that the Washington Health Alliance has published since 2008.

With the tenth Community Checkup report, it's worth reflecting on the importance of transparency—and its limitations. We have always known that transparency by *itself* would not lead to significant improvement. We understand the role transparency plays in health care transformation: it's absolutely necessary, but it's not sufficient on its own. Making data available that is comparable, relevant and understandable and that comes from a trusted source is vitally important, but it is just the start of the cycle for transformation. *Using information* to identify opportunities and to motivate action is a critical next step.

Ongoing reporting through the Community Checkup is a valuable tool in this process of transformation and helps us, collectively, to understand over time whether efforts to improve are working. We also know that health care is far too complex for any one organization, or even any one stakeholder group (e.g., providers) to transform care on its own. Transformation requires all of us working together, across organizations and stakeholder groups, to drive change in an aligned and supportive manner. This is why convening continues to be such a critical component of the Alliance's mission.

The chart on the following page highlights the series of steps necessary to move from data to action. A database is just a collection of data points unless there is the infrastructure and trust to ensure that it is accessed and used to its fullest capacity. Moving data to information means making data comparable, relevant and understandable. It also requires that the information come from a trusted source.

The next step is moving to action. Action includes such things as benefit design and changing practice patterns among providers. This is a crucial step, the one in which information drives changes in our health care system. The Alliance adds value to this step of the process by convening various stakeholders to share ideas, learn from one another and align efforts for value-based action.

It's only when all of these steps come together that we are able to achieve the outcomes that we seek. By working to bring all of these elements of the continuum together, the Alliance is focused on helping Washington to achieve the Triple Aim: better care, better health and lower costs.

WHAT'S NEW IN THIS REPORT

- For the first time, results are now available for primary care medical groups and clinics of four or more providers for the entire state, a big step forward for Washington state transparency efforts.
- Results reflect the full expansion of Medicaid enrollment, which began in 2013.
- Results are included for new measures on behavioral health, including mental health service penetration and substance use disorder service penetration.

Health care is far too complex for any one organization, or even any one stakeholder group (e.g., providers) to transform care on its own. Transformation requires all of us working together, across organizations and stakeholder groups, to drive change in an aligned and supportive manner.

Steps Required to Achieve the Triple Aim



- Complete
- Accurate
- Valid Measures



- Trusted Source
- Comparable
- Relevant
- Understandable



- Purchasing
- Benefit Design
- Changing Practice Patterns
- Behavior Change



- Top 10%
- Better Health
- Better Care
- Less Waste
- Lower Cost

Yet, despite the best efforts of the Alliance and its hundreds of stakeholders, the significant quality improvements that we envisioned when the first Community Checkup report was released in 2008 remain elusive. To their credit, individual medical groups and providers have undertaken major efforts to improve their performance. Health plans have taken steps to redesign provider payment to link it to quality. Plans and purchasers have made some headway to create different benefit designs. Yet there are still plenty of opportunities for improvement.

Variation is as much a theme in this report as it was in the 2008 report. Despite the spotlight that the Community Checkup has placed on it, variation in the quality of health care is endemic. Even for tests and treatments supported by overwhelming evidence, there remains a remarkable range among the frequency with which they are likely to be provided. This variation can be among facilities (medical groups, clinics, hospitals) or geographies (counties or Accountable Communities of Health). This continuing pattern of significant variation underscores how important it is that we continue to measure, analyze and report results to target opportunities for improvement. It also underscores how challenging it is for all of us—providers, purchasers, health plans and consumers—to significantly move the needle through concerted changes in clinical decision making and in incentivizing quality.

HEALTHIER WASHINGTON IS MOVING THE MARKET TO VALUE

This report is the second time that the Alliance has reported results for the Washington State Common Measure Set for Health Care Quality and Cost. In 2016, the Common Measure Set includes 55 measures that enable a common way of tracking important elements of health and how well the health care system is performing. This year's results include four new measures: mental health services for children and adults, substance use disorder services for children and adults, medication management for people with asthma and statin therapy for patients with cardiovascular disease.

The Common Measure Set is an important element in the state's Healthier Washington initiative, an innovative and ambitious effort to improve health care in our state. Funded by a State Innovation Model (SIM) grant from the Centers for Medicare & Medicaid, Healthier Washington is employing three overarching strategies to achieve its transformational goals:

1. **Supporting multi-sector engagement.** To build a healthier Washington, the State is empowering people to come together at the local level. This includes connecting health care providers who are working to address an individual's physical and mental health needs with community-based resources that provide support-like assistance with housing, employment or the activities of daily living. Making these critical connections will help Washington address the social and economic issues that can play an important role in an individual's health.
2. **Integrating care and social support.** Strengthening the connections across the health care sector and communities is one step to transforming care. Another step is through investment in knowledge, training and tools to help providers deliver effective care where people are, when they need it. The state will promote change to improve coordination of care, connect providers to community resources and shift to paying for value rather than volume.
3. **Paying for value.** The state is testing new ways to pay for health care to lower costs, improve the care people receive and ensure that health care dollars are spent wisely. This includes rewarding providers for the quality of care people receive rather than the number of procedures or patient visits they receive. To do this effectively, the state is developing methods of collecting and sharing information so that the state, health plans, providers and citizens can see how the system is really performing—and work toward improvements based on this information. The Common Measure Set is foundational to understanding and measuring value.

Variation in the quality of health care is endemic. Even for tests and treatments supported by overwhelming evidence, there remains a remarkable range among the frequency with which they are likely to be provided.

New Area of Focus: Behavioral Health



BEHAVIORAL HEALTH GETS A CLOSER LOOK

Another significant focus area for Healthier Washington is improving behavioral health care and more effectively integrating behavioral and physical health. In 2016, two new measures were added to the Common Measure Set to try and get a better understanding of behavioral health in our state. The Mental Health Services and Substance Use Disorder Services measures were developed by the Washington State Department of Social and Health Services' Research and Data Analysis Division (RDA). They are designed to measure access to services to treat or manage behavioral health conditions.

The measures use a two-year window to identify need for mental health or substance use disorder treatment services, and then measure the proportion of those in need who received qualifying services in the measurement year.² The measures have been shown in several studies (including some in peer-reviewed journals) to have a strong relationship to patient outcomes. That is, patients who receive treatment after a need has been identified have better outcomes along many domains (e.g., health service utilization, cost, disease progression, mortality, criminal justice involvement, employment, housing stability) compared to people who do not receive treatment after having a need identified.

These are important measures to include in the Common Measure Set for several reasons.

- Behavioral health risk factors are a key driver of health care utilization across physical and behavioral health settings.
- Behavioral health conditions are key risk factors affecting patient experiences and quality of life across many functional domains.
- Behavioral health services have been historically underfunded in relation to physical health care—recognition of this circumstance helped lead to behavioral health parity requirements under the Affordable Care Act.

These measures have been implemented in the Washington state Medicaid environment for some time, where they were deployed to help support the movement towards increasingly integrated delivery of physical and behavioral health care. As is the case with many measures, including NCQA HEDIS measures, we expect that the metrics will be revised over time based on input from plans, providers and other key stakeholders. In particular, there is an expectation that the metrics will continue to evolve to more comprehensively capture services provided to manage behavioral health conditions in a primary care setting.

Mental health services for children and adults

For the first time in 2016, we have results for the mental health service penetration measure (Mental Health Services for Children and Adults) for the commercially insured population in Washington. Results for both commercial and Medicaid health plans are reported in 2016, along with results by county and Accountable Community of Health.

KEY FINDINGS

- Mental health service penetration is better overall within the Medicaid insured population for both children and adults.
- Only one-third of commercially insured children and adults received mental health services following a diagnosed need for mental health services. Among the Medicaid insured, approximately two-thirds of children and one-half of adults received mental health services following a diagnosed need.
- There is significant variation among counties for both the commercially and Medicaid insured populations, which may be a reflection of different levels of access to services across different parts of the state.

2. The two-year window to identify need is motivated by the tendency for behavioral health conditions to be under-identified in insurance claims data. Given that there can be significant variation across health plans and other reporting units in the proportion of enrolled populations with behavioral health needs, using a need-based denominator provides a form of case-mix adjustment to achieve fairer comparisons of access across reporting organizations.

Figure 7: Mental Health Services for Children, Ages 6–17

RESULTS FOR HEALTH PLANS				RESULTS FOR COUNTIES			
Commercial Health Plans		Medicaid Managed Care Organizations		Washington Counties, Commercially Insured		Washington Counties, Medicaid Insured	
State Average = 35%		State Average = 63%		State Average = 35%		State Average = 63%	
Lowest performance	Highest performance	Lowest performance	Highest performance	Lowest performance	Highest performance	Lowest performance	Highest performance
15%	68%	56%	64%	11%	55%	53%	71%

Figure 8: Mental Health Services for Adults, Ages 18–64

RESULTS FOR HEALTH PLANS				RESULTS FOR COUNTIES			
Commercial Health Plans		Medicaid Managed Care Organizations		Washington Counties, Commercially Insured		Washington Counties, Medicaid Insured	
State Average = 29%		State Average = 46%		State Average = 29%		State Average = 46%	
Lowest performance	Highest performance	Lowest performance	Highest performance	Lowest performance	Highest performance	Lowest performance	Highest performance
16%	53%	42%	48%	15%	44%	35%	52%

Figure 9: Variation among **Counties** for Mental Health Services for **Commercially Insured** Adults, Ages 18–64

STATE AVERAGE: 29%

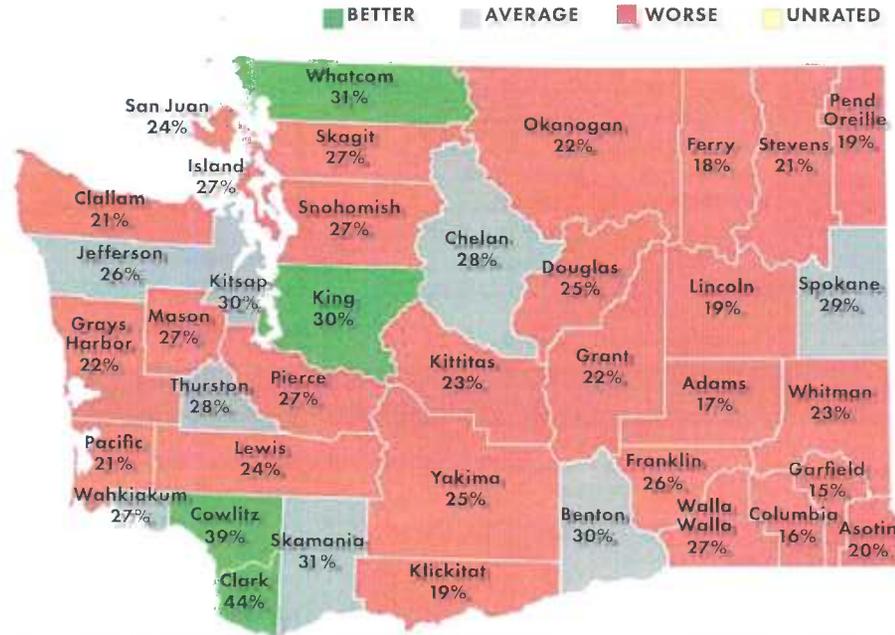


Figure 10: Variation among **Accountable Communities of Health** for Mental Health Services for **Commercially Insured** Adults, Ages 18–64

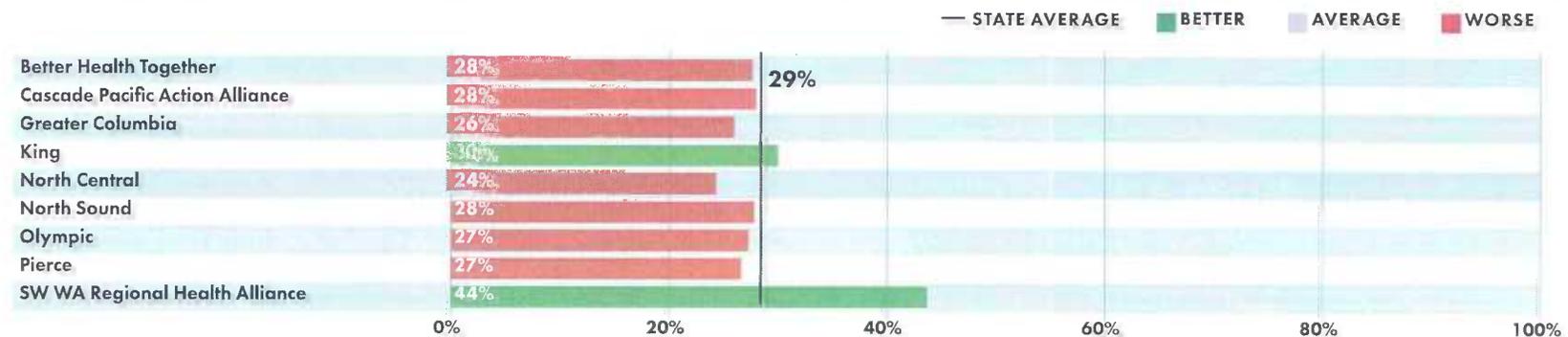


Figure 11: Variation among **Counties** for Mental Health Services for **Medicaid Insured** Adults, Ages 18–64

STATE AVERAGE: 46%

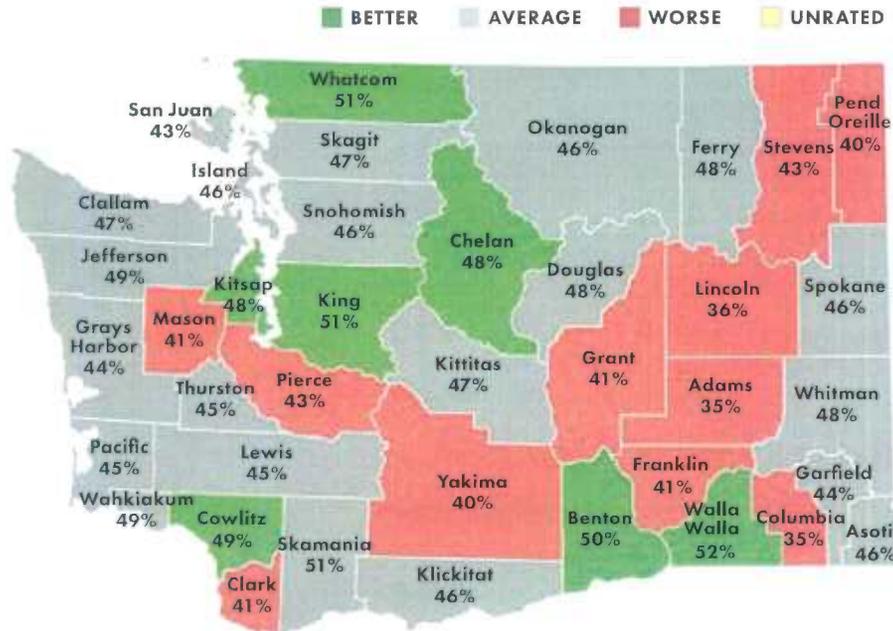
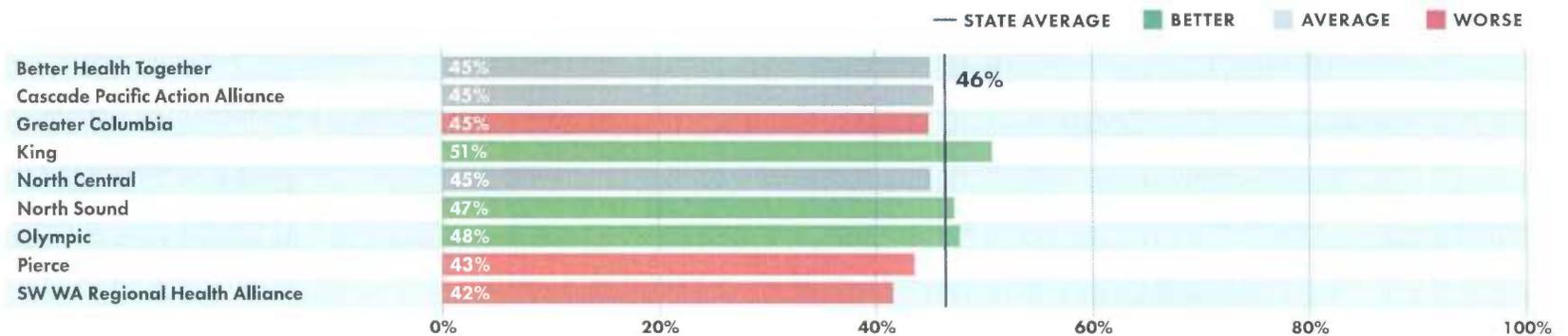


Figure 12: Variation among **Accountable Communities of Health** for Mental Health Services for **Medicaid Insured** Adults, Ages 18–64



Community Checkup report:
www.WACommunityCheckup.org

More about the Alliance:
www.WAHealthAlliance.org

More about Healthier Washington:
www.hca.wa.gov/hw/

Substance use disorder services for children and adults

The measure for Substance Use Disorder Service Penetration (Substance Use Disorder Services for Children and Adults) only includes the Medicaid population in 2016 and results are available at the county and Accountable Communities of Health levels. Results for both children and adults highlight the gap between the need for services and services delivered. On average across the state, only 28 percent of adult Medicaid enrollees received substance use disorder services following a diagnosed need for substance use disorder. For children the rate was 36 percent. Even in the best performing counties, about one of three children and six of ten adults do not get the follow-up treatment they should. Given the opioid epidemic in the state and the toll that it has taken, these numbers underscore the need for a concerted effort to improve access to substance use disorder treatment services.

Figure 13: Variation among **Counties** for Substance Use Disorder Services for **Medicaid Insured** Adults, Ages 18–64

STATE AVERAGE: 28%

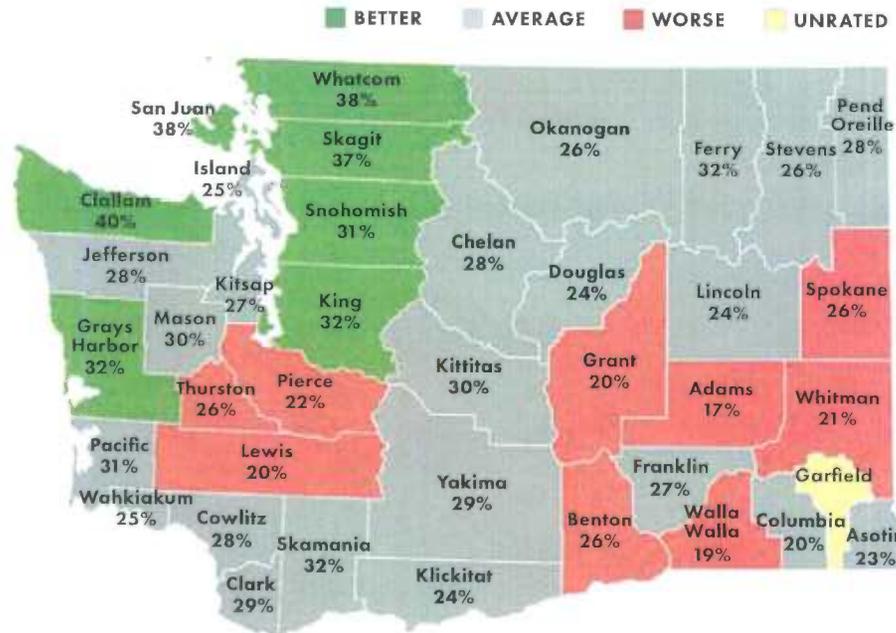


Figure 14: Variation among **Accountable Communities of Health** for Substance Use Disorder Services for **Medicaid Insured** Adults, Ages 18–64

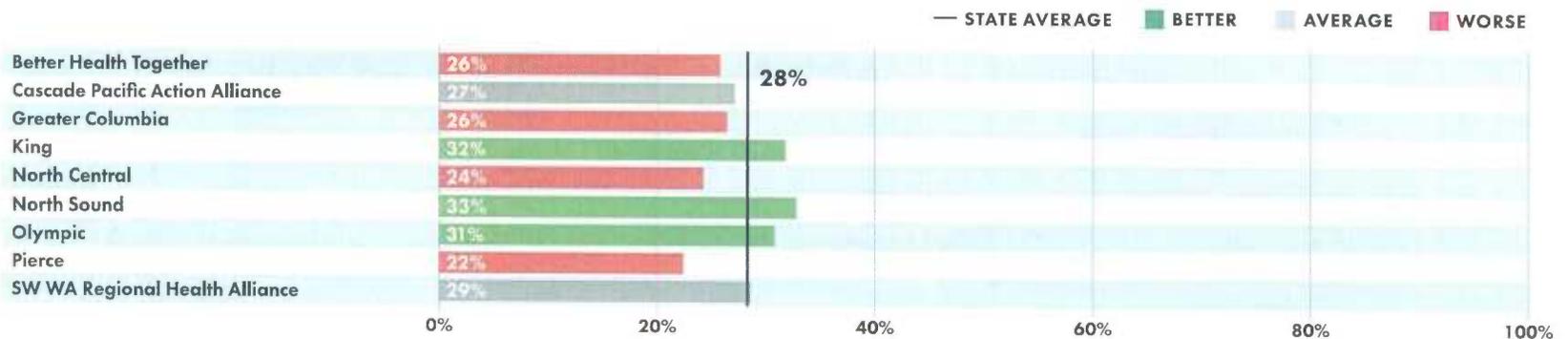


Figure 15: Variation among **Counties** for Substance Use Disorder Services for **Medicaid Insured** Children, Ages 6–17

STATE AVERAGE: 36%

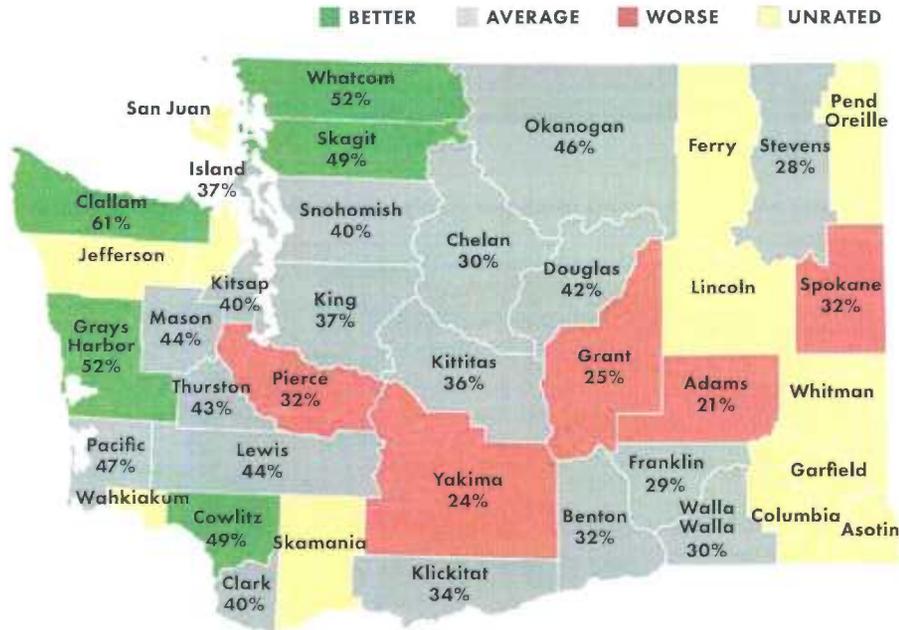
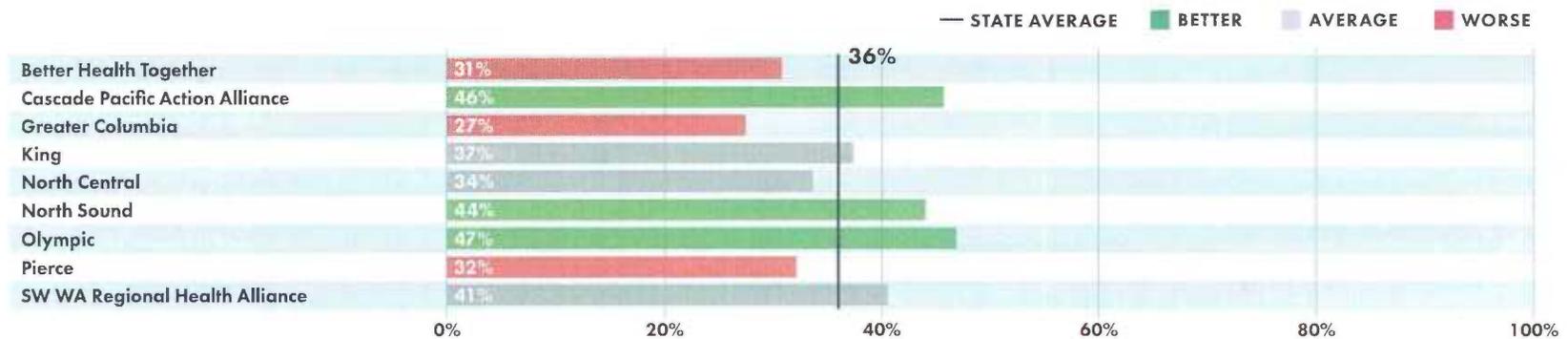


Figure 16: Variation among **Accountable Communities of Health** for Substance Use Disorder Services for **Medicaid Insured** Children, Ages 6–17





SALISH BHO

PROVIDER MONITORING POLICIES AND PROCEDURES

Policy Name: CORRECTIVE ACTION PLANS

Policy Number: 9.10

Reference: DSHS and Provider Contract

Effective Date: 7/2005

Revision Date(s): 6/2016

Reviewed Date: 6/2016; 6/2017

Approved by: SBHO Executive Board

CROSS REFERENCES

- Plan: Quality Management Plan
- Policy: Provider and Subcontractor Non-Compliance Penalties

PURPOSE

The Salish Behavioral Health Organization (SBHO) monitors contracted agencies according to the monitoring policy. The SBHO shall require contracted providers to develop corrective action plans when a provider is found to not be in compliance with the contract or when other monitored functions and services are found to be deficient.

PROCEDURE

1. Reasons the SBHO may request a Corrective Action Plan (CAP) include, but are not limited to the following:
 - The provider is found to be out of compliance with contract or working agreement requirements.
 - Provider performance is below the standard as outlined in the SBHO Quality Management Plan
 - A trend of sub-standard performance has been identified.
 - A problem exists that negatively impacts individuals receiving services.
 - The provider has failed to perform any of the contractually required behavioral health services.

Corrective Action Plans 9.10

Salish BHO Policies and Procedures

- The provider has failed to develop, produce, and/or deliver to the SBHO any requested statements, reports, data, data corrections, accountings, claims, and/or documentation.
 - The provider has failed to implement corrective action required by the SBHO within prescribed time frames.
2. Corrective action plans developed by the provider must be submitted for approval to the SBHO within 30 calendar days of notification.
 3. Corrective action plans may require modification of any policies or procedures by the provider relating to the fulfillment of its contractual obligations.
 4. The SBHO may extend or reduce the time allowed for corrective action depending upon the nature of the situation.
 5. Corrective action plans are reviewed by the SBHO, which determines if they are acceptable.
 6. The Corrective Action Plan will include:
 - Date of the Plan
 - Identified item of non-compliance
 - Any specified actions specifically required by the SBHO
 - Any dates specified by the SBHO by which the provider must be compliant
 - Specific action(s) the provider proposes to bring the item into compliance
 - Specific goal(s) and/or outcome(s) the provider's action addresses
 - Date by which the action(s) will be completed
 - Date by which the goal(s) and/or outcome(s) will be attained
 - Proposed documentation evidencing completion of the action(s) and
 - Attainment of the goal(s)/outcome(s)
 7. Performance in the identified area is monitored by the SBHO to determine if the corrective action plan has been successfully implemented. If compliance and/or performance continues to be insufficient, the SBHO may:
 - Require a revised corrective action plan
 - Offer technical assistance to the provider
 - Reject the plan
 - Require the provider to obtain outside technical assistance
 - Following the corrective action steps included the subcontract, withhold payments and /or invoke financial penalties
 8. The SBHO may inform the provider of any substantial noncompliance, which places the provider at risk of punitive action. Any such notification, if verbal, will be followed by a written memorandum generated within 36 hours of the verbal notification.
-

MONITORING

This policy is a mandated by contract and statute.

1. This policy is monitored through use of SBHO:
 - Annual SBHO Provider and Subcontractor Administrative Review
 - Quality Management Plan activities, such as review targeted issues for trends and recommendations
 - Annual Provider Chart Reviews
 - Review of previous Provider Corrective Action Plans related to policy, including provider profiles related to performance on targeted indicators
2. If a contractor or subcontractor consistently performs below expected standards during a contract period, the SBHO has the option of imposing punitive action and/or financial penalties as outlined in the contract.

SUD Expenditure Report							
Month: September							
Through billing month: August							
Line Item	Budget	July	August	LTD	Percent	Balance	Expected
Medicaid							
Outpatient	\$ 8,050,000.00	\$ 311,604.21	\$ 325,411.85	\$ 637,016.06	7.91%	\$ 7,412,983.94	
Residential	\$ 2,000,000.00	\$ 217,080.54	\$ 203,189.18	\$ 420,269.72	21.01%	\$ 1,579,730.28	
Withdrawal Management	\$ 660,000.00	\$ 43,146.64	\$ 48,334.12	\$ 91,480.76	13.86%	\$ 568,519.24	
Substance Abuse Block Grant							
Outpatient	\$ 962,438.00	\$ 18,006.44	\$ 52,343.63	\$ 70,350.07	7.31%	\$ 892,087.93	
Residential	\$ 700,000.00	\$ 174,704.12	\$ 153,932.66	\$ 328,636.78	46.95%	\$ 371,363.22	
Nurse Care Manager	\$ 248,743.00	\$ 6,395.66	\$ -	\$ 6,395.66	2.57%	\$ 242,347.34	
Criminal Justice Treatment Act							
Outpatient	\$ 226,000.00	\$ 583.84	\$ 10,726.70	\$ 11,310.54	5.00%	\$ 214,689.46	
Residential	\$ 226,000.00	\$ -	\$ 25,595.57	\$ 25,595.57	11.33%	\$ 200,404.43	
IMD Backfill							
Residential (billed to SABG)	\$ 821,000.00	\$ -	\$ 272,764.70	\$ 272,764.70	33.22%	\$ 548,235.30	
State							
Outpatient	\$ 389,000.00	\$ -	\$ 30,192.59	\$ 30,192.59	7.76%	\$ 358,807.41	
Residential	\$ 300,000.00	\$ -	\$ -	\$ -	0.00%	\$ 300,000.00	
Withdrawal Management	\$ 40,000.00	\$ -	\$ 4,143.92	\$ 4,143.92	10.36%	\$ 35,856.08	
SABG Child Care/PPW							
		\$ 5,284.00	\$ 5,173.01	\$ 10,457.01			
Residential							
IMD		\$ 174,704.12	\$ 153,932.66				
Non-IMD		\$ 217,080.54	\$ 203,189.18				
Total	\$ 14,623,181	\$ 776,805	\$ 1,131,808	\$ 1,908,613	13.05%		

Does not include KRC OP for August.
NOHN has only billed for MAT in July.

Washington Apple Health (Medicaid) caseload decline analysis

Background

From January 2017 to August 2017, the total amount of individuals receiving Washington Apple Health (Medicaid) coverage declined. This decline appears to have affected the Modified Adjusted Gross Income (MAGI) population more than any other. The MAGI population includes non-disabled adults and children and the new adult group. The decline can be seen in the number of premium payments made to the managed care plans and behavioral health organizations as well as in the total number of eligible medical assistance clients covered by the Health Care Authority (HCA), regardless of service delivery model (managed care or fee for service).

The decline in eligible clients from January 2017 to August 2017 is not typical and not due to seasonal fluctuations. The decline can be explained by increased eligibility reviews and a targeted review of client addresses.

Post-Eligibility Reviews

In January 2017, HCA hired 20 non-permanent Medical Eligibility Determination Services (MEDS) staff to work for six months on the post-eligibility review backlog. At the time they were hired, the backlog (reviews older than 60 days) of post-eligibility reviews totaled 77,000 cases. This figure is currently at a total of 55,000 cases.

HCA also employed lean techniques to improve the post-eligibility review process. This resulted in an increase in the amount of reviews being completed by eligibility staff. In August 2016, MEDS staff worked an average of about 5,000 cases per week. In August 2017, staff worked an average of 11,000 cases per week. The increase in cases we are able to review results in an increase in the number of cases terminated for being over the income standard or for not verifying their income.

LexisNexis

In 2015, the Legislature directed HCA to use LexisNexis residency data to verify residency for Apple Health recipients. From June 2017 through August 2017, HCA sent 64,000 Apple Health households notices asking them to review their residency status. Most of the households responded to the request and verified they were Washington residents; however, 18,000 individuals did not respond to the request for information and had their Apple Health coverage terminated.

Medical Eligibility and Community Support – Caseload Decline 09/18/2017

Minimum Wage Increase

Minimum wage increased again this year. It may be a little early to see the effects of this increase, but general economic strength may also be contributing to the lower caseload.

Summary

These three drivers influenced the decrease in clients eligible for medical assistance. The Caseload Forecast Council (CFC) will use this information to inform an adjustment to the CFC Caseload Forecast. This adjustment will decrease eligible clients from July 2017 to September 2017. The CFC will determine the magnitude of the adjustment, however, the HCA has seen a drop in premium payments for the new adult group of 5.62% from June 2017 to August 2017 and a 2.52% drop in premium payments for the non-disabled children, for the same time period.

Medical Eligibility and Community Support – Caseload Decline 09/18/2017



SALISH BHO

ADVISORY BOARD MEETING

DATE: Friday, November 3, 2017
TIME: 10:00 AM – 12:00 PM
LOCATION: City of Sequim, Civic Center
152 W Cedar Street, Sequim WA 98382

A G E N D A

<http://www.kitsapgov.com/hs/sbho/sbhoboard.htm>

1. Call To Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics (limited to 3 minutes each)
4. Approval of Agenda
5. Approval of October 6, 2017 Minutes (Attachment 5)
6. Action Items
7. Informational Items
 - a. Healthcare Integration
 - Status of Each Region (Attachment 7.a.1)
 - Conditions (Attachments 7.a.2; 7.a.3)
 - b. Options for the Future
 - Becoming a Behavioral Health Administrative Service Organization (Attachments 7.b.1; 7.b.2; 7.b.3; 7.b.4; 7.b.5)
 - c. Medicaid Transformation Project Update (Attachments 7.c.1; 7.c.2; 7.c.3)
 - d. Funding Update (Attachment 7.d)
8. Opportunity for Public Comment (limited to 3 minutes each)
9. Board Member Check-in
10. Adjournment

ACRONYMS

ACH	Accountable Community of Health
ASAM	Criteria used to determine substance use disorder treatment
BHO	Behavioral Health Organization, replaced the Regional Support Network
CAP	Corrective Action Plan
CMHA	Community Mental Health Agency
CMS	Center for Medicaid & Medicare Services (federal)
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DDA	Developmental Disabilities Administration
DMHP	Designated Mental Health Professional
DSHS	Department of Social and Health Services
E&T	Evaluation and Treatment Center (i.e., AUI, YIU)
EBP	Evidence Based Practice
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FBG	Federal Block Grant (specifically MHBG and SABG)
FIMC	Full Integration of Medicaid Services
FYSPRT	Family, Youth and System Partner Round Table
HARPS	Housing and Recovery through Peer Services
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HRSA	Health and Rehabilitation Services Administration
IMD	Institutes for the Mentally Diseased
IS	Information Services
ITA	Involuntary Treatment Act
LOC	Level of Care
MAT	Medical Assisted Treatment
LRA	Least Restrictive Alternative
MCO	Managed Care Organization
MOU	Memorandum of Understanding
OCH	Olympic Community of Health
OST	Opiate Substitution Treatment
PACT	Program of Assertive Community Treatment
PATH	Programs to Aid in the Transition from Homelessness
PIHP	Prepaid Inpatient Health Plans
PIP	Performance Improvement Project
P&P	Policies and Procedures
QA, QI	Quality Assurance, Quality Improvement
QUIC	Quality Improvement Committee
QRT	Quality Review Team
RCW	Revised Code Washington
RFP, RFQ	Requests for Proposal, Requests for Qualifications
SAPT	Substance Abuse Prevention Treatment
SBHO	Salish Behavioral Health Organization
SUD	Substance Use Disorder
UM	Utilization Management
WAC	Washington Administrative Code
WM	Withdrawal Management
WSH	Western State Hospital, Tacoma

Action Items

None

Informational Items

a. HEALTHCARE INTEGRATION

The state continues to encourage counties and Behavioral Health Organizations (BHOs) to become fully integrated in any way they can, having given extensions for decision making beyond the September 15th deadline to three BHOs. In addition to extensions, the Health Care Authority is also beginning to make concessions of various kinds to get counties to agree to fully integrated care. Staff will discuss the status of regions across the state and provide the latest updates.

- Status of each Region

Attached is a map which shows which BHOs have submitted letters committing to becoming mid-adopters of fully financially integrated care.

- Conditions

Many of the BHOs which have submitted letters agreeing to mid-adopter status have put conditions on their participation. The most flushed out of these are that of North Sound BHO and Spokane County Regional BHO, which are attached. The Executive Board has directed staff to develop conditions relevant to our regions participation, and the Advisory Board is asked to consider what conditions may be relevant from its point of view.

b. OPTIONS FOR THE FUTURE

- Becoming a Behavioral Health Administrative Service Organization

The Health Care Authority released a request (attached) on October 10 offering Behavioral Health Organizations the first right of refusal to become Administrative Service Organizations when their region becomes fully integrated. The commitment is not due until January 12, and is rescindable until March of 2019 for those anticipating becoming fully integrated in January of 2020. Portions of the most recent RFP for the BH ASO in North Central Washington are attached, and staff will have an analysis of the current contract available at the meeting. The Executive Board has made a preliminary decision to submit a letter of intent, but is open to Advisory Board input.

c. MEDICAID TRANSFORMATION PROJECT

The Medicaid Transformation Project has hit a significant funding glitch, and the Olympic Community of health has been notified that their revenue will be 27% less than expected during the course of the project. The OCH continues to move forward with all of the projects they initially planned on completing, a brief survey of which is attached.

d. FUNDING UPDATE

Staff will provide an update on a variety of financial issues.

**MINUTES OF THE
SALISH BEHAVIORAL HEALTH ORGANIZATION
ADVISORY BOARD**

**10:00 a.m., Friday, October 6, 2017
City of Sequim, Transit Center
190 W Cedar Street, Sequim WA 98382**

CALL TO ORDER – Jon Stoup, Vice Chair, called the meeting to order at 10:03 a.m.

INTRODUCTIONS – Self introductions were conducted around the room.

OPPORTUNITY FOR PUBLIC TO ADDRESS THE BOARD ON AGENDA TOPICS:

- It was requested that a PA system be used for future meetings so that it is easier to hear all in attendance. SBHO staff will consider options.
- A former long-standing member of the board, John Freeburg, passed away. A memorial service will be held at 2:00pm on October 22, 2017 at the Kitsap Unitarian Universalist Fellowship (4418 Perry Ave NE, Bremerton, WA 98310).

APPROVAL OF THE AGENDA

Catharine Robinson moved to approve the agenda as submitted. Anne Dean seconded. Motion carried unanimously.

APPROVAL OF MAY 5, 2017 MINUTES

MOTION: Lois Hoell moved to approve the minutes of the May 5, 2017 meeting as submitted. Catharine Robinson seconded. Motion carried unanimously.

APPROVAL OF AUGUST 4, 2017 MINUTES

MOTION: Catharine Robinson moved to approve the minutes of the August 4, 2017 meeting as submitted. Lois Hoell seconded. Motion carried unanimously.

APPROVAL OF SEPTEMBER 8, 2017 MINUTES

MOTION: Lois Hoell moved to approve the minutes of the September 8, 2017 meeting with the request to change the word bud on page 16 to bid. Motion carried.

INFORMATIONAL ITEMS

- Healthcare Integration
 - The state Health Care Authority has put significant pressure on the larger BHOs to become mid-adopter regions. North Sound, Greater Columbia, and Spokane counties have all asked for an extension date on submitting a letter of mid-adoption.
 - King County and Pierce County have submitted letters of intent for mid-adoption

with conditions. The conditions are related to the BHOs continuing to manage the behavioral health system; SBHO staff do not know the specifics, but will continue to provide updates.

- The state is asking BHOs to come up with their own vision of what integration looks like.
- The Olympic Community of Health (OCH) that oversees the demonstration grant funds for our regions was notified that their budget was significantly cut by \$50 million dollars from \$138 million. It is believed that the Health Care Authority over estimated the number of Medicaid eligibles for our region.
- At an upcoming meeting, the SBHO Executive Board will have to decide if the SBHO will assume the role of being the Administrative Service Organization (ASO) once integration occurs by submitting a non-binding letter. Under integration, all the Medicaid funding would run through the MCO's; block grant, state funds, crisis services, and some residential care would run through the ASO.

➤ Quality Assurance

- SBHO QA staff presented an update on the encounter data validation and performance measures.
- The Advisory Board requested SBHO staff work with each of the agencies to coach and train the providers on properly coding so that when integration occurs, they will be set up for success in a fee-for-service system.
- QA staff are working on aligning their expectations with that of the audit review team to improve our data and scores.
- QA staff discussed the policies and procedures the SBHO follows regarding corrective action plans (CAPS) and performance improvement plans (PIPS).
- QA staff also discussed the 2016 Community Checkup report from Healthier Washington. The report found that service penetration for mental health is better within the Medicaid insured population.
- The board requested that the SBHO share all issued CAPS at future meetings.

➤ Funding Update

SUD Expenditures FY 18

- The board discussed the SUD expenditure report that outlines the various funding streams through August of 2017.
- More of the funding should be going to outpatient services instead of residential as we can serve more people and stretch the funding.
- SBHO staff are tracking this very carefully to ensure that we have sufficient non-Medicaid funding for the year.
- An RFP will be going out soon for Substance Abuse Block Grant to hold agencies more accountable with spending the funds.

Number of Medicaid Enrollees

- After the healthcare expansion in 2014, the state fell behind by 70,000 cases in checking Medicaid eligibility. The state has hired temporary staff to assist with the backlog and as they are checking, they are dropping Medicaid to those who are not eligible. Therefore, our region is seeing a dip in those who are eligible for Medicaid. This is concerning as the SBHO gets paid on a per member, per

month rate for Medicaid clients in our region.

- The legislature directed the Health Care Authority to use LexisNexis residency data to verify residency for Medicaid recipients by sending out 64,000 notices to Medicaid enrollees asking them to review their residency status. If the Health Care Authority did not receive a response, their eligibility was terminated. This is concerning as the chronically mentally ill population are often transient and do not receive or open their mail. The list of names has been requested so that BHOs can compare the names on the terminated list against our caseloads to see if it is the chronically mentally ill population.

American Indian/Alaskan Native Exemption

- The state has produced the first reports related to the number of American Indian/Alaskan Native individuals who have been exempted from behavioral health managed care and those who have opted in. The numbers for the SBHO are very skewed, with only 39 out of 5,700 individuals opting in for behavioral health services for the month of August. The statewide rate was expected to be approximately fifty percent based on the state's experience with health care managed care.

OPPORTUNITY FOR PUBLIC COMMENT

- None

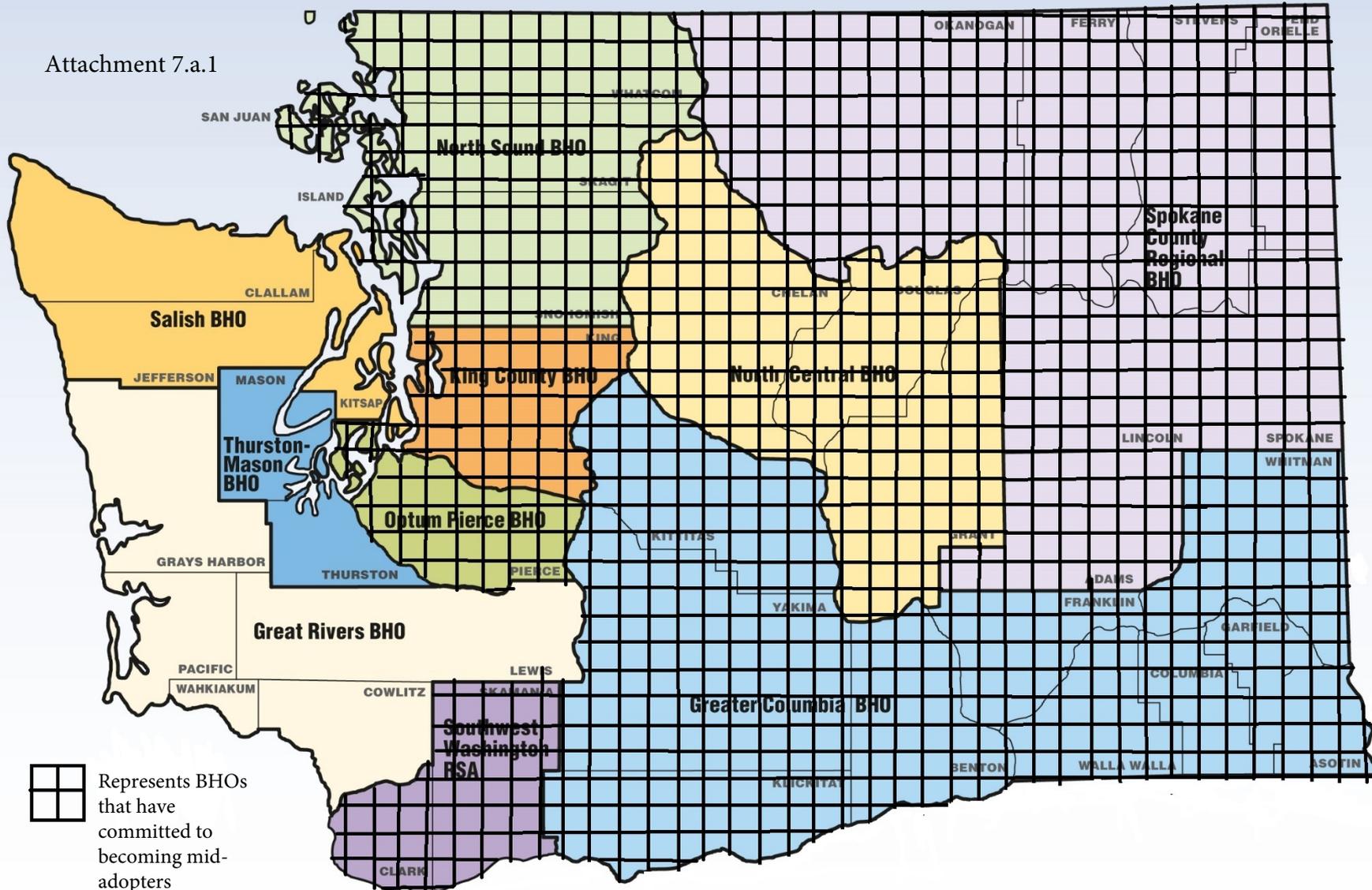
FOR THE GOOD OF THE ORDER

- Board Member Check-In:
 - Janet – What is happening with State hospitals?
The former Superintendent of the state hospitals is now Secretary of DSHS. A physician is temporarily acting as the Superintendent. Currently, 33 beds are open at the state hospitals with 100 individuals waiting to get in. These individuals are waiting in community hospital beds which the BHOs are having to pay for.
 - Charles – With funds being diminished how are counties and hospitals/agencies expected to come up with funding?
This is an issue BHOs have focused on with planning for integration. The BHOs do not know who is going to handle this. SBHO staff will continue to provide updates on integration.
 - Sandy – So much to do, so little funding, and so little time. Does the SBHO have any funding available for an alternative suicides program?
The SBHO will consider the program and do further research.
 - Jon – Thank you for being here and your participation.
 - Jennifer – We do not need to go away as a board with integration. we need to look at the future and what we look like in 2020; this very well could include a citizen's board.
 - Roberta – Thank you to the QA staff for the data and the questions and answers.
 - Stephen – Agreed with Jennifer's statement and added that we do not need to give up our rights.
 - Catharine – Thank you QA staff for the data and thanks you to the providers for attendee.
 - Anne - I see the benefits that our providers do in our communities and the success stories.

ADJOURNMENT - The meeting adjourned at 12:08 p.m.

ATTENDANCE

MEMBERS	GUESTS	STAFF
<u>Present</u> Helen Morrison Janet Nickolaus Roberta Charles Charles Pridgen Sandy Goodwick Catharine Robinson Jon Stroup Jennifer Kreidler-Moss Anne Dean Jolene George Lois Hoell <u>Absent/Excused</u> Jennifer Risinger Freida Fenn Russell Hartman	Ellen Epstein, RMH Services Vivian Morey, Ombuds Wendy Sisk, Peninsula Behavioral Health G'Nell Ashley, Reflections Counseling Services Group Josh and Elan Keele, Community Members Joe Roszak, KMHS Helen E Havens, Kitsap PCAP Sally O'Callaghan, QUIC Mental Health Kim Yacklin, Clallam Co. HHS Andy Brastad, Clallam Co. HHS	Doug Washburn Anders Edgerton Richelle Jordan Ileea Nehus Alexandra Hardy



 Represents BHOs that have committed to becoming mid-adopters

**Motion #17-79- As Amended at the October 5, 2017 Meeting of the County Authorities
Executive Committee**

- Send a letter of intent on behalf of all the North Sound Counties to the Health Care Authority to become a “Mid-Adopter” of Fully Integrated Managed Care in January 2019, and to become the Behavioral Health Administrative Organization [BH-ASO] for the North Sound region.
- This letter should also indicate that the North Sound Region chooses to use the “2019 Transition Year” option in which the MCOs subcontract an agreed upon set of services and/or functions to the BHO for one year, and in which the BHO maintains non-Medicaid BH contracts for one year.
- This letter should include the following conditions:
 1. Agreement from the Governor’s Office and the Health Care Authority to fully support adoption of a statute establishing a permanent regional “Interlocal Leadership Structures” to be chaired by county authorities. This statute language will be modeled on the “BHO Proviso Language” that was introduced in the 2017 Legislative Session. In addition, the statute establishing the Interlocal Leadership Structure should address clear roles and responsibilities of the System Stakeholders and how decisions will be made to support and implement the new system efficiently to maximize health outcomes. Consideration should be given to reduce unnecessary duplication of administrative cost in order to preserve money for direct services, provide transparency so that system outcomes in relationship to cost can be evaluated, and provide a mechanism for Counties and the BH-ASO to have meaningful influence on identifying community specific health care priorities and consistency of services for both Medicaid and non-Medicaid individuals to maintain and increase the overall health of the North Sound region as a whole.
 2. Agreement from the Governor’s Office and the Health Care Authority to seek a legislative budget appropriation providing sufficient dedicated funding to the North Sound Region to operate the BH-ASO. This funding should be sufficient to maintain the current continuum of care in the North Sound BHO administered Crisis Services and Diversion programs. This funding agreement will also allow the North Sound to submit a spending plan that will allow it to maintain a portion of their existing reserves and unspent funds to cover the estimated start-up costs of transitioning to a BH-ASO. In addition to the above funding assurances, a secure funding source (outside of county one tenth of one percent sales tax) needs to be established sufficient to ensure ongoing support, at current levels, for Counties for administrative functions; including allied systems coordination. Regional Advisory Board; Quality Management Support; Allied System Coordination; Community

- Coordination; Housing and Recovery through Peer Supports and Housing Subsidies, Criminal Justice Treatment Account; Family Youth System Partner Roundtable FYSPT (Skagit County only); Appointment of a County Coordinator; Resource Management Support; Local Oversight Committee; Coordinated Quality Improvement Program Committee. Additionally, the State shall commit necessary funding for operating and maintain existing and expanded treatment facilities serving both Medicaid and non-Medicaid clients. Additionally, there needs to be dedicated State funding to provide critical community based intensive services that are essential to maximizing prolonged recovery success for both Medicaid and non-Medicaid clients.
3. Agreement from the Health Care Authority to allow the MCOs selected to serve the North Sound Region to contract with the BH-ASO for certain Medicaid Behavioral Health Services based on the proposed plan for fully integrated managed care developed by the North Sound Interlocal Leadership Structure. This plan should assure that clients are at the center of care delivery and should support integrated delivery of physical and behavioral health care at the provider level. This plan should also minimize duplication in administrative functions and support coordination of care as described in the “BHO Proviso Language”. During calendar year 2019, MCOs must contract back to the BHO and/or BH-ASO certain Medicaid behavioral health services to maintain the stability of the current system, to ensure an optimal transition, and to allow for continued design and planning of a full integration model and continuum of care prior to full implementation by January 1,2020; and, beginning calendar year 2019, a comprehensive plan determining contracting relationship to ensure funding for the above services in condition #2 needs to be established.
 4. Agreement from the Health Care Authority to allow Counties through the Interlocal Leadership Structure to provide specific input into the North Sound “Addendum” to the 2018 RFP that will be used to procure the MCOs that will be providing Fully Integrated Managed Care in the North Sound. This should include the ability to recommend specific criteria to ensure that all persons in the North Sound region have equal access to Medicaid health and behavioral health services, including those persons living in geographically challenged areas. The RFP for MCO’s should require the selected MCO’s to demonstrate how they are minimizing barriers of entry for those needing services and articulate their plan for addressing community specific health care priorities. Further, MCO’s should have a clear plan to address the

overlay of their treatment obligations with coordinated crisis care and transition care services.

5. A stipulation that the North Sound region may withdraw its agreement to become a mid-adopter if the majority of the Counties conclude that these conditions are not being satisfactorily addressed.

Mid-Adopter Decision Guidance Document

Attachment 7.a.3

1 Vote Per County

Select Only 1 Option

Option 1:

Effective October 18, 2017

This option is selected based on Attachment A captioned "FULLY INTEGRATED MANAGED CARE (FIMC) BACKGROUND AND CONDITIONS OF SPOKANE COUNTY AGREEMENT TO MID-ADOPTER OPTION WITH WASHINGTON STATE HEALTH CARE AUTHORITY" (HCA), to include:

- I. Background and Purpose,
- II. Roles, Responsibilities and Conditions for FIMC,
- III. Conditions of FIMC and Mid-Adopter Option

The signator counties authorize Spokane County to negotiate with HCA regarding the provisions within Attachment A.

Option 1: Mid-Adopter Immediate Option Effective 1/1/2019

1. Region Becomes BH-ASO*

- a. Counties Retain Direct Decision Making Influence in Non-Medicaid Allowable Uses to Support and Maintain the Crisis Continuum of Care
- b. Responsible for BH-ASO* Effective 1/1/2019 Forward (region can change this decision with State notification by 3/1/2018)
- c. Leverage Knowledgeable BHO Staff to Support and Stabilize the Transition for this Option
- d. With Legislative Change, State Contract Funding Could Become Adequate for BH-ASO Functions
- e. MCOs are Responsible for Inpatient Risk and Costs for Medicaid Enrollees Effective 1/1/2019
- f. Spokane County Continues to Bear Financial Risk for Non-Medicaid Eligible Individuals After 1/1/2019 if Region's BH-ASO
- g. Without Legislative Changes, State Takes All Reserves 1/1/2019 (for outstanding BHO inpatient claims and incurred expenses)
- h. Without an HCA Contract Change, Surety Bond Required from Non-State Provided Funds if Region is BH-ASO
- i. Region Contracts/Funding Continue with State for Non-Medicaid Eligible Individuals after 1/1/2020 if Region's BH-ASO
- j. Region Required to Give 9 Month Notice to Terminate BH-ASO Option

2. HCA Procures BH-ASO for Region

- a. Counties Lose Opportunity for Direct Decision Making Influence in Non-Medicaid Allowable Uses to Support and Maintain the Crisis Continuum of Care Effective 1/1/2019
- b. Responsibility for BHO Ends 1/1/2019, No Responsibility for BH-ASO
- c. Removes BHO & BH-ASO Financial Risk to Spokane County Effective 1/1/2019 if Not Region's BH-ASO
- d. Without Legislative Changes, State Takes All Reserves 1/1/2019 (for outstanding inpatient claims and incurred expenses)
- e. Region (BHO) Contracts/Funding Directly with State until 1/1/2019 if Not Region's BH-ASO
- f. 30 Day Termination for Convenience Option with State and Subcontractors

Note: All information contained in this guidance document is based on information provided to date from HCA as of October 11, 2017, and is accurate as of this date.

Mid-Adopter Decision Guidance Document

1 Vote Per County

Select Only 1 Option

Option 1:

Effective October 18, 2017

Option 1: Mid-Adopter Immediate Option Effective 1/1/2019 Continued...

SCRBHO currently administers and funds all the BH-ASO activities and responsibilities described below:

* BH-ASO Definition and Information:

BH-ASO decision not required until January 2018, and region can change this decision with 9 months' notice to HCA (e.g. 3/1/18 if Mid-Adopter, 3/1/19 if late adopter). Once a region decides not to become the region BH-ASO, the region cannot later change this decision and become the region BH-ASO.

BH-ASO responsible for:

- Providing crisis services to all individuals (Medicaid and Non-Medicaid eligible individuals), and all Involuntary Treatment Act (ITA) services and court costs.
- Providing all contracted Behavioral Health Services for Non-Medicaid eligible individuals, which includes crisis services, outpatient treatment services, Evaluation and Treatment (E&T) services, stabilization services, community hospital psychiatric inpatient services, state hospital inpatient services (beyond state allocation), etc.
- Functions of Utilization Management, Grievances & Appeals, Network Development and Management, Provider Relations, Quality Management, Data Management and Reporting, Claims and Financial Management, etc.

Decision letter due October 18, 2017 to Al French, Christine Barada, Kathleen Torella, and

MaryAnne Lindeblad (HCA)

Note: All information contained in this guidance document is based on information provided to date from HCA as of October 11, 2017, and is accurate as of this date.

ATTACHMENT A
FULLY INTEGRATED MANAGED CARE (FIMC)
BACKGROUND AND CONDITIONS
OF SPOKANE COUNTY AGREEMENT TO MID-ADOPTER OPTION
WITH
WASHINGTON STATE HEALTH CARE AUTHORITY (HCA)

I. BACKGROUND AND PURPOSE

In 2014, the Legislature enacted ESSB 6312, which required: (1) the integrated purchasing of mental health and substance use treatment services (collectively "behavioral health") for the Medicaid program through managed care contracting by April 1, 2016, and (2) the full integration of physical and behavioral health known as Fully Integrated Managed Care (FIMC) contracting for the Medicaid program by January 1, 2020.

With respect to the provision of behavioral health services for individuals meeting certain diagnostic criteria, the previous system of Regional Support Networks and County Chemical Dependency Coordinators was replaced by Behavioral Health Organizations (individually a "BHO" and collectively the "BHOs"). BHOs are local entities that have responsibility for providing most Medicaid-funded inpatient and outpatient mental health and substance use disorder treatment services for those individuals meeting certain diagnostic criteria. On April 1, 2016, Spokane County, through the Community Services, Housing, and Community Development Department, became the BHO for the Spokane County region of seven counties consisting of Adams, Pend Oreille, Ferry, Stevens, Lincoln, Okanogan, and Spokane.

Effective with the FIMC decision, Spokane County, through the Community Services, Housing, and Community Development Department, continues as the BHO for the "Spokane County Region" of six counties consisting of Adams, Ferry, Lincoln, Pend Oreille, Stevens and Spokane.

The Managed Care Organizations (MCOs) have contracted with the Washington State Health Care Authority and/or Department of Social and Health Services (HCA/DSHS) to provide physical health services and certain behavioral health services to Medicaid enrollees in Spokane County. It is anticipated that all five MCOs will respond to an upcoming Request for Proposals ("RFP") from HCA/DSHS to provide FIMC in the Spokane County Region. The Spokane County Region is supportive of all five MCOs continuing to work in the Spokane County Region, provided each meets the standards and requirements in the HCA/DSHS RFP. The Spokane County Region recognizes that HCA/DSHS has the final decision on which MCOs will be selected under the RFP. The MCOs currently have responsibility for providing the continuum of Medicaid-funded inpatient and outpatient physical health care services and a subset of behavioral health services. In accordance with ESSB 6312, by January 1, 2020, HCA/DSHS will purchase all physical and behavioral health services through single, integrated contracts with MCOs (FIMC contracts), and BHO roles and responsibilities for Medicaid beneficiaries under the current model will be distributed among MCOs and a regional Behavioral Health Administrative Service Organization ("BH-ASO"). By a letter dated May 11, 2017, HCA/DSHS advised counties that significant incentive funding will be made available to regions that become mid-adopters through a binding letter of intent submitted to HCA/DSHS.

II. ROLES, RESPONSIBILITIES, AND CONDITIONS FOR FIMC

The Spokane County Region has established the Multi-County Governmental Group (MCGG), through a Memorandum of Understanding (MOU), dated August 1, 2017, for the purpose of

educating commissioners on integration, as well as monitoring and addressing the communities need for a stable system of care throughout the region.

The Spokane County Region supports the MCGG as the county leadership group during the transition to FIMC and in subsequent years as the "Interlocal Leadership Structure" if established by legislation addressed in III (Conditions of FIMC and Mid Adopter Option), subparagraph 3 hereinafter.

III. CONDITIONS OF FIMC AND MID-ADOPTER OPTION

1. It is anticipated that, under the FIMC mid-adopter option, payments for Medicaid mental health and substance use disorder treatment services for beneficiaries enrolled in FIMC will be made by HCA/DSHS to the MCOs and the BH-ASO operating in the Spokane County Region. The reimbursement rate will be established by HCA/DSHS. HCA/DSHS will establish the rate in consultation with an actuarial firm, selected by HCA/DSHS. The established rates must be actuarially sound and will be subject to the approval of CMS and accepted by each managed care entity that HCA/DSHS selects under the RFP.
2. Recognizing that contract rates for such services are subject to adequacy of capitated rates from HCA/DSHS to each MCO and the BH-ASO, the Spokane County Region shares the goal of continuing to provide services and reimbursement at the current funding levels immediately prior to the transition period.
3. Agreement from the Governor's Office and HCA/DSHS to fully support the adoption of legislation establishing a permanent regional "Interlocal Leadership Structure" to be chaired by county authorities. This legislation language will be modeled on the "BHO Proviso Language" that was introduced in the 2017 Legislative Session. In addition, the legislation establishing the Interlocal Leadership Structure should address clear roles and responsibilities of the system stakeholders and how decisions will be made to support and implement the new system efficiently to maximize health outcomes. Consideration should be given to reduce unnecessary duplication of administrative cost in order to preserve money for direct services, provide transparency so that system outcomes in relationship to cost can be evaluated, and provide a mechanism for the Spokane County Region's counties [and the BH-ASO] to have meaningful influence on identifying community specific health care priorities and consistency of services for both Medicaid and non-Medicaid individuals to maintain and increase the overall health of the Spokane County Region as a whole.
4. Agreement from the Governor's Office and HCA/DSHS to seek a legislative budget appropriation providing sufficient dedicated funding to the Spokane County Region to operate the BH-ASO. This funding should be sufficient to maintain the continuum of care contained within the Spokane County Regional Behavioral Health Organization's administered Crisis Services and Diversion programs immediately prior to the transition date. In addition to the above funding assurances, a secure funding source (outside of the Spokane County's one tenth of one percent sales tax) needs to be established sufficient to ensure ongoing support, at current levels, for the Spokane County Region's administrative functions; including regional Advisory Board, Quality Management Support, regional Performance Improvement Projects, Allied Systems Coordination, Community Partners Coordination, Projects for Assistance in Transition from Homelessness (PATH), Housing and Recovery Through Peer Supports (HARPS) and Housing Subsidies, Peer Bridgers, Ombuds services and Quality Review Team, jail services, crisis coordination planning with local Tribes, Criminal

Justice Treatment Account, Family Youth System Partner Roundtable (FYSPRT), youth and adult task force forums, recognition of existing County Coordinators, Resource Management Support, Local Oversight Committee, and Coordinated Quality Improvement Program Committee.

5. The Governor's Office and HCA/DSHS shall commit necessary funding to the Spokane County Region for operating and maintaining existing treatment facilities serving both Medicaid and non-Medicaid eligible individuals. The Governor's Office and HCA/DSHS shall commit necessary funding to the Spokane County Region to provide critical community based intensive services that are essential to maximizing prolonged recovery success for both Medicaid and non-Medicaid eligible individuals.
6. HCA/DSHS will provide MCGG with sufficient funding in conjunction with participating in the ongoing development of performance measures with HCA/DSHS, as well as performing outcome analysis and monitoring improvement processes, to ensure the quality of the FIMC produces an increase in overall health to the Spokane County Region as a whole.
7. Prior to the transition period in becoming a FIMC region, the Spokane County Region, HCA/DSHS, the BH-ASO, and the MCOs will work to determine specific or sub contractual arrangements that adhere to all applicable state and federal regulations and requirements, as well as performance and outcome measures as detailed in the FIMC contract.
8. This condition only applies to Mid Adopter Transition Year Option: Subject to the availability of funding and other HCA/DSHS requirements, as well as MCO negotiations, it is anticipated that the Spokane County Region could "contract back" (subcontract) to the MCOs to provide administration of certain agreed upon funds and programs, including and not limited to, hospital care coordination, jail diversion, Block Grants, Criminal Justice Treatment Accounts, proviso funding programs, other non Medicaid funding programs, employment of an independent behavioral health ombudsman, data analysis/reconciliation and data analytics, monitoring, and management of a community behavioral health advisory board (BHAB). This condition should assure the individuals served are at the center of care delivery and should support integrated delivery of behavioral health care at the provider level. This should also minimize duplication in administrative functions and support coordination of care as described in the "BHO Proviso Language", and maintain the stability of the current system, to ensure an optimal transition, and to allow for continued design and planning of a fully integrated model and continuum of care.
9. RFP Addendum: Agreement from HCA/DSHS to allow the SCRBHO and MCGG to provide specific input into the Spokane County Region's "Addendum" to the 2018 RFP that will be used to procure the MCOs [and possibly BH-ASO] that will be providing FIMC in the Spokane County Region. HCA/DSHS will give due consideration to any input from the Spokane County Region. This input will include the ability to recommend specific criteria to ensure all persons in the Spokane County Region have equal local access to Medicaid health and behavioral health services, including those persons living in geographically challenged areas. The RFP for MCOs and BH-ASO should require the selected MCOs and BH-ASO demonstrate how they are minimizing barriers of entry for those needing services and articulate their plan for addressing community specific health care priorities. Further, the MCOs and BH-ASO should have a clear plan to address the overlay of their treatment obligations with coordinated crisis care and transition care services.

10. **Period of Performance:** It is the intent of the Spokane County Region that the period of performance of these conditions shall commence as needed by the FIMC option chosen. Notwithstanding the foregoing, the obligations under this document shall end if any of the following occur:
- The Spokane County Region decides not to participate for the 2019 calendar year; or
 - The Spokane County Region may withdraw its determination to become a mid-adopter if the majority of the Spokane County Region's counties conclude that these conditions are not being satisfactorily addressed; or
 - CMS, HCA/DSHS and/or the Washington state legislature do not approve and authorize use of the Medicaid waiver funding as incentive dollars for the mid-adopter option; or
 - An MCO is not granted an FIMC Medicaid contract for the Spokane County Region.
11. **Termination for Convenience:** Notwithstanding the provisions of the preceding paragraph, the agreement shall also include a provision which allows Spokane County for any reason whatsoever to terminate the agreement referenced in paragraph 10 upon providing 30 days' prior written notice to HCA/DSHS.
12. **Contract:** A contract will be executed between Spokane County and HCA/DSHS which includes the conditions set forth in III of this document.
13. **Reserves: Mid-Adopter, January 1, 2019:** In the Spokane County Region's reserve plan, Spokane County, CSHCD, and SCRBHO will only be required and obligated to pay incurred inpatient claims and other incurred expenses for the time period from July 1, 2017 through December 31, 2018, and SCRBHO will be allowed to spend down all reserve funds in accordance with the respective PIHP and BHSC contracts.
14. **Reserves:** The maximum length of the reimbursement period from SCRBHO's reserves for inpatient claims and incurred expenses will not exceed eighteen (18) months.
15. **Reserves:** HCA/DSHS will retain Spokane County Region and SCRBHO's reserve funds in a separate account at the State and the reserve funds are initially used to pay all outstanding claims and invoices incurred by SCRBHO from July 1, 2017 through December 31, 2018. After the 18-month timeframe, HCA/DSHS agrees to indemnify and hold harmless Spokane County for any outstanding claims and invoices incurred by SCRBHO.
16. **Washington State Legislature Proviso Funding:** HCA/DSHS and the Governor's Office will commit to supporting Spokane County's efforts to make current annual proviso funds from the legislature labeled "Acute Care Diversion Proviso Funding" in the amount of \$1,125,000.00 into an automatic legislative budget line item. This proviso funding is currently used to fund two adult Spokane County E&T facilities. Whether this proviso funding is appropriated as it is currently, or based on an automatic legislative budget line item, to Spokane County or HCA/DSHS for this purpose, it will be made available to the selected MCOs and/or BH-ASO for this purpose only. Additionally, as part of the FIMC, no administrative fees will be taken by the MCOs and/or BH-ASO from this proviso funding.
17. **Buildings:** HCA/DSHS acknowledges that all county buildings currently owned by the Spokane County Region's counties (Adams, Ferry, Lincoln, Pend Oreille, Stevens and

Spokane), as approved through numerous state and federal audits, will remain the assets of each respective county.

18. BHO Post FIMC Obligations: Spokane County, CSHCD, and SCRBHO will not have any financial obligations to Washington State for any contractual obligations of the SCRBHO, and all liabilities will cease on January 1, 2019.
19. HCA/DSHS and all Spokane County Region's counties agree that Spokane County has the sole right to decide if Spokane County will become the Spokane County Region's BH-ASO, and that Spokane County will be the only county in the Spokane County Region to have the option of becoming the Spokane County Region's BH-ASO with regard to the FIMC implementation.
20. HCA/DSHS and all Spokane County Region's counties agree to authorize Spokane County with the sole right to rescind any decision previously made regarding Spokane County becoming the Spokane County Region's BH-ASO.
21. This condition only applies to Mid Adopter Option: HCA/DSHS commits to the Spokane County Region to change the last date for the region to rescind their decision to be the region's BH-ASO, as part of the Mid Adopter Immediate or Mid Adopter Transitional Year Option, from March 1, 2018, to sine die of the 2018 legislative session, in order for the Spokane County Region to be able to make a decision regarding adequate funding for the BH-ASO decision.
22. HCA/DSHS commits to the Spokane County Region that HCA/DSHS will eliminate the contract requirement for having a surety bond from the region's BH-ASO if Spokane County decides to become the Spokane County Region's BH-ASO.
23. HCA/DSHS commits to provide the Spokane County Region with \$2,000,000.00 for start up costs, if Spokane County decides to become the Spokane County Region's BH-ASO, and that these moneys can not only be used for start up costs but also can be utilized by the Spokane County Region's BH-ASO for inpatient and operating reserves as part of becoming the BH-ASO.
24. HCA/DSHS commits to the Spokane County Region that HCA/DSHS will require in contract(s) with the selected MCOs and BH-ASO that they provide the Spokane County Region, and any entity designated by the Spokane County Region, with the Spokane County Region's data, in a mutually agreed upon standard file format, for the purpose of storing the data for performing data analysis and developing data analytics and reports related to measuring, validating, and analyzing Spokane County Region's performance and outcomes. This MCO and BH-ASO contract requirement will include historical data and ongoing data updates (e.g. monthly), including historical data corrections, at both the aggregate data level and at the correlating de-identified lowest and most detail level of raw data, including but not limited to, service encounters, client demographics, early warning signs, authorizations, funding sources, emergency room visits, community and state hospital stays, jail arrests, housing, employment etc. at the related MCO/BH-ASO, county, agency and program levels (allowing for data slicing, dicing, and drill down capabilities based on a variety of data dimensions and attributes).



**STATE OF WASHINGTON
HEALTH CARE AUTHORITY**

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

October 6, 2017

Dear BHO Administrators:

**SUBJECT: BEHAVIORAL HEALTH – ADMINISTRATIVE SERVICES
ORGANIZATION DECISION**

Per Senate Bill 6312, which passed in 2014, the Health Care Authority (HCA) is implementing integrated managed care in Washington State by January 1, 2020. Integrated managed care will provide a holistic benefit package of medical, mental health, and substance abuse treatment services to Medicaid beneficiaries through their Apple Health managed care plan. As part of this model, HCA will contract with a Behavioral Health Administrative Service Organization (BH-ASO) in each Regional Service Area beginning January 1, 2020.

Counties have the first right of refusal to operate a BH-ASO in their region. In a multi-county region, all counties must agree to the operation of a county-based BH-ASO. If a region does not want to operate a BH-ASO, HCA will procure a contracted organization to serve this role.

HCA requests that all counties notify us by **Friday, January 12, 2017** if they would like to operate a county-based BH-ASO, or if they would like HCA to procure a BH-ASO. To notify HCA of your region's decision, please send a letter to MaryAnne Lindeblad via email at MaryAnne.Lindeblad@hca.wa.gov.

If you have decided to operate a county-based BH-ASO, but subsequently decide to reverse that decision and would like a procured BH-ASO, HCA requires nine months' notice. For 2019 implementation, the deadline to reverse the decision to operate a county-based BH-ASO is March 1, 2018. For 2020 implementation, the deadline is March 1, 2019.¹

If a region decides to procure a BH-ASO, HCA will not be able to allow a change in decision after we have released our procurement (March, 2018).

For information on the scope of the BH-ASO role, please review the HCA's recent [BH-ASO procurement](#), as well as a [sample contract](#).

The services and functions described in RFP #2253 and the sample contract represent the minimum role for this organization. The BH-ASO may also negotiate to manage or provide additional services the region, as a subcontractor of the integrated managed care plans. Examples

¹ This also does not apply for transitional counties: Okanogan and Klickitat.

of additional services could include: management of a Wraparound with Intensive Services (WISe) program, management of a Program for Assertive Community Treatment (PACT) program, specialized care management, allied system coordination, coordination of workforce development, training or capacity building activities, etc.

For more information, HCA has posted recent questions & answers on our Website, as well as fact sheets about reserves and other waiver funding available to support integration activities. If you have additional questions, please contact Isabel Jones, Integration Policy Manager by telephone at 360-725-0862 or via email at Isabel.Jones@hca.wa.gov and Alice Lind, Manager of Grants and Program Development by phone at 360-725-2053 or via email at Alice.Lind@hca.wa.gov. HCA staff are available to meet in your region to further discuss the BH-ASO decision and answer questions.

Thank you again for your continued partnership as we work to improve services for those we serve.

Sincerely,



MaryAnne Lindeblad, BSN, MPH
Medicaid Director

By email

cc: Jason McGill, Health Policy Advisor, Office of the Governor
Rick Weaver, Senior Policy Advisor, BHI, GOV
Alice Lind, Grants and Program Development Manager, MPOI, HCA
Isabel Jones, Integration Policy manager, PPP, HCA
Chris Imhoff, Director, DBHR, BHA, DSHS



The Southwest Washington Behavioral Health Administrative Service Organization

In April 2016 Clark and Skamania become the first counties in the state to provide whole-person care to Medicaid (Apple Health) clients. They will receive a full continuum of physical health, mental health and substance use disorder services within the Apple Health program. The majority of these services will be provided through managed care organizations (MCOs) and the Washington State Health Care Authority (HCA), which purchases health care services for Medicaid clients.

Some services in this community, such as response services for individuals experiencing a mental health crisis, must be available to all individuals in Southwest Washington regardless of their insurance status or income level. For this reason, the HCA will have a contract with an organization known as a Behavioral Health Administrative Service Organization (BH-ASO) to provide these services in Clark and Skamania counties.

How is a BH-ASO different from a Behavioral Health Organization (BHO)?

The HCA and the Department of Social and Health Services (DSHS) purchase physical and behavioral health services along boundaries known as regional service areas (RSAs). There are 10 RSAs across the state. In every region except Southwest Washington, Medicaid beneficiaries will receive their specialty mental health services and substance use disorder services through an organization known as a Behavioral Health Organization (BHO).

In these regions, the BHOs will also operate the mental health crisis system and be responsible for some of the same administrative functions as the BH-ASO.

Southwest Washington has elected to pursue a different model, in which most Medicaid services, including physical health, mental health and substance use disorder services, will be provided through an Apple Health plan.

Unlike the BHO, the BH-ASO is not responsible for the full continuum of behavioral health services for the Medicaid population. The BH-ASO is only responsible for a subset of crisis-related services for Medicaid clients, and is responsible for providing limited services to individuals who are not eligible for Medicaid, as well as managing certain administrative functions.

Fact sheet produced by the Washington State Health Care Authority, November 2015

Healthier Washington is Governor Inslee's multi-sector partnership to improve health, transform health care delivery, and reduce costs. The Health Care Authority provides strategic oversight for this initiative.

For more information on BHOs, please visit: www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery/developing-behavioral-health-organizations .

What services will the BH-ASO provide to anyone in the region, regardless of insurance status?

Certain services must be available to anyone in Southwest Washington, regardless of their insurance status or income level. The following services may be provided by the BH-ASO to anyone in the region who is experiencing a mental health or substance use disorder crisis:

- A 24/7/365 regional crisis hotline to triage, refer and dispatch calls for mental health and substance use disorder crises;
- Mental health crisis services, including the dispatch of mobile crisis outreach teams staffed by mental health professionals and certified peer counselors;
- Short-term substance use disorder crisis services for people intoxicated or incapacitated in public;
- Designated Mental Health Professionals (DMHPs) who can apply the Mental Health Involuntary Treatment Act, available 24/7 to conduct Involuntary Treatment Act assessments and file detention petitions;
- Chemical dependency specialist who can apply the substance use disorder involuntary commitment statute, including services to identify and evaluate alcohol and drug involved individuals who may need protective custody, detention, etc. The chemical dependency specialist will also manage case findings and legal proceedings for substance use disorder involuntary commitment cases.

What services will the BH-ASO provide only to people who are low income, uninsured, and not eligible for Medicaid?

The BH-ASO may provide certain mental health and substance use disorder services to people who are not enrolled in or otherwise eligible for Medicaid. For some services, like services funded through the federal Substance Abuse Prevention and Treatment (SAPT) block grant, individuals may need to meet other priority population requirements to be considered eligible.

The BH-ASO may provide the following services to individuals who are not eligible for Medicaid:

- Mental health evaluation and treatment services for individuals who are involuntarily detained or agree to a voluntary commitment;
- Residential substance use disorder treatment services for individuals involuntarily detained as described in state law;

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

- Outpatient mental health or substance use disorder treatment services, in accordance with a Less Restrictive Alternative court order;
- Within available resources, the BH-ASO may provide non-crisis behavioral health services, such as outpatient substance use disorder and/or mental health services or residential substance use disorder and/or mental health services, to low-income individuals who are not eligible for Medicaid and meet other eligibility criteria.

What other administrative functions will the BH-ASO manage in the region?

- Provide a Behavioral Health Ombudsman to assist individuals with grievances and appeals;
- Manage the mental health block grant based on the locally approved mental health block grant plan;
- Manage Criminal Justice Treatment Account (CJTA) funds and Juvenile Drug Court funds based on CJTA panel's plans for Clark and Skamania counties.

Learn more about the plan to integrate physical and behavioral health at the Healthier Washington website: www.hca.wa.gov/hw/Pages/integrated_purchasing.aspx.

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

REQUEST FOR PROPOSALS (RFP)

RFP NO. 2253

PROJECT TITLE: Behavioral Health-Administrative Service Organization (BH-ASO) Mid-Adopter

PROPOSAL DUE DATE: May 10, 2017 by 2:00 p.m. *Pacific Time*, Olympia, Washington, USA.

Faxed bids will not be accepted.

ESTIMATED TIME PERIOD FOR CONTRACT: January 1, 2018 to December 31, 2019

The Health Care Authority reserves the right to extend the contract for up to two additional years in increments of one (1) month to twenty-four (24) months.

BIDDER ELIGIBILITY: This procurement is open to those Bidders that satisfy the minimum qualifications stated herein and that are available for work in Washington State.

1. INTRODUCTION

1.1. PURPOSE AND BACKGROUND

The State Health Care Innovation Plan, Healthier Washington, and E2SSB 6312, passed by the Washington State legislature in 2014, provide policy direction for Washington State to regionalize Medicaid purchasing and provide Medicaid beneficiaries with the full continuum of physical health and behavioral health (i.e., mental health and Substance Use Disorder [SUD]) treatment services through managed care by 2020. This program is known as “Apple Health- Integrated Managed Care” (IMC) and is implemented through contracts between the Health Care Authority (HCA) and Medicaid Managed Care Organizations (MCOs), with MCOs at risk for the full continuum of physical and behavioral health services for Medicaid beneficiaries (RCW 71.24.850).

County Authorities are required to submit a binding letter of intent to HCA if they plan to implement IMC prior to 2020. Grant, Chelan and Douglas counties, forming the North Central Regional Service Area (RSA), submitted letters declaring their intent to move forward by January 1, 2018.

Through a separate procurement ([RFP1812](#)), released by HCA on February 16, 2017, MCOs will be selected to provide integrated behavioral health and physical health services to all Medicaid enrollees in the North Central RSA. Each MCO selected through RFP1812 will be awarded both a Medicaid contract and a non-Medicaid contract with HCA in order to furnish the full continuum of services available to Medicaid enrollees. All MCOs selected through RFP1812 will be required to Contract with the Behavioral Health-Administrative Service Organization (BH-ASO) selected under this procurement, for the provision of services for their enrollees.

This RFP, is being released for the purpose of procuring a BH-ASO in North Central RSA that will perform all services listed herein, which includes some services in conjunction with the accompanying regional MCO procurement. The Contractor awarded under this procurement shall provide services as listed below.

1.2. OBJECTIVES AND SCOPE OF WORK

1.2.1. HCA is seeking an ongoing partnership with an organization that demonstrates innovative models to provide care that can meet the needs of a complex, high-risk population with behavioral health conditions. The objectives of this program are to.

- 1.2.1.1.** Operate as part of continuum of integrated services, with deep connections to community resources and in seamless partnership with North Central’s IMC plans selected under RFP1812;
- 1.2.1.2.** To the extent possible within Available Resources, operate an integrated behavioral health crisis response system that serves the entire North Central RSA, rather than a fragmented mental health crisis/Involuntary Treatment Act (ITA) system and a separate SUD/Involuntary Commitment system;
- 1.2.1.3.** Demonstrate the ability to apply a recovery and resiliency-oriented philosophy and clinical design aimed at producing tangible, improved outcomes;
- 1.2.1.4.** Develop appropriate coordination across the continuum of care and improve access to care for high needs enrollees by linking the crisis response system, community resources, and clinical services;

- 1.2.1.5. Maintain a network capable of ensuring access and continuity of all contracted services within the RSA;
- 1.2.1.6. Provide seamless transitions as Consumers move across systems of care, based on the Consumer's needs and rights; and;
- 1.2.1.7. Partner with the Accountable Community of Health (ACH) and MCOs to meet the goals and objectives of the Regional Health Improvement Plan and improve the health and well-being of RSA residents.

1.2.2. Services for Medicaid and non-Medicaid Consumers.

The BH-ASO will be responsible for the following services for all Consumers in need of services in the North Central RSA, including Medicaid beneficiaries:

- 1.2.2.1. Maintenance of a 24/7/365 regional crisis hotline, accessible to all Consumers regardless of insurance status, income level, ability to pay, or residence;
- 1.2.2.2. Provision of mental health crisis services, including dispatch of a mobile crisis outreach team staffed by mental health professionals and/or Designated Mental Health Professionals (DMHPs) and certified peer counselors;
- 1.2.2.3. Administration of the ITA (Chapters 71.05 and 71.34 RCW), including:
 - 1.2.2.3.1. Reimbursing the county for court costs associated with ITA;
 - 1.2.2.3.2. 24/7 availability of DMHPs to conduct assessments and emergency detentions; and
 - 1.2.2.3.3. 24/7 availability of DMHPs to file petitions for detentions and provide testimony for ITA services.
- 1.2.2.4. Administration of the chemical dependency ITA in accordance with RCW 70.96A.120 and RCW 70.96A.140, including the availability of a Designated Chemical Dependency Specialist (DCDS) to:
 - 1.2.2.4.1. Provide services to identify and evaluate alcohol and drug involved Consumers requiring protective custody, detention, or involuntary commitment services; and
 - 1.2.2.4.2. Manage the case finding, investigation activities, assessment activities, and legal proceeding associated with CD ITA cases.
- 1.2.2.5. Provision of SUD crisis services on a short term basis to intoxicated or incapacitated Consumers in public, including:
 - 1.2.2.5.1. General assessment of the Consumer's condition;
 - 1.2.2.5.2. Interview for diagnostic or therapeutic purposes; and
 - 1.2.2.5.3. Transportation home or to an approved treatment facility.
- 1.2.2.6. Operation of a behavioral health Ombudsman.
- 1.2.2.7. Manage the administration of the Mental Health Block Grant (MHBG) and the Substance Abuse Prevention and Treatment (SAPT) Block Grant, in accordance

with the local block grant plans, as approved by the regional Community Behavioral Health Advisory Board;

1.2.2.8. Manage the administration of the Criminal Justice Treatment Account (CJTA) funds in accordance with the North Central RSA CJTA panel plan; and

1.2.2.9. Manage the administration of state dollars and designated funding sources.

1.2.3. Services that must be available to non-Medicaid Individuals

Certain services must also be provided to Consumers who are not eligible for Medicaid, the awarded Contractor will provide the following additional services on a regional basis for non-Medicaid Consumers:

1.2.3.1. Evaluation and Treatment (E&T) services, for individuals detained in accordance with RCW 71.05 and RCW 71.34 and pursuant to court order;

1.2.3.2. Residential SUD treatment services, for individuals detained in accordance with RCW 70.96A.140; and

1.2.3.3. Outpatient mental health or SUD treatment services, in accordance with a Less Restrictive Alternative (LRA) court order and monitoring compliance with LRA court orders (RCW 71.05.320).

After prioritization of funds for services described in this section, the awarded Contractor also has discretion to provide non-crisis behavioral health services to low-income individuals (under 220% of the Federal Poverty Level) who are uninsured and not eligible for Medicaid. The awarded Contractor is expected to prioritize the use of Available Resources for non-crisis services on SAPT block grant priority populations or on populations that have excessively utilized crisis services, emergency department services due to a mental health condition or SUD, detoxification services, or sobering services, as identified in Attachment 1, Draft Sample BH-ASO Contract.

1.2.4. Other new aspects of the program include the following:

1.2.4.1. Consent to Release

Before any SUD treatment is disclosed, the awarded Contractor or contracted providers must ensure they have a current Consumer (or legal guardian) signed consent to release the information. Notices must include a disclosure of information concerning a Consumer in alcohol/drug treatment. This information from records is protected by federal confidentiality rules, 42 C.F.R. Part 2. The federal rules prohibit the awarded Contractor from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

1.2.4.2. Integrated Managed Care Partnership

Each MCO contracted through RFP1812 is required to subcontract with the awarded Contractor, for the provision of crisis services to their enrollees. If a MCO's enrollee is placed on a Less Restrictive Alternative (LRA) court order, the MCO is responsible for monitoring compliance and offering mental health services in compliance with the LRA requirements, per RCW 71.05.320. Additionally, if an involuntary detention ensues from contact with the crisis system and a MCO's enrollee is detained to a free-standing Evaluation and Treatment facility, a hospital-based evaluation and treatment bed, or SUD

residential treatment, the MCO is responsible for the provision of all services as ordered by the court. MCOs are also responsible for ensuring medically necessary crisis diversion and crisis stabilization services are available to their enrollees.

The awarded Contractor and MCOs are expected to operate in very close coordination with one another and may need to establish data-sharing agreements to monitor the needs and utilization of any Medicaid enrollee who accesses a crisis service through the awarded Contractor, and to provide notification of eligibility changes for Consumers whose Medicaid eligibility changes frequently (e.g. spend-down population, etc.). Additionally, the awarded Contractor is expected to coordinate with the statewide foster care MCO in the event that a foster child in the North Central RSA accesses crisis services.

1.2.4.3. Accountable Community of Health Partnership

As part of the Healthier Washington initiative and authorized in E2SHB 2572, Accountable Communities of Health (ACHs) are designated and operational in all Regional Service Areas. ACHs are groups of leaders from a variety of sectors in given geographic areas with a common interest in improving health and health equity. The North Central ACH has been designated as a formal ACH, and has begun a Whole Person Care Collaborative targeting primary care. The RFP1812 selected MCOs and the awarded Contractor are expected to participate in the regional ACH and coordinate closely with ACH partners on regional health improvement strategies.

1.2.4.4. Criminal Justice Treatment Account

In Integrated Managed Care regions, HCA will contract with the awarded Contractor for the administration of Criminal Justice Treatment Account (CJTA) funds. The CJTA funding amounts are provided in Attachment 1, Draft Sample BH-ASO Contract. Under RCW 70.96.A.350, each county must have an established CJTA panel that creates a local CJTA plan to determine how the CJTA funds will be distributed. The plan must be approved by the county legislative authorities and the state CJTA panel, and submitted to the awarded Contractor for implementation. The local CJTA panels will consist of:

- 1.2.4.4.1. County alcohol and drug coordinator;
- 1.2.4.4.2. County prosecutor;
- 1.2.4.4.3. County sheriff;
- 1.2.4.4.4. County superior court;
- 1.2.4.4.5. Substance use treatment provider appointed by the county authority;
- and
- 1.2.4.4.6. Representative of the county drug court (where there is a drug court).

While the awarded Contractor is not required to participate directly in the activities of the local CJTA panels, the awarded Contractor is required to administer the funds in accordance with direction provided in the local CJTA plan, which may provide details such as: target high-risk populations for service prioritization, preferred providers, or required contracting for the provision of drug court coordinators.

1.2.4.5. Federal Block Grants

The Department of Social and Health Services (DSHS) is a grantee of the Substance Abuse and Mental Health Service Administration (SAMSHA) Mental Health Block Grant (MHBG), and the Substance Abuse Prevention and Treatment (SAPT) Block Grant. Currently, these federal block grants are contracted between DSHS and the Behavioral Health Organizations (BHOs), in regions other than Southwest Washington. In North Central, HCA will contract with the awarded Contractor for the administration of the MHBG and SAPT, and provide the awarded Contractor the allocation of block grants for the North Central region. The federal block grant funding levels are included in Exhibit I, Non-

Medicaid Funding Allocation. The block grants must be administered in accordance with the annual block grant plans, which are approved annually by a Community Behavioral Health Advisory Board (a board within the ACH) and subsequently approved by the state. Sample block grant plans are attached as Exhibit G, Sample Mental Health Block Grant Plan and H, Sample Substance Abuse Block Grant Plan. The awarded Contractor is required to participate in local block grant planning and priority setting as well as the local Community Behavioral Health Advisory Board (BHAB) which must endorse annual block grant project plans.

1.3. MINIMUM QUALIFICATIONS

The following are the minimum qualifications for bidders:

- 1.3.1. Licensed to do business in the state of Washington;
- 1.3.2. Submit a Letter of Intent to Propose by the March 31, 2017 deadline in order to submit a response to this RFP;
- 1.3.3. Bidder must be willing and able to obtain a surety bond if requested.
 - 1.3.3.1. It is HCA's position, and as noted in the sample contract that the ASB cannot be subject to Title 48 RCW and will not be subject to regulation by the Washington State Office of the Insurance Commissioner (OIC);

1.4. FUNDING

1.4.1. Any contract awarded as a result of this procurement is contingent upon the availability of funding to HCA. In its sole discretion, HCA will determine whether the required amount of funding is available.

1.4.2. Funding

A maximum level of available funding for the Regional Service Area (RSA) will be determined by HCA and the awarded Contractor will receive monthly payments of state funds, and monthly allocations of federal block grant funds. The estimated allocation is provided in Exhibit I, Non-Medicaid Funding Allocation.

1.5. PERIOD OF PERFORMANCE

The period of performance of any contract resulting from this RFP is tentatively scheduled to begin on or about January 1, 2018 and to end on December 31, 2019. Amendments extending the period of performance, if any, will be at the sole discretion of HCA.

HCA intends that the Contracts awarded as the result of this RFP will be aligned with the changes to the Apple Health Managed Care contract, as appropriate to this program. Any changes made to the Apple Health Managed Care contract will be reviewed by HCA for inclusion into the FIMC Medicaid Contract. Behavioral health benefits may also be updated for parity and alignment with changes in state or federal law or funding.

1.6. CONTRACTING WITH CURRENT OR FORMER STATE EMPLOYEES

Specific restrictions apply to contracting with current or former state employees pursuant to chapter 42.52 of the Revised Code of Washington. Bidders should familiarize themselves with the requirements prior to submitting a proposal that includes current or former state employees.

Medicaid Enrollees

Crisis Response Organization Responsible For:

Managed Care Plan Responsible For:

- **Regional Crisis Hotline**
 - Staffed by live person 24/7/365
 - Provides initial triage/documents calls and outcomes
- **Mobile Crisis Outreach Team**
 - Team staffed by MHPs (CDPs on call) who respond to crises, assess for mental health/drug related issues, provide initial stabilization, and refer to appropriate services (DMHP or other)
- **DMHPS (funded by GF-S only)**
 - Must be available 24/7 to conduct evaluation of need for emergency detention or to determine if person will receive appropriate care from triage facility or stabilization unit
 - File petitions for detentions
- **ITA Costs (funded by GF-S only)**
 - Testimony for ITA services
 - Reimburse county for Court costs associated with ITA

- **Crisis Stabilization Services**
 - Available 24/7; often referred to as hospital diversion
 - Typically managed by specific programs, apart from initial/emergent crisis services
 - Services provided for up to 14 days by an MHP, CDP or DMHP to individuals experience a mental health crisis, in the persons home or a home-like setting including:
 - Face-to-face assistance with life skills & medication management; follow up to crisis
- **Evaluation and Treatment Services**
 - Services provided in freestanding inpatient residential facilities or community hospitals to provide medically necessary evaluation and treatment services, including:
 - Evaluation, stabilization and treatment under direction of psychiatrist, nurse or other MHPs; discharge planning; nursing care; and clinical treatment including: individual an family therapy, milieu therapy, psycho-educational groups, pharmacology .
- **E&T Room and Board Costs (GF-S only)**
- **All other urgent and routine physical/behavioral health services**

Crisis Response Organization State-only Funds provide the following services to non-Medicaid individuals:

- **Regional Crisis Hotline**
 - Staffed by live person 24/7/365
 - Provides initial triage/documents calls and outcomes
- **Mobile Crisis Outreach Team**
 - Team staffed by MHPs (CDPs on call) who respond to crises, assess for mental health/drug related issues, provide initial stabilization, and refer to appropriate services (DMHP or other)
- **DMHPS**
 - Must be available 24/7 to conduct evaluation of need for emergency detention or to determine if person will receive appropriate care from triage facility or stabilization unit
 - File petitions for detentions
- **ITA Costs (funded by GF-S only)**
 - Testimony for ITA services
 - Reimburse county for Court costs associated with ITA
- **Crisis Stabilization Services**
 - Available 24/7; often referred to as hospital diversion
 - Typically managed by specific programs, apart from initial/emergent crisis services
 - Services provided for up to 14 days by an MHP, CDP or DMHP to individuals experience a mental health crisis, in the persons home or a home-like setting including:
 - Face-to-face assistance with life skills & medication management; follow up to crisis
- **Evaluation and Treatment Services**
 - Services provided in freestanding inpatient residential facilities or community hospitals to provide medically necessary evaluation and treatment services, including:
 - Evaluation, stabilization and treatment under direction of psychiatrist, nurse or other MHPs; discharge planning; nursing care; and clinical treatment including: individual an family therapy, milieu therapy, psycho-educational groups, pharmacology .
- **E&T Room and Board Costs**

Which services would the Crisis Response Organization manage for Medicaid/Non-Medicaid individuals and how are they funded?

Medicaid Enrollee

Non-Medicaid Individual

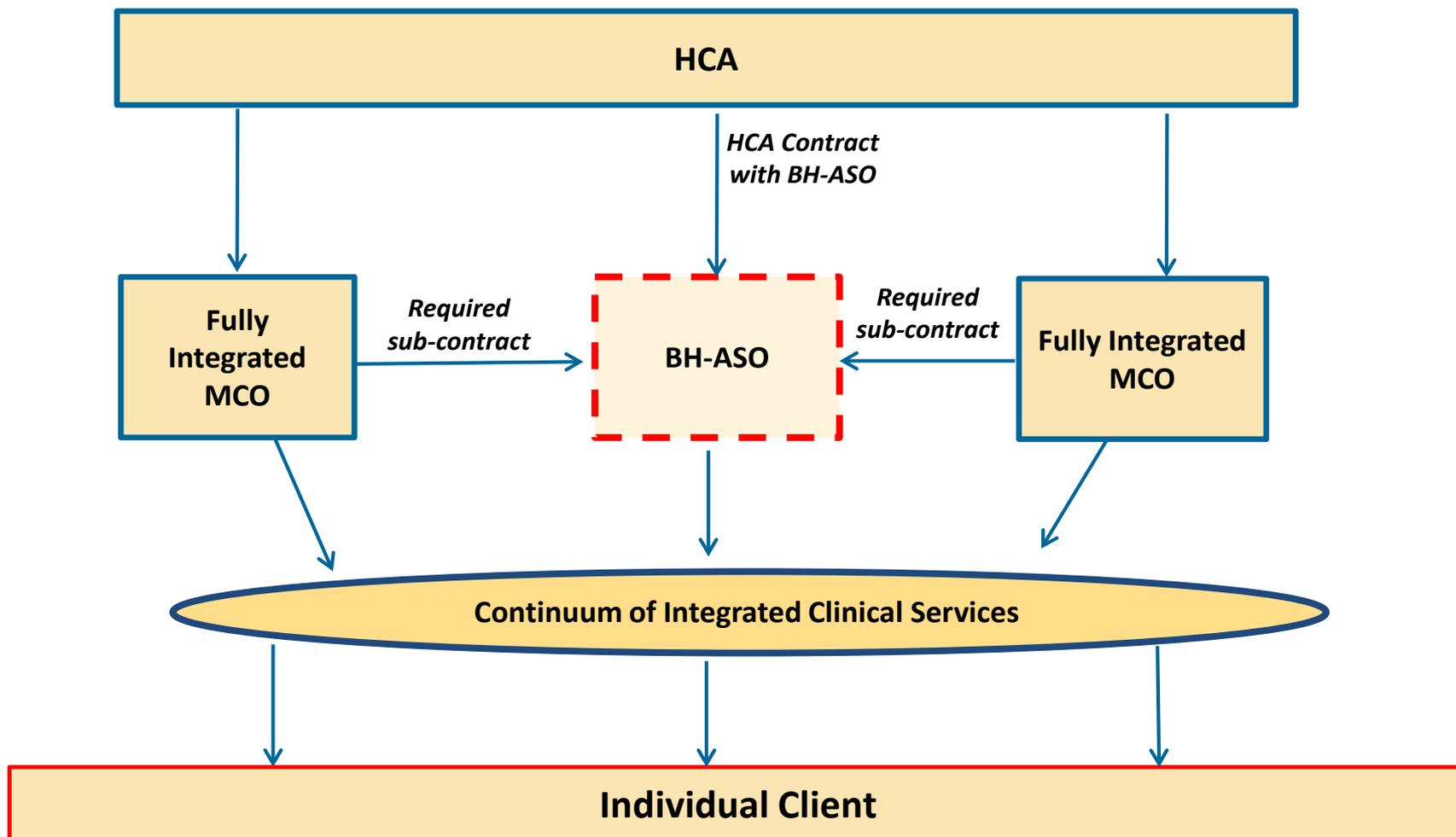
Medicaid Funded Service	State-Funded Service
<p>Regional Crisis Hotline</p> <ul style="list-style-type: none"> Staffed by live person to do triage 24/7 <p>Mobile Crisis Outreach Team</p> <ul style="list-style-type: none"> Staffed by MHPs who respond to crises, assess, initially stabilize, and refer. Available 24/7. CDPs available. 	<p>Cost Associated with Involuntary Treatment Act (involuntarily detaining someone for a mental health crisis)</p> <ul style="list-style-type: none"> Testimony for ITA services , reimburse county for Court costs ,DMHPs available 24/7 to conduct an evaluation and file petitions for involuntary detention.
	<p>Regional Crisis Hotline</p> <ul style="list-style-type: none"> Staffed by live person to do triage 24/7 <p>Mobile Crisis Outreach Team</p> <ul style="list-style-type: none"> Staffed by MHPs who respond to crises, assess, initially stabilize, and refer. Available 24/7. CDPs available. <p>ITA-Associated Costs</p> <ul style="list-style-type: none"> Court costs, testimony for ITA services, DMHPs available 24/7 to assess and file petitions <p>Crisis Stabilization Services**</p> <ul style="list-style-type: none"> 14 day crisis diversion programs <p>Evaluation and Treatment Services**</p> <ul style="list-style-type: none"> Evaluation and treatment services/room and board costs provided in E&T facilities following involuntary detention

** Medicaid enrollees will also have access to crisis stabilization and E&T services, however MCOs will contract directly for those “secondary” and longer term services for their members.

What services will the MCOs manage?

- All Medicaid benefits will continue to be defined by the State Plan
- Fully-Integrated Managed Care Plans will provide all Medicaid physical, mental health, and substance use disorder (SUD) services
- Fully-Integrated Managed Care plans will also provide services to Medicaid enrollees that complement the Medicaid benefit package, funded by general state funds and federal block grants
 - ❖ Examples of these services include: services provided in Institutes for Mental Disease (IMD) interim SUD services, community outreach.
- Plans must have an adequate provider network in place before enrollment begins

How will the crisis system be managed?



Additional Functions of BH-ASO

- Monitor Less Restrictive Alternative (LRA) court orders for individuals who are not eligible for Medicaid
- Maintain a Behavioral Health ombudsman for SW Region
- Administer the Mental Health Block Grant, CJTA Funds & Juvenile Drug Court funds, in accordance with local plans
- Provide limited non-crisis behavioral health services to low-income individuals who are not eligible for Medicaid

Olympic Community of Health

Portfolio Summary

Approved by the Board of Directors, September 11, 2017

The purpose of this document is to provide a summary of the OCH Demonstration Portfolio as of September 2017. The selection of specific evidence-based programs will undergo ongoing development until November 2017.

Portfolio Summary

Project	Timeline	Evidence-Base	Rationale	Baseline Assessment
2A. Bi-Directional Integration	Board voted FLAGSHIP 7.10.17 *Required*	Bree Collaborative; Collaborative Care Model; Millbank Report	Required. High need. Strong willingness.	Mental health treatment penetration: OCH 44% vs. State 43% SUD treatment penetration: OCH 28% vs. State 27% Anti-depression Rx Management (acute): OCH 53% vs. State 52% Anti-depression Rx Management (cont.): OCH 36% vs. State 33%
3.A. Opioid Response	Board voted FLAGSHIP 7.10.17 *Required*	State's Interagency Plan; Six Building Blocks; CDC guidelines; AMDG guidelines	Required. High need. Strong willingness.	Medication assisted therapy OCH 17% vs. State 27% Patients on high dose chronic opioid Rx OCH 20% vs. State 20%
2.D. Diversion	Board voted FLAGSHIP 7.10.17 8.14.17 9.11.17	ER is for emergencies; Community health workers in ED and jails; Community paramedicine; Law enforcement-assisted diversion	Low performers in ED utilization. Opportunity for workforce development.	Outpatient ED visits/1000 MM (18yo+) OCH 89 vs. State 68 Outpatient ED visits/1000 MM (< 18 yo) OCH 46 vs. State 37 Percent arrested OCH 6% vs. State 7%
3.D. Chronic Disease	Board voted FLAGSHIP 7.10.17	Chronic Care Model; Stanford Chronic Disease Self-Management; Diabetes Prevention Program; Asthma home visiting/healthy homes	Emphasis on practice transformation. Strong willingness from clinical and non-clinical providers. Good preparation for value-based contracting.	Diabetes care: nephropathy OCH 83% vs. State 86% Diabetes care: HbA1c OCH 83% vs. State 84% Med Management for asthma OCH 29% vs. State 28%

<p>Domain 1. Population Health Management/I. T.</p>	<p>Board voted to pilot Apple Integrator 7.10.17 9.11.17</p>	<p>Cloud-based e-referral and eventually care coordination system. Focus on care coordination between healthcare providers and substance use treatment providers to support people with opioid use disorder.</p>	<p>Create a community health shared information network. Supports entire portfolio. Right-sized and can be scaled. Address information chasm between substance use treatment and medical providers.</p>	<p>Not applicable</p>
<p>3B. Maternal, Child, and Reproductive Health</p>	<p>Board voted 8.14.17</p>	<p>Bright Futures</p>	<p>Focus on prevention. Good preparation for value-based contracting. Opportunity to move the measures.</p>	<p>Childhood immunization status OCH 10% vs. State 12% Chlamydia screening OCH 49% vs. State 51% Contraceptive care – access to LARC OCH 7% vs. State 8% Contraceptive care – access to effective methods OCH 33% vs. State 31% Prenatal care in first trimester OCH 63% vs. State 65%</p>
<p>3C. Access to Oral Health Services</p>	<p>Board voted 8.14.17</p>	<p>Expansion of FQHC dental; Dental hygiene services in long term care settings; Expansion of school based clinics; Oral-primary care integration</p>	<p>Strong community interest. Strong community need. Project partners can deliver.</p>	<p>Dental sealants for high-risk kids (6-9yo) OCH 43.2% vs. State 37.9% Dental sealants for high-risk kids (10-14 yo) OCH 17.8% vs. State 14.7% Primary caries prevention as part of well child visit OCH 0.1% vs. State 0.4%</p>

Ten things to know about the Medicaid Transformation Demonstration

On January 9, 2017, the Centers for Medicare & Medicaid Services (CMS) approved a Section 1115 Medicaid waiver, known in Washington State as the Medicaid Transformation Demonstration. This five-year contract with CMS authorizes up to \$1.5 billion in federal investments to promote innovative, sustainable and systemic changes that improve the overall health of Washingtonians.

Here are the ten things you need to know:

1. The Demonstration is a part of the Health Care Authority's Healthier Washington initiative.
2. The Demonstration's goals over the next five years are to:
 - Integrate physical and behavioral health
 - Convert 90 percent of Medicaid provider payments to reward quality of care
 - Improve health equity so all can benefit
 - Increase and improve services that support our aging population
3. The Demonstration is divided into three, inter-dependent initiatives:
 - Initiative 1: Transformation through Accountable Communities of Health (ACH)
 - Initiative 2: Long-term Services and Supports (LTSS) for the aging population
 - Initiative 3: Foundational Community Support Services (FCS)
4. Under Initiative 1, ACHs will work with community partners on four to eight regionally critical projects that will improve population health and transform the way health care is provided.

An independent assessor will review regional project plan applications, and make recommendations to support project approval. The state will work with the independent assessor to develop a project plan review tool.
5. Project funding is triggered by the achievement of community health milestones, which are laid out in the project plans. Funds will be disbursed through a financial executor.
6. The state will engage and coordinate with tribal governments to assess Demonstration impacts.
7. Long-term Services and Supports includes services to assist unpaid caregivers such as, training, education, specialized medical equipment, and assistance. It also provides a personal care benefit for anyone who does not have a caregiver.
8. Foundational Community Support Services assists clients with complex needs with finding and maintaining stable housing and employment.
9. At the end of five years, an independent party will conduct an evaluation to verify that the initiatives are sustainable.
10. Demonstration activities will not require new funding from the state's General Fund.

Fact sheet revised by the Washington State Health Care Authority, October 2017

Community Based Care Coordination Project – The “HUB”

Synopsis

Rationale: Care coordination is essential for ensuring that children and adults with complex health service needs are connected to the evidence-based interventions and services that will improve their outcomes. Appropriately coordinated care is especially important for high-risk populations, such as those living with chronic conditions, those impacted by the social determinants of health such as unstable housing and/or food insecurity, the aging community, and those dependent on institutionalized settings. Communities are challenged to leverage and coordinate existing services, as well as establish new services to fill gaps. Without a centralized approach to “coordinating the coordinators,” a single person might be assigned multiple care coordinators who are unaware of one another, potentially provide redundant services, and risk creating confusion for the individual.

Description: A hub-based care coordination model provides a platform for communication among multiple care coordination resources, so that each is able to work to the maximum benefit of the individual in a more coordinated fashion. In addition to improving communication across multiple care coordination resources, a centralized approach allows for standardization of evidence-based care coordination protocols across various providers of care coordination services. Under this approach, care coordination resources remain available in multiple organizations and settings, but are working in a more consistent way as a team. This project is built on the elements of an evidence-based model for establishing a model for care coordination that includes adoption of standardized requirements, and establishment of centralized processes, systems, and resources to allow accountable tracking of those being served, and a method to tie care coordination work products or units to payments and to outcomes.

Population: Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as, serious mental illness, moderate to severe substance use disorder, HIV, birth defects, cancer, diabetes, depression, heart disease and stroke) and at least one risk factor (e.g., obesity, unstable housing, food insecurity, high EMS utilization).

Approach: This project is essentially offering a single model: the Pathways Hub Care Coordination model. A graphic depiction of this model is below:

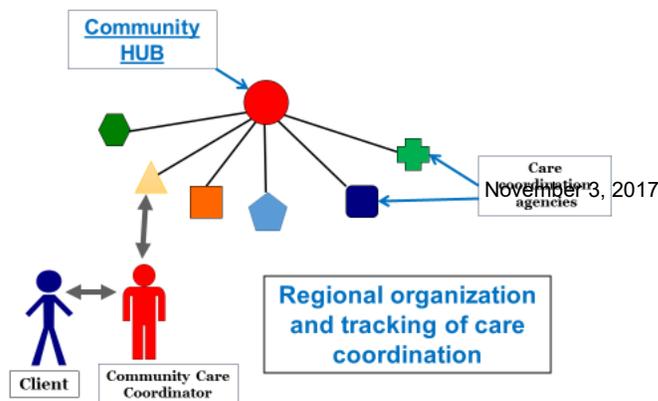


Image is from presentation from Dr. Sarah Redding, co-developer of the Pathways Model, 12/6/2016

Complete this survey to score all six optional projects: <https://www.surveymonkey.com/r/PBVB89Y>

Transitions of Care

Synopsis

Rationale: Transitional care services provide opportunities to eliminate avoidable admissions and readmissions to the hospital and avoidable incarcerations in the jail. While some readmissions are appropriate, many are due to potentially avoidable events. Individuals discharged from the hospital may not have a stable environment to return to or may lack access to reliable care. Transitions can be especially difficult on patients and their caregivers when there are substantial changes in medications or routines or an increase in care tasks. One population particularly at-risk for disruptions in care and barriers to (re)engaging with care are people incarcerated in prison or jail. This project includes multiple care management and transitional care approaches. The OCH must select at least one.

Description: Transitional care services out of intensive settings (like a hospital) of care or institutional settings (like a jail) in order to reduce potentially avoidable events.

Population: Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with serious mental illness discharged from inpatient care, or client returning to the community from prison or jail.

Sample Approaches:

1. Interventions to Reduce Acute Care Transfers, [INTERACT™4.0](#), a quality improvement program that focuses on the management of acute change in resident condition
2. [Transitional Care Model \(TCM\)](#), a nurse led model of transitional care for high-risk older adults that provides comprehensive in-hospital planning and home follow-up
3. The [Care Transitions Intervention® \(CTI®\)](#), a multi-disciplinary approach toward system redesign incorporating physical, behavioral, and social health needs and perspectives. Note: The Care Transitions Intervention® is also known as the Skill Transfer Model™, the Coleman Transitions Intervention Model®, and the Coleman Model®.
4. [Care Transitions Interventions in Mental Health](#), provides a set of components of effective transitional care that can be adapted for managing transitions among persons with serious mental illness (SMI)
5. Evidence-informed Approaches to Transitional Care for People with Health and Behavioral Health Needs Leaving Incarceration



A health coach works goes over medications and discharge instructions in the patient's home following a hospital visit.

Photo from Area Agency on Aging Lower Rio Grand Valley

Complete this survey to score all six optional projects: <https://www.surveymonkey.com/r/PBVB89Y>

Diversion Interventions

Synopsis

Rationale: Diversion strategies provide opportunities to re-direct individuals away from high-cost medical and legal avenues and into community-based health care and social services that can offer comprehensive assessment, care/case planning and management to lead to more positive outcomes. The sample approaches offered below promote appropriate use of emergency care services and also support person-centered care through increased access to primary care and social services, especially for medically underserved populations.

Description: There are three diversion approaches recommended under this project (see below). The OCH must select at least one.

Population:

Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

Sample Approaches:

1. [Emergency Department \(ED\) Diversion](#), a systematic approach to re-directing and managing persons who present at the ED for non-emergency conditions, which may be oral health, general physical health, and/or behavioral health conditions.
2. [Community Paramedicine Model](#), an evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations.
3. [Law Enforcement Assisted Diversion, LEAD](#)[®], a pre-booking approach to redirect low-level offenders engaged in drug or prostitution activity to community-based services, instead of jail and prosecution. The goal is to improve public safety and public order, and reduce the criminal behavior of people who participate in the program.



*Community paramedic programs are popping up all over the Washington State. This photo is from a new program in Bellingham, WA.
Photo from City of Bellingham webpage*

Complete this survey to score all six optional projects: <https://www.surveymonkey.com/r/PBVB89Y>

Maternal and Child Health

Synopsis

Rationale: Providing mothers and their children with home visits and ongoing access to care has been demonstrated to improve maternal and child health. Child health promotion is a state priority to keep children as healthy and safe as possible, which includes parents accessing timely and routine preventative care for children, especially well-child screenings and assessments. Additionally, maternal and child health is a primary focus for the Medicaid program as Medicaid funds more than half of the births in the state and provides coverage to more than half of Washington’s children.

Description: Home visitors work with the expectant or new mother in supporting a healthy pregnancy, by recognizing and reducing risk factors, promoting prenatal health care through healthy diet, exercise, stress management, ongoing well-woman care, and by supporting positive parenting practices that facilitate the infant and young child’s safe and healthy development. This project will ensure that women access ongoing well women care and improve utilization of effective family planning strategies through implementation of the CDC’s recommendations to improve women’s health before a first, or subsequent, pregnancy.

Population: Medicaid beneficiaries who are women of preconception age, Pregnant Women, Mothers of children ages 0-2, and children ages 0-17.

Sample Approaches:

1. Evidence-based home-visiting models for pregnant high risk mothers such as [Nurse Family Partnership](#) and [Early Health Start Home-Based Model](#)
2. Promising practice to improve well-visit rates for children such as Bright Futures
3. Implementation of [recommendations](#) to improve preconception health and health care.



Jefferson County Board of Health Honors 2015 Public Health Heroes, including Jefferson County Nurse-Family Partnership
<http://www.jeffersoncountypublichealth.org/index.php?public-health-heroes>

Complete this survey to score all six optional projects: <https://www.surveymonkey.com/r/PBVB89Y>

Oral Health Access

Synopsis

Rationale: Oral health impacts overall health and quality life, and most oral disease is preventable. Oral disease has been referred to as a “silent epidemic” and has been associated with increased risk for serious adverse health outcomes. Increasing access to oral health services for adults provides an opportunity to prevent or control the progression of oral disease, and to reduce reliance on emergency departments for oral pain and related conditions. While many initiatives have addressed the oral health needs of children during crucial preventive windows, less attention has been paid to increasing access to oral health services for adults.

Description: This project focuses on enhancing access to dental services, improving continuity of care, improving coordination of services, incenting use of appropriate service locations, and fostering integration of service siloes. The toolkit focuses on providing oral health screening and assessment, intervention, and referral in the primary care setting, or through the deployment of mobile clinics and/or portable equipment. However, we encourage people to think broader, such as piloting value-based payment models in the dental care setting and greatly broadening access to dental care for adults.

Population: All Medicaid beneficiaries, especially adults.

Sample Approaches:

1. Oral health in primary care
2. Mobile/portable dental care
3. Increase adult Medicaid use rate through creation of [ABCD](#)-like program for adults
4. School-based well child visits that include oral health care
5. Pay or incentivize dentists for improve oral health outcomes (aka value-based care)

Dental ER visits doubled from 1.1 million in 2000 to 2.2 million in 2012



That's one visit every 15 seconds

ER visits cost 3 times as much as dental visits



Costing the health system \$1.6 billion annually



80% of dental-related ER visits are due to preventable conditions



Potentially saving the healthcare system \$1.7 billion

Up to 1.65 million ER visits can be referred to dental clinics

Preventable Dental Emergencies
 American Dental Association
ADA.org/action

Complete this survey to score all six optional projects: <https://www.surveymonkey.com/r/PBVB89Y>

Rationale: Chronic health conditions are prevalent among Washington’s Medicaid beneficiaries, and the number of individuals with or at risk for chronic disease is increasing. Disease prevention and effective management is critical to quality of life and longevity. Many individuals face cultural, linguistic and structural barriers to accessing quality care, navigating the health care system, and understanding how to take steps to improve their health.

Description: The Chronic Disease Prevention and Control Project focuses on integrating health system and community approaches to improve chronic disease management and control. The Chronic Care Model is the single evidence-based approach to be tailored by the ACH to address specific populations and disease categories. Within the Chronic Care Model, there is opportunity to include specific change strategies that target the regionally defined health disease/condition and to address the identified barriers to care for Medicaid beneficiaries experiencing the greatest burden of chronic disease.

Population: Medicaid beneficiaries (children and adults) with, or at risk for, asthma, diabetes, heart disease, and/or at risk for obesity, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the three-county region.

Sample Approaches:

1. [Chronic Care Model](#): Includes the following specific strategies to be implemented: 1) self-management support, 2) delivery system design, 3) decision support, 4) clinical information systems, 5) community-based resources and policy, and 6) health care organization strategies that ensure high quality.
2. [The Community Guide](#)
3. [Million Hearts Campaign](#)
4. [Stanford Chronic Disease Self-Management Program](#)
5. [CDC-recognized National Diabetes Prevention Programs](#) (NDPP)
6. [Community Paramedicine](#)

Additional resources:

1. [Guidelines for the Diagnosis and Management of Asthma](#) (EPR-3)
2. [JNC 8 Guidelines for the Management of Hypertension in Adults](#)
3. [American Diabetes Association Standards of Medical Care in Diabetes – 2016](#)



Our very own Olympic Peninsula Healthy Community Coalition in Clallam County marching in a parade to support 5-2-1-0 (5 fruits or vegetables, 2 hours or less recreational screen time; 1 hour or more physical activity; 0 sugary drinks)

Complete this survey to score all six optional projects: <https://www.surveymonkey.com/r/PBVB89Y>

SUD Expenditure Report

Month: October

Through billing month: November

Line Item	Budget	July	August	September	LTD	Percent	Balance	Expected
Medicaid								
Outpatient	\$ 8,050,000.00	\$ 335,104.21	\$ 351,791.85	\$ 387,665.00	\$ 1,074,561.06	0.00%	\$ 6,975,438.94	
Residential	\$ 2,000,000.00	\$ 217,080.54	\$ 185,962.12	\$ 140,560.04	\$ 543,602.70	27.18%	\$ 1,456,397.30	
Withdrawal Management	\$ 660,000.00	\$ 43,146.64	\$ 48,299.20	\$ 39,586.04	\$ 131,031.88	19.85%	\$ 528,968.12	
Substance Abuse Block Grant								
Outpatient	\$ 962,438.00	\$ 62,299.79	\$ 54,513.56	\$ 61,874.10	\$ 178,687.45	18.57%	\$ 783,750.55	
Residential	\$ 700,000.00	\$ 26,690.52	\$ 23,722.32	\$ 19,881.12	\$ 70,293.96	10.04%	\$ 629,706.04	
Nurse Care Manager	\$ 248,743.00	\$ 6,395.66	\$ 15,677.46	\$ 17,471.45	\$ 39,544.57	15.90%	\$ 209,198.43	
Criminal Justice Treatment Act								
Outpatient	\$ 226,000.00	\$ 6,137.80	\$ 7,238.62	\$ 5,694.03	\$ 19,070.45	8.44%	\$ 206,929.55	
Residential	\$ 226,000.00	\$ 25,595.57	\$ 24,647.59	\$ 27,107.43	\$ 77,350.59	34.23%	\$ 148,649.41	
IMD Backfill								
Residential (billed to SABG)	\$ 821,000.00	\$ 147,858.44	\$ 123,577.62	\$ 100,944.46	\$ 372,380.52	45.36%	\$ 448,619.48	
State								
Outpatient	\$ 389,000.00				\$ -	0.00%	\$ 389,000.00	
Residential	\$ 300,000.00			\$ 2,670.48	\$ 2,670.48	0.89%	\$ 297,329.52	
Withdrawal Management	\$ 40,000.00	\$ 1,130.16	\$ 3,013.76	\$ 4,520.64	\$ 8,664.56	21.66%	\$ 31,335.44	
SABG Child Care/PPW		\$ 7,169.00	\$ 7,687.00	\$ 11,150.23	\$ 26,006.23			
Residential								
IMD		\$ 26,690.52	\$ 23,722.32	\$ 19,881.12				
Non-IMD		\$ 217,080.54	\$ 185,962.12	\$ 140,560.04				
Total	\$ 14,623,181.00	\$ 878,608.33	\$ 846,131.10	\$ 819,125.02	\$ 2,543,864.45	17.40%		