MEETING of the
PENINSULA REGIONAL SUPPORT NETWORK
ADVISORY BOARD

DATE: **May 14, 2015**
TIME: **1:00 pm**
LOCATION: **Quimper Unitarian Universalist Fellowship, Conference Room**
2333 San Juan Avenue, Port Townsend, WA

A G E N D A

1. Call to Order
2. Announcements/Introductions
3. Opportunity to Address the Board on Agenda Topics
   (Limited to 3 minutes per speaker)
4. Approval of Agenda
5. Approval of April 9, 2015 Minutes (Attachment 5)
6. Action Items
   a. Behavioral Health Organization (BHO) Advisory Board (Attachment 6.a)
7. Informational Items
   a. State Budget
   b. BHO Developments (Attachment 7.b)
   c. State Performance Measures (Attachment 7.c)
   d. Health Care Reform (Attachments 7.d.1 -2)
   e. Data Project
   f. Performance Statistics (Attachments 7.f.1-2)
8. New Business
9. Old Business
10. Provider Update
11. For the Good of the Order
12. Adjournment

ACRONYMS

AAA	Area Agency on Aging
ACH	Accountable Community of Health
AIU	Adult Inpatient Unit, KMHS, Bremerton
ARNP	Advanced Registered Nurse Practitioner
BHO	Behavioral Health Organization
CAP	Corrective Action Plan
CFT	Child and Family Treatment
CLIP	Children's Long term Inpatient Program
CMS	Center for Medicaid & Medicare Services (federal)
CSTC	Child Studies and Treatment Center
DBHR	Division of Behavioral Health & Recovery
DCFS	Division of Child & Family Services
DDA	Developmental Disabilities Administration
DMHP	Designated Mental Health Professional
DRC	Dispute Resolution Center of Kitsap, Bremerton, Kitsap County
DVR	Division of Vocational Rehabilitation
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
HCA	Health Care Authority
HCS	Home and Community Services
HIPAA	Health Insurance Portability & Accountability Act
HMC	Harrison Medical Center, Bremerton
ITA	Involuntary Treatment Act
JMHS	Jefferson Mental Health Services, Port Townsend, Jefferson County
KMHS	Kitsap Mental Health Services, Bremerton, Kitsap County
LRA	Least Restrictive Alternative
MCO	Managed Care Organization
OMC	Olympic Memorial Center, Port Angeles
PBH	Peninsula Behavioral Health, Port Angeles, Clallam County
PIHP	Prepaid Inpatient Health Plans
PRSN	Peninsula Regional Support Network
QA/I	Quality Assurance/Improvement
QUIC	Quality Improvement Committee
QRT	Quality Review Team
RCW	Revised Code Washington
RFP, RFQ	Requests for Proposal, Requests for Qualifications
RMHS	RMH Services, Bremerton, Kitsap County
RSN	Regional Support Network
SSI	Supplemental Security Income
WEOS	West End Outreach Services, Forks, Clallam County
WSH	Western State Hospital, Tacoma
YIU	Youth Inpatient Unit, KMHS, Bremerton

Go to http://www.kitsapgov.com/hr/wsolympic/prsn/prsnpolicies.htm for a full listing of definitions and acronyms.

PENINSULA REGIONAL SUPPORT NETWORK
AGENDA BRIEFING
May 14, 2015

6. ACTION ITEMS

a. Behavioral Health Organization (BHO) Advisory Board

One of the tasks in establishing a Behavioral Health Organization will be putting together a new Advisory Board. Staff has put together a recommended procedure for setting up the Board, which is attached, and is asking for this Board to make a recommendation to the Executive Board.

7. INFORMATIONAL ITEMS

a. State Budget

The Senate and House continue their face off on the state biennial budget. There have been no public developments related to the public mental health system funding. Staff distributed a document at the last meeting illustrating what the budget impact of the Senate budget would be – an approximate 20% cut in funding. There is some hope that State funding cuts might be restored, and that the Medicaid rate cuts might be limited to a lower percent for the Peninsula and Timberlands RSNs, which are the only two RSNs with over a 10% rate cut.

b. BHO Developments

The Region is advertising for an IS manager, who will oversee the IS development contract and manage the system once it is developed. Staff is continuing to meet with providers in the Chemical Dependency (CD) field across the region, and we are working on a provider reimbursement model for CD services. We are also looking at Co-Occurring programs, and how to best implement models that are most effective.

We are anxiously awaiting funding figures so that programmatic decisions can be firmed up.

c. State Performance Measures

Attached is information related to how the state intends to implement the first two statewide performance measures – Penetration Rate and 30-day Rehospitalization. The way these are being proposed, there is no way for the RSN to measure its own performance.

d. Health Care Reform

The state is now considering applying for a new “global” Medicaid waiver called an 11-15 waiver which allows sates to use a wide variety of state match to draw down matching Federal funds. During one recent presentation, it was implied that many of these new funds would be utilized for housing.

On the Full Integration front, Chelan-Douglas RSN has now submitted a letter of interest to become an Early Adopter, and Southwest RSN (Clark, Cowlitz and

Skamania Counties) will break up in July as Clark and Skamania pursue Early Adopter status under full integration.

The Olympic Community of Health, the Accountable Community of Health for the PRSN area, has been awarded a $100,000 design grant, and is hiring a Project Manager on a contract basis to assist in development efforts.

e. Data Project

The statement of work for development of a complete Information Reporting System for the Peninsula RSN is in the final stages of development.

f. Performance Statistics

Agency statistics are attached for the Board's perusal.

Attachment 5

ATTENDANCE

MEMBERS	GUESTS	STAFF
Present Dawn Acuna Christina Brinch Jackie Brown Ethan Green John Freeburg Lois Hoell Allen Lapin Helen Morrison Sally O'Callaghan Steve Schermerhorn Absent/Excused Randy Bailey Karen Ciccarone Bill Mosiman	Robin Runyan, Jefferson Mental Health Services Joe Roszak, Kitsap Mental Health Services Pam Brown, West End Outreach Services Wendy Sisk, Peninsula Behavioral Health Ellen Epstein, RMH Services	Anders Edgerton Linda Ward

Attachment 6.a

Plan for Establishing BHO Advisory Board

1. Establish a Nominating Committee
    a. Each county's Chemical Dependency board appoints one member
    b. The PRSN Advisory Board appoints one member from each county
    c. PRSN staffs committee
2. Nominating Committee reviews applications
    a. Applicants recruited from current boards, through advertising, and recruitment at provider agencies
    b. Nominating Committee meets in person to review applications
    c. Makes initial appointment recommendations ensuring that state criteria are met
3. PRSN Executive Board makes BHO Advisory Board appointments

It would be advantageous to have a BHO Board in place during the planning phase to comment on and make recommendations on BHO development.

SSSB 6312 requires DSHS to request a detailed plan from the entities identified in SSSB 6312 and described herein, the BHOs, that demonstrates compliance with the contractual elements of the act and federal regulations related to Medicaid managed care contracting. Any potential BHO that submits a detailed plan that demonstrates that it can meet the Detailed Plan requirements will be awarded the contract to serve as the BHO. Those requirements include:

- Contractual provisions consistent with the intent expressed in RCW 71.24.015, 71.36.005, 70.96A.010, and 70.96A.011;
- Standards regarding the quality of services to be provided, including increased use of evidence-based, research-based, and promising practices, as defined in RCW 71.24.025;
- Accountability for the client outcomes established in RCW 35 43.20A.895, 70.320.020, and 71.36.025 and performance measures linked to those outcomes;
- Standards requiring behavioral health organizations to maintain a network of appropriate providers that is supported by written agreements sufficient to provide adequate access to all services covered under the contract with the DSHS and to protect essential existing behavioral health system infrastructure and capacity, including a continuum of chemical dependency services;
- Provisions to require that medically necessary chemical dependency and mental health treatment services be available to clients;
- Standards requiring the use of behavioral health service provider reimbursement methods that incentivize improved performance with respect to the client outcomes established in RCW 43.20A.895 and 71.36.025, integration of behavioral health and primary care services at the clinical level, and improved care coordination for individuals with complex care needs;
- Standards related to the financial integrity of the responding organization.
- Mechanisms for monitoring performance under the contract and remedies for failure to substantially comply with the requirements of the contract.
- Provisions to maintain the decision-making independence of designated mental health professionals or designated chemical dependency specialists; and
- Provisions stating that public funds appropriated by the legislature may not be used to promote or deter, encourage, or discourage employees from exercising their rights under Title 29, 36 chapter 7, subchapter II, United States Code or chapter 41.56 RCW.

1519/5732 BHO Performance Measure Committee Notes & Recommendations

April 27, 2015

Attendees

Name	Affiliation
Michelle Alger	PN RSN
Tracey Thompson (on phone)	PN RSN
Charissa Westergard	NS RSN
Deb Srebnik	KI RSN
Kathleen Troella	SP RSN
Suzie McDaniel	SP RSN
Kara Panek	DSHS/BHSIA
Katie Weaver Randall	DSHS/BHSIA/DBHR
Aaron Starks	DSHS/BHSIA/DBHR
Ted Lamb	DSHS/BHSIA/DBHR
Jason Bean-Mortinson	DSHS/BHSIA/DBHR
Lois Kim	TM RSN
Beverly Court	DSHS/SESA/RDA
David Mancuso	DSHS/SESA/RDA
Gregory Robinson	WCMHC
Jamie Rundhaug	GC RSN

Purpose of the meeting was to follow up on the Mental Health (MH) Penetration measure recommendations and to make recommendations for the 30-day psychiatric readmission measure.

MH Penetration Measure Follow up on recommendations from 3/30/2015 meeting:

The purpose of the MH penetration measure is to broadly measure whether Medicaid enrolled clients with an indication of need for mental health services are accessing services through the BHOs.

The mental health penetration measure will be created 2 ways using the measurement specifications on the Mental Health Treatment Penetration Measure Definition document:

1) using the MH treatment need (as defined in the documentation) in the denominator
2) not using the MH treatment need in the denominator

Comparison of the two approaches:

With Treatment Need	Without Treatment Need
• Penetration higher (approx. 30%) • Comparable to HCA measure, which needs to include MH treatment need to account for varying risk profiles across health plans.	• Penetration lower (approx.2%) • Not comparable to HCA measure and this undermines intent of the legislation and will make RSNs look like they are underperforming compared to health plans.

• Not as easily compared to other states because MH treatment need is Washington specific.	• More easily replicated and simpler measure to understand.

Recommendations for the 30-day psychiatric readmission measure

To elicit measurement recommendations from the RSNs on the following measure specified under the 1519/5732 measurement work:

Utilization	
Measure	Psychiatric Hospitalization Readmission Rate
Definition	Proportion of acute psychiatric inpatient stays during the measurement year that were followed by an acute psychiatric readmission within 30 days
Populations	All service contracting entities
Source	Modified version of NCQA HEDIS "Plan All-Cause Readmission" metric

See attached measure definition which provides detail on what is included/excluded in numerator and denominator.

Next Steps:

1. Workgroup members share information from the meeting with RSN administrators and others at RSN.
2. Workgroup members provide DBHR feedback on the 30-day readmission measure definition by EOB, Friday May 8.
3. DBHR bring both MH penetration measure and 30-day readmit measure definitions to the 1519/5732 DBHR convened cross-agency (HCA and HCS) workgroup.
4. RDA provide counts and % of hospital episodes that are identified by using primary diagnosis = psychiatric.
5. Explore whether patients on "spend down" can be identified in the data.
6. Provide RDA with the measure definitions so they can generate baseline for the next meeting.
7. Bring measure discussion to RSN administrators meeting on May 28, 2015.
8. Next workgroup meeting on May 29, 2015.
    a. Review baseline and finalize MH penetration & 30-day readmission measures.
    b. Discuss approach, workgroup membership to address CD measures (penetration & retention)

1519/5732 Mental Health Treatment Penetration Measure Definition

Access and effectiveness of care	
Measure	Mental Health Treatment Penetration
Definition	Percent of adults identified as in need of mental health treatment where treatment is received during the measurement year
Populations	All service contracting entities
Source	State defined

Type of Measure

This is an annual-experience measure which generally examines a client's experience over the course of the reporting year to identify whether a specific qualifying event (e.g., a primary 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.

Denominator or Target Population

Annual experience measures use the following criteria to attribute patients to a service contracting entity (RSN or BHO):

- Regional Support Networks or Behavioral Health Organizations
  - Resided in the RSN service area in at least 11 months in the measurement year AND
  - Presented an indication of a mental health treatment need in the 24 months leading up to the end of the measurement year AND
  - Met Medicaid coverage, dual eligibility and third-party liability coverage criteria (as detailed below)

Medicaid Coverage, Dual Eligibility and Third-Party Liability Coverage (TPL) Criteria

Must be continuously enrolled in Medicaid for the 12 months covered by the reporting period.

Persons with Third Payer Liability (TPL) will be excluded from the measure because key measure-defining service events are not reliably observed in Medicaid claims and encounter data.

Dually-eligible persons will be included because the Medicare Part A and B claims and Part D encounter data are integrated into the performance measurement process. Note that dual eligible enrolled in Medicare Advantage plans will continue to be excluded if associated Medicare Part C encounter data is not available for integration into the performance measurement process.

Definition of the Numerator

To be included in the numerator, the person must meet all the conditions of the denominator and receive one of the state plan modality services or one of the listed services within the reporting timeframe.

a. Engagement & Outreach,

b. Supported Employment
c. Mental Health Clubhouse
d. Community Based Wraparound Services
e. Co-Occurring treatment.
f. Crisis services (this is a state plan modality service)

1519/5732 Psychiatric Hospitalization Readmission Measure Definition

Utilization	
Measure	Psychiatric Hospitalization Readmission Rate
Definition	Proportion of acute psychiatric inpatient stays during the measurement year that were followed by an acute psychiatric readmission within 30 days
Populations	All service contracting entities
Source	Modified version of NCQA HEDIS "Plan All-Cause Readmission" metric

Type of Measure

This is an index-event measure which reflects the occurrence of a sentinel "index event" (e.g., a hospital discharge, a release from incarceration, or a death) at some time during the measurement period. These measures have a somewhat less restrictive continuous enrollment criterion (6 months of continuous enrollment up to and including the month containing the index event) for client attribution to a service contracting entity.

Four types of data will be used to identify index hospitalizations:

1. Provider One claims data will be used to identify community hospital episodes.
2. Provider One encounter data will be used to identify evaluation and treatment center episodes.
3. Consumer Information System data will be used to identify a evaluation and treatment center episodes that are not submitted through Provider One.
4. State hospital and CLIP/CSTC data (for 18+ yrs of age)

Definition of the Denominator (Target Population)

For hospital episodes to be included in the denominator the person must meet all the following conditions:

1. Resided in the RSN service area continuously in the 12 months up to/including the index-event and Medicaid-enrolled continuously for 12 months up to/including the index-event

2. No Third Payer Liability (TPL) within the 12 months up to/including the index-event because key measure-defining service events are not reliably observed in Medicaid claims and encounter data.
3. No D coupons or address confidentiality restrictions within the 12 months up to/including the index-event because the persons' address does not accurately reflect their physical location and the RSN where they would receive services.

4. Dually-eligible persons are included because the Medicare Part A and B claims and Part D encounter data are being integrated into the performance measurement process. Note that dual eligible enrolled in Medicare Advantage plans will continue to be excluded if associated Medicare Part C encounter data is not available for integration into the performance measurement process.

Definition of the Numerator

Hospital episodes to include in the numerator:

1. The hospitalization following the index hospitalization must occur greater than 1 day after the index hospitalization.

2. If psychiatric hospitalization is immediately followed by a physical healthcare hospitalization and then another psychiatric hospitalization, this should be considered one episode. Not a new episode. For example, E&T episode to Swedish for appendectomy, and then back to E&T = 1 episode.

Additional Considerations:

- Hospitals don't notify RSNs of hospitalizations/discharges for dual-eligible clients.
- Need to do a separate measure that looks at re-admission for all D coupon and confidential address clients and clients who don't meet the residence requirement.
- Need to do a separate measure that only includes the hospital episodes that RSNs authorize and do not authorize to support quality improvement efforts.
- Need to consider how we can engage hospitals. Do we do a facility level report?
- Can we identify patients on spend down and if so, does it make sense to exclude them from the measure?
- What type of information would be helpful to support RSNs/BHOs in doing QI work – a file with flags on clients that are and are not included in the measure? These options can be discussed after June 30, 2015 when the MH penetration measure and 30-day psychiatric readmission measure are operationalized and baseline data is produced.
- Should we include hospital episodes with a primary psychiatric diagnosis in the denominator? RDA will generate a report should the number of hospital episodes by RSN, but it is a significant number.

WASHINGTON STATE
HEALTH CARE AUTHORITY
P.O. Box 42700 • Olympia, Washington 98504-2700

April 17, 2015

15-014 – RFI – Behavioral Health Administrative Service Organization

1. Introduction

1.1 Summary

The Washington State Health Care Authority (HCA) is releasing a Request for Information (RFI) seeking comment on its plan to procure a Behavioral Health Administrative Service Organization (BH-ASO) to manage a regional crisis system in Southwest Washington, for the provision of insurance-blind crisis services to individuals residing in the Southwest Washington Regional Service Area (RSA) by April, 2016, as well as to provide substance use disorder residential services (adult and youth) and limited outpatient services for individuals who are not eligible for Medicaid.

HCA seeks to obtain details on organizations' capacity and interest to, by April, 2016:

1) Manage a regional mental health crisis system for the delivery of Medicaid and non-Medicaid crisis services for the Southwest Washington population;
2) Manage a system for the delivery of certain non-Medicaid behavioral health services to individuals who are not eligible for Medicaid;
3) Demonstrate an ability to apply a recovery and resiliency-oriented philosophy and clinical design aimed at producing tangible, improved outcomes;
4) Operate as part of continuum of integrated services, with deep connections to community resources and in seamless partnership with SWWA managed care plans.

Please review the questions and background below and provide your response by May 8, 2015. Any additional information which may be of assistance is welcome.

1.2 Overview and Purpose of this Request for Information

In Washington, the State Health Care Innovation Plan (Healthier Washington) E2SHB 2572 and E2SSB 6312 provided the policy direction for a transition towards regionalized Medicaid purchasing through fully-integrated managed care systems that provide physical health and behavioral health (i.e. mental health and substance use disorder services) for Medicaid enrollees. Counties in the Southwest Washington RSA (Clark, Klickitat & Skamania) have declared their intent to adopt a purchasing model in which care for Medicaid beneficiaries is delivered through contracts between HCA and Managed Care Organizations (MCOs), at risk for the full continuum of physical and behavioral health services, and where financing is leveraged to support the integrated delivery of whole-person care.

Adoption of a regional approach for Medicaid purchasing with a transition to fully integrated managed care systems beginning in 2016 will set the foundation for major transformation of Washington's health care delivery system in 2020. HCA anticipates significant opportunities for the BH-ASO to bid for contracts in additional regions as the State moves towards fully integrated managed care between 2016 and 2020.

Beginning in April 2016, the current Regional Support Network (RSN) system managing specialty mental health services in Southwest Washington will cease operation. Specialty mental health services and state/county-managed fee-for-service substance use disorder services will transition into the fully-integrated managed care system.

Currently, the crisis system in Southwest Washington is managed by the Southwest Behavioral Health RSN (Clark and Skamania counties) and the Greater Columbia RSN (Klickitat County). However, in summer 2015 HCA intends to release a Request for Proposals (RFP) to procure a regional organization to provide insurance blind crisis services, and non-Medicaid behavioral health service to non-Medicaid individuals, on a regional basis in the new SWWA RSA (Clark, Skamania & Klickitat counties). There may be additional responsibilities/funding sources for the BH-ASO to manage on a regional basis, noted below.

Southwest Washington's population is 456,747 and HCA, as a purchaser, currently provides health insurance to 116,000 people through the Washington Apple Health Medicaid Program in Southwest Washington.

The purpose of the RFI is to measure interest in responding to the BH-ASO RFP, and to assess potential capacity to administer crisis services and non-Medicaid services on a regional basis in April, 2016.

1.3 Summary of HCA's Intended Model

The Problem	The Approach	A Model for Change
With the transition of mental health and substance use disorder services into fully-integrated managed care, and the absence of a Regional Support Network system to manage an insurance blind crisis system on a regional basis, HCA must procure a separate organization to provide these services, and services to non-Medicaid individuals, in the SWWA region. While managed care organizations will serve the Medicaid population, one organization must be available to serve the entire SWWA population, using a blend of Medicaid and non-Medicaid funds to provide crisis services and certain non-Medicaid behavioral health services. By State law, any individual in the SWWA region, regardless of their insurance status or level of income has access to crisis services.	With the transition to a fully-integrated physical and behavioral health system, Southwest Washington has a unique opportunity to provide better coordinated, whole-person care. The crisis system plays a key role as the entry-point to care for many of the most at-risk individuals in the population. HCA's approach is to establish a single regional organization, to subcontract with an established regional behavioral health crisis provider system for the delivery of Medicaid and non-Medicaid crisis services to Medicaid and non-Medicaid individuals. Additionally, this organization will receive State General Fund resources and federal Substance Abuse Prevention and Treatment (SAPT) block grant funds to provide non-Medicaid behavioral health services to a limited population of non-Medicaid individuals. MCOs in the region will be required to subcontract with the BH-ASO for provision of crisis services to their enrollees.	HCA is seeking an organization that can: • Coordinate closely and intersect with the community court system, first responders, criminal justice system, inpatient/residential service providers, outpatient behavioral health providers, and Medicaid managed care plans. • Demonstrate a resiliency and recovery oriented philosophy, clinical design and crisis resolution model that is focused on stabilization, triage and diversion rather than detention evaluation-only. • Work in close partnership with health plans to operate a seamless crisis and acute care system that is deeply connected to the full-continuum of health services.

1.4 Mental Health Crisis Services

HCA's model, Exhibit A, intends to establish a contract with the BH-ASO funded with State funds, for the provision of non-Medicaid crisis services to Medicaid and non-Medicaid individuals.

Additionally HCA's model requires all MCOs operating in Southwest Washington to subcontract with the BH-ASO to support the maintenance of a "crisis response system" that will serve anyone in the region. A crisis response system is a system available 24/7 to provide initial crisis response services, such as a regional crisis hotline and the provision of crisis stabilization/assessment services by mental health professionals (MHPs), mobile crisis outreach teams, or designated mental health professionals (DMHPs). Additionally, this BH-ASO will be responsible for the administration of the Involuntary Treatment Act 71.05 for all individuals in the region, regardless of their Medicaid enrollment status.

All crisis services, including initial response services (crisis hotline, mobile outreach teams, 24/7 DMHP availability) and secondary crisis services (E&T services, crisis stabilization programs, etc.) will be available to all individuals in the region, however secondary crisis services will be managed for Medicaid enrollees directly by their managed care organization. Using Medicaid and non-Medicaid funds, the BH-ASO is expected to maintain the crisis response system for the region, to conduct utilization management of secondary crisis services for non-Medicaid individuals, and to administer the Involuntary Treatment Act 71.05.

HCA intends to include funds for administration in the BH-ASO contract; however administrative expenses would likely be set at a 10% cap, as is the current standard in the RSN system.

The following mental health crisis services will be funded through a contract with HCA, using state general funds:

- Regional Crisis Hotline[1]
  - Staffed 24/7/365
  - Provides initial triage/documents calls and outcomes

- Mobile Crisis Outreach Team[2]
  - Team staffed by MHPs and/or DMHPs (CDPs on call 24/7) and Certified Peer Counselors, who respond to crises, assess for mental health/drug related issues, provide initial stabilization, and refer to appropriate services (DMHP or other).

- Administer the Involuntary Treatment Act (ITA) 71.05 for all individuals in SWWA[3]
  - Testimony for ITA services.
  - Reimburse county for court costs associated with ITA.
  - DMHPs 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.
  - DMHPS file petitions for detentions.

[1] Fully-integrated MCOs operating in SWWA will be required to subcontract with the BH-ASO and allocate funds to support the use of the regional hotline by Medicaid individuals.
[2] Fully-integrated MCOs operating in SWWA will be required to subcontract with the BH-ASO and allocate funds to support Medicaid funded crisis services (i.e. mobile crisis outreach team, etc.)
[3] BH-ASO will receive state-funds to administer the Involuntary Treatment Act for both Medicaid and non-Medicaid individuals.

- Crisis Stabilization Services for Non-Medicaid Individuals[4]
  - 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 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 for Non-Medicaid individuals[5]
  - Services provided in freestanding inpatient residential facilities or hospitals certified to 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 and family therapy, milieu therapy, psycho-educational groups, pharmacology.

- E&T room and board costs for non-Medicaid individuals.[6]

1.5 Services for Non-Medicaid Individuals

Additionally, the BH-ASO contract with HCA will include state funds and SAPT block grant funds for the provision of substance use disorder outpatient and residential services for low income, priority non-Medicaid individuals. If state funds for mental health services remain available (after prioritization in the crisis system), the BH-ASO will have the discretion to provide outpatient/inpatient mental health services to non-Medicaid individuals as well. Due to federal restrictions, no administrative funds will be available through the SAPT block grant.

1.6 Additional potential responsibilities

HCA is interested in receiving feedback through this RFI on additional potential responsibilities for the BH-ASO. Opportunities include:

- Manage the Chemical Dependency Involuntary Treatment Act in accordance with RCW 70.96A.120-140, including providing services to identify and evaluate alcohol and drug involved individuals requiring protective custody, detention, or involuntary commitment services as well as manage the case finding, investigation activities, assessment activities, and legal proceeding associated with these cases;
- Provide substance use disorder crisis services on a very short term basis to intoxicated or incapacitated individuals on the streets or in other public places. This may include general assessment of the patient's condition, an interview for diagnostic or therapeutic purposes, and transportation home or to an approved treatment facility. Services may be provided by telephone or in person, in a facility or in the field, and may or may not lead to ongoing treatment;

[4] Fully-integrated MCOs operating in SWWA will contract directly for the provision of crisis stabilizations services for Medicaid enrollees.
[5] Fully-integrated MCOs operating in SWWA will contract directly for the provision of evaluation & treatment services for Medicaid enrollees, including initial E&T services provided during a 72 hour detention.
[6] Fully-integrated MCOs operating in SWWA will finance the room and board costs when their members utilize E&T services through the MCOs non-Medicaid Contract with HCA.

- Manage the distribution and data collection for the Federal Mental Health Block Grant funds on behalf of the Southwest Washington region;
- Operate a regional Behavioral Health Ombuds;
- Monitoring of Less Restrictive Court Orders for mental health treatment.

1.7 HCA's Estimated Procurement Timeline

HCA intends to release a Request for Proposals to procure a BH-ASO in summer 2015. HCA does not currently have any limitation on the types of entities that may bid (i.e. public/private/for-profit/non-profit).

2. RFP Instructions and Questions

2.1 RFI Directions

Please send your RFI response to contracts@hca.wa.gov and Attention Kristy Brodersen – RFI 15-014 in the subject line of the email.

Your response should include a cover letter outlining your entity structure, and the response to the questions per Exhibit B.

2.3 RFI Questions

Please see Exhibit B.

Attachment 7.d.1

Early Adopter Regional Crisis Model Draft

DRAFT

DRAFT

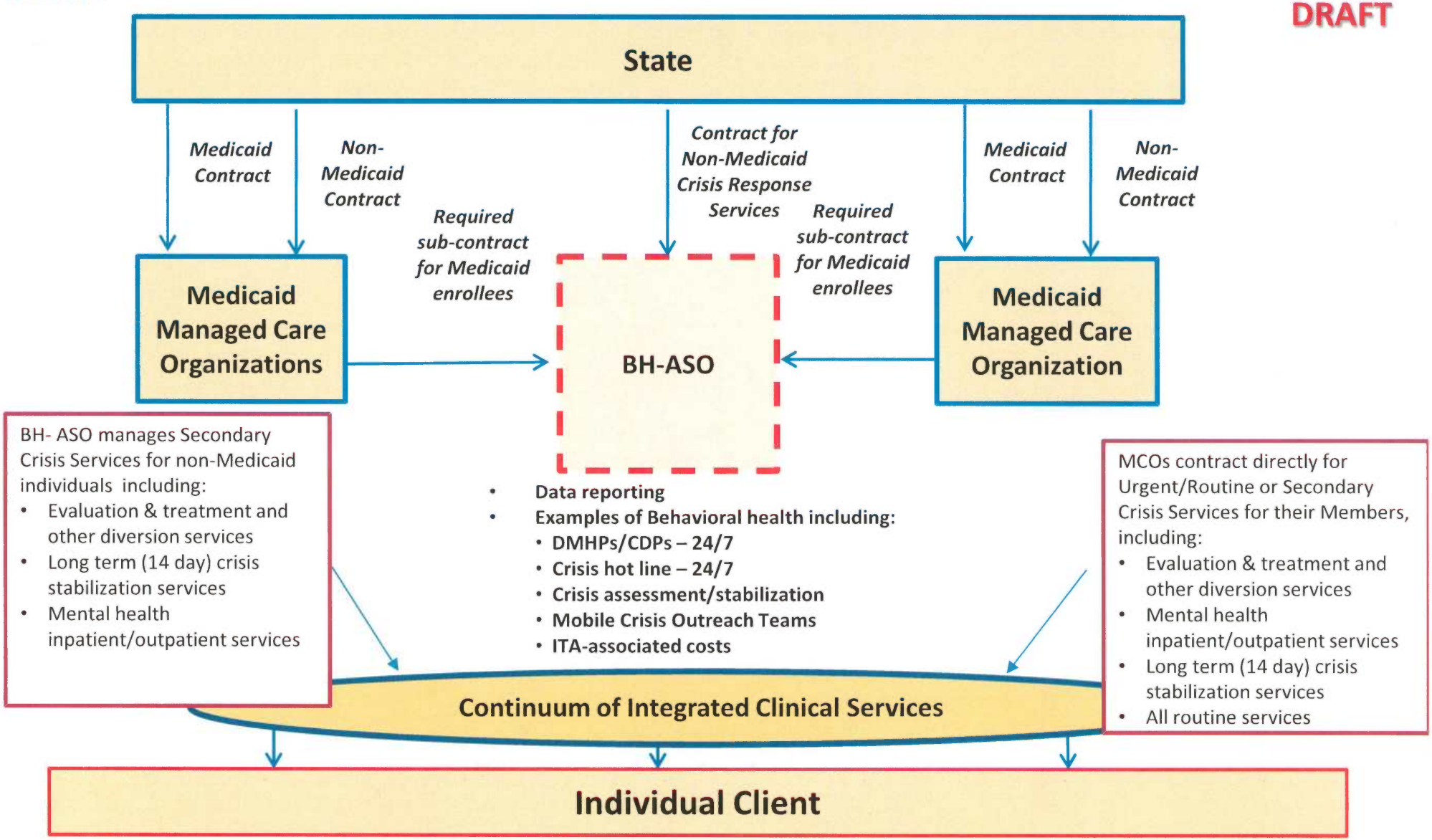


Exhibit A

Attachment 7.d.2

Transforming Lives

Behavioral Healthcare System Redesign

What do “Regional Service Areas”, “Behavioral Health Organizations”, “Early Adopters”, “SIM”, and “Accountable Communities of Health” mean?

Transforming Lives

What are Regional Service Areas?

New geographical boundaries for state purchased behavioral and physical healthcare through managed care contracts

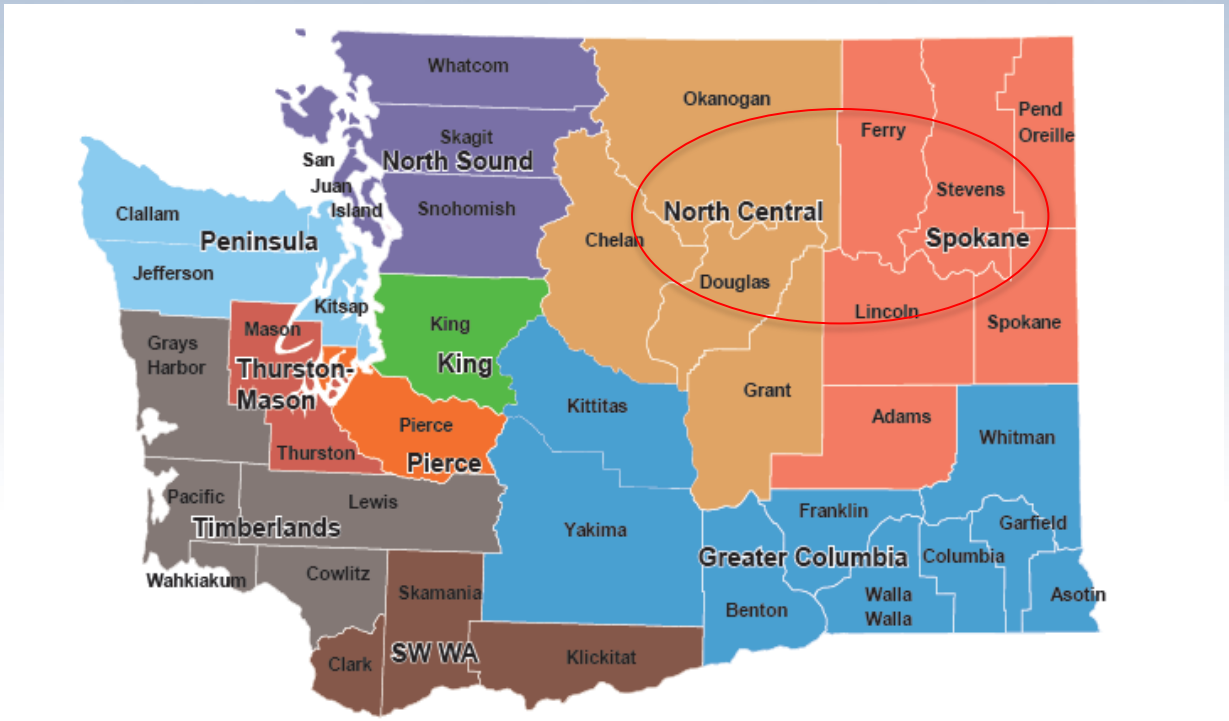
- Regional Service Areas (RSAs) were authorized by legislation in 2014
- RSAs are different from RSNs- they are regions on a map, **not** an organization that oversees services
- Regions were developed following broad direction in the law:
  - Include full counties that are contiguous with each other
  - Contain at least 60,000 people on Medicaid in the region
  - Reflect natural medical and behavioral health service patterns

Regional Service Areas:

Transforming Lives

New purchasing regions designated by DSHS and HCA on November 5, 2014

*** Note: <u>North Central and Spokane RSAs constitute one, combined BHO</u>**



Transforming Lives

What are Behavioral Health Organizations?

Organizations that combine the local administration and purchase of mental health and chemical dependency under managed care

- Behavioral Health Organizations (BHOs), authorized by SB 6312 in the 2014
- One BHO will purchase and administer behavioral health services in each Regional Service Area (or for both Spokane & North Central RSAs)
- A single, local entity maintains the responsibility and risk for substance use disorder treatment and all of the mental health services previously overseen by the RSNs (inpatient, outpatient, ITA and crisis services, jail proviso services and services funded by the federal block grants)
- DBHR will begin the contracting process for BHOs in 2015, for services starting April 2016

Transforming Lives

What are "Early Adopters?"

An alternate way to purchase services in the Regional Service Areas

- SB 6312 also authorized this option
- Regions can choose to integrate physical and behavioral health purchasing into contracts with multiple managed care organizations (MCOs) and **not** have a BHO (or a RSN)
- HCA will manage these contracts, planned to start in 2016
- All counties within an RSA must agree on becoming either a BHO or "early adopter"
- Counties may choose this option because they may receive up to 10 % of state savings resulting from this model

Transforming Lives

What are SIM, SHCIP and Healthier Washington?

It's all part of the same thing- just at different points in the process

- In 2013, HCA received a "State Innovations Models" (SIM) planning grant from the Center for Medicare and Medicaid Innovation (CMMI)
- The grant enabled the development of the State Health Care Innovation Plan (SHCIP)
- HCA used the SHCIP as the basis for a grant proposal entitled "Healthier Washington" and the state was awarded $65 million from CMMI
- HCA leads this project with support from DSHS and DOH and oversight from other state agencies and offices
- Due to Healthier Washington's large scope, other transformation initiatives are being folded under its umbrella

What will Healthier Washington do?

Transforming Lives

The grant proposal focuses on five investments:

- **Community empowerment and accountability**- development of the "Accountable Communities of Health" (ACH)
- **Practice transformation support**- a transformation hub model to support providers in increasing their capacity and coordinating care
- **Payment redesign**- state efforts to move the insurance market towards "value-based" purchasing that rewards cost-effective quality over quantity
- **Analytics, interoperability and measurement**- new infrastructure to support performance monitoring and reporting and improved clinical linkages
- **Project management**- the staff and support needed to provide the four previous investments

Transforming Lives

What are Accountable Communities of Health?

Regional organizations designed to leverage local innovation and collaboration in communities by bringing local health and social service partners together

- The Accountable Community of Health (ACH) model was authorized under HB 2572 and is still being developed , however it is **not** financial risk-bearing entity
- Two pilot ACHs have been designated:
  - **North Sound ACH** covering Whatcom, San Juan, Skagit, Island, and Snohomish counties
  - **Cascade Pacific Action Alliance** covering Thurston, Mason, Grays Harbor, Pacific, Lewis, Cowlitz, and Wahkiakum counties
- Other "community of health" groups have formed and continue to develop
- More information: http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx

Transforming Lives

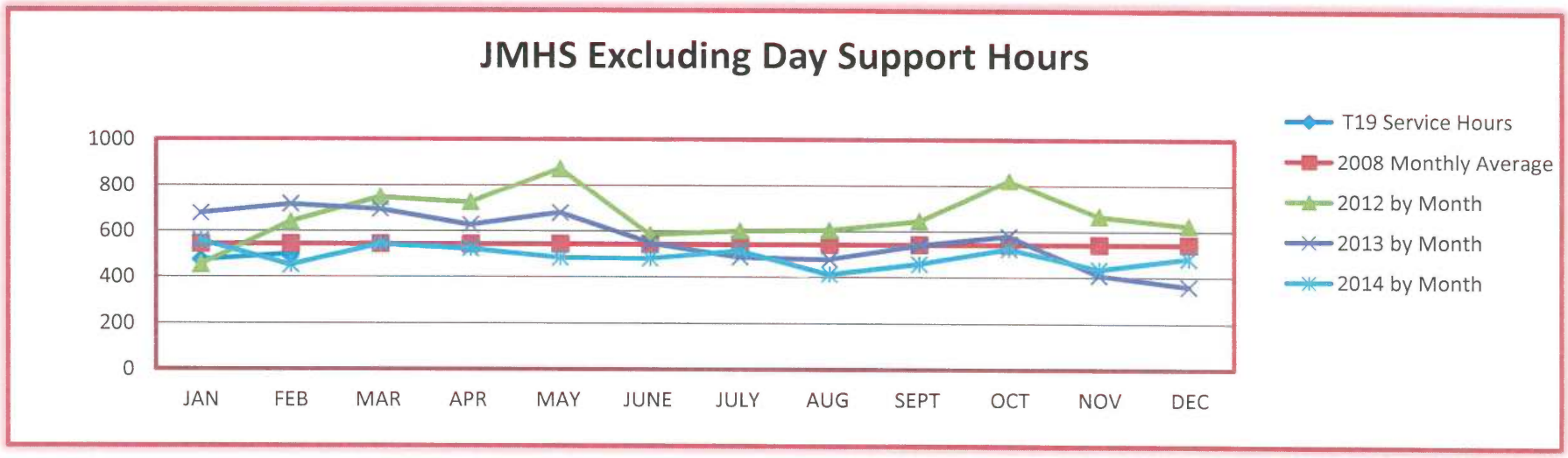
For more information:

BHO Development Webpage:
http://www.dshs.wa.gov/bhsia/division-behavioral-heath-and-recovery/developing-behavioral-health-organizations

BHO Questions Mailbox:
BHOtransition@dshs.wa.gov

HCA's Healthier Washington Webpage:
http://www.hca.wa.gov/hw/Pages/default.aspx

Healthier Washington Question Mailbox:
HealthierWA@hca.wa.gov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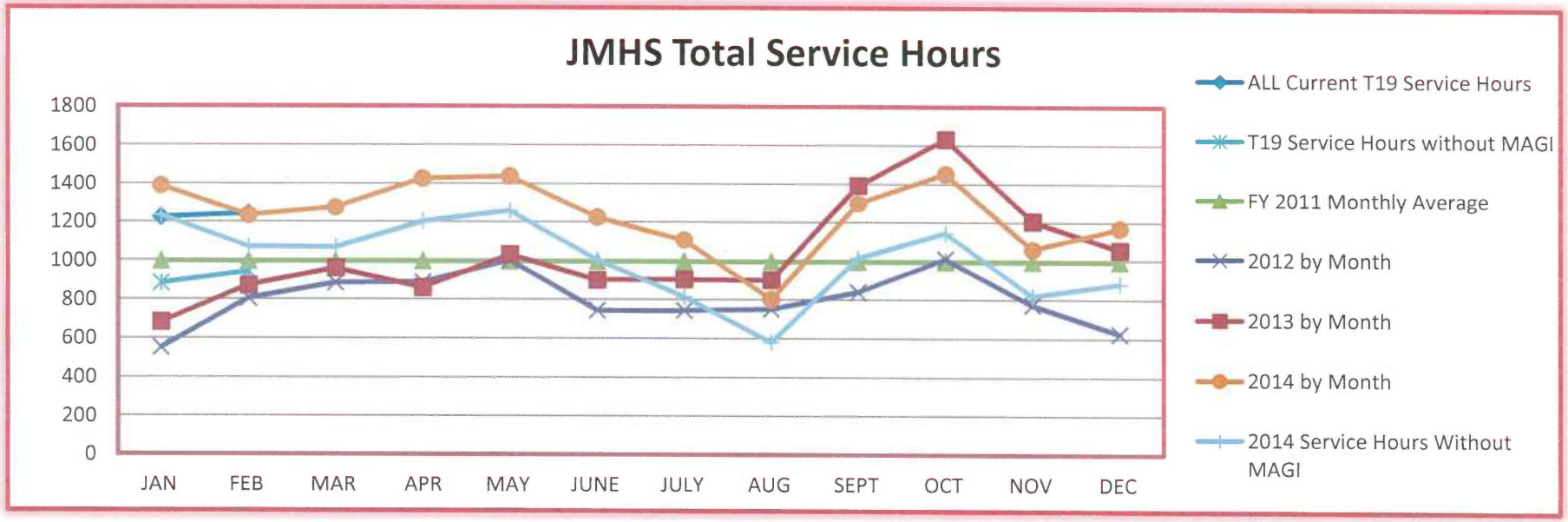
800
600
400
200
0
JAN
FEB
MAR
APR
MAY
JUNE
JULY
AUG
SEPT
OCT
NOV
DEC
T19 Service Hours
2008 Monthly Average
2012 by Month
2013 by Month
2014 by Month


JMHS Total Service Hours
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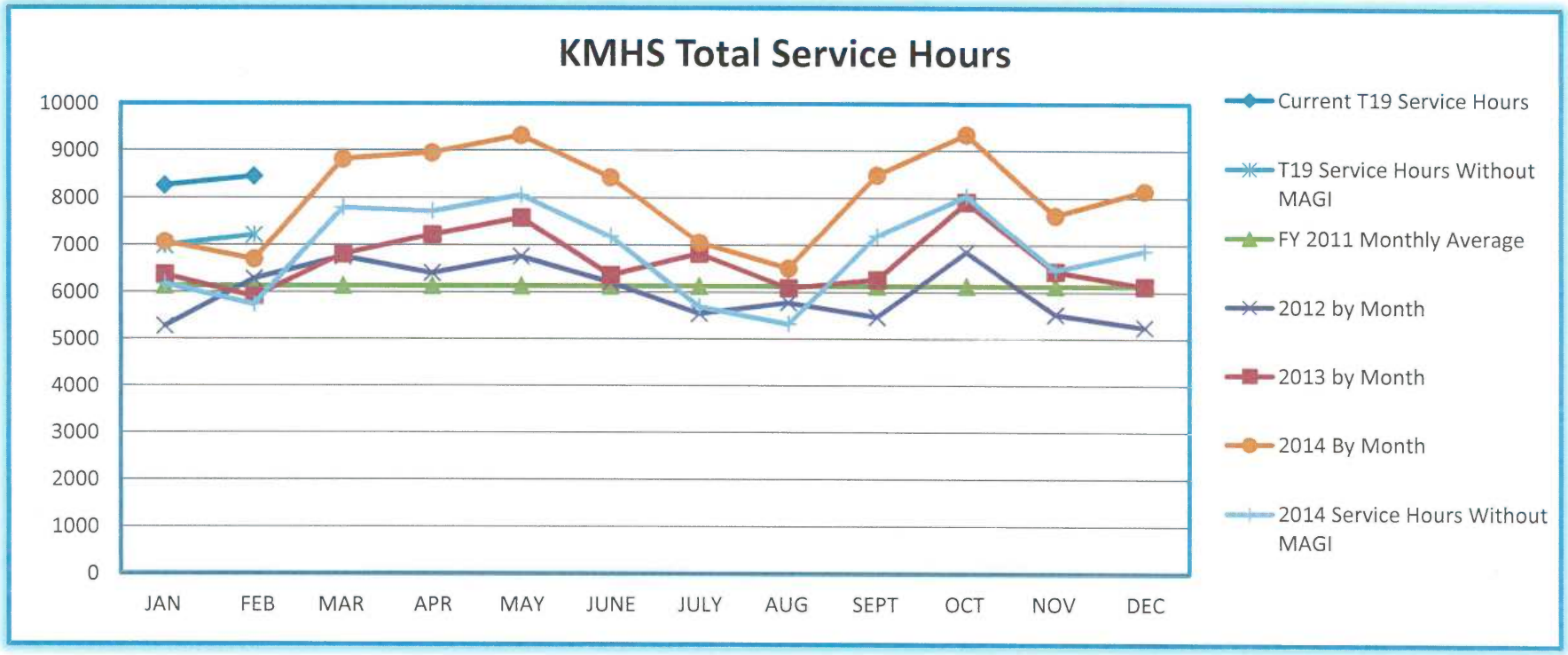
1600
1400
1200
1000
800
600
400
200
0
JAN
FEB
MAR
APR
MAY
JUNE
JULY
AUG
SEPT
OCT
NOV
DEC
ALL Current T19 Service Hours
T19 Service Hours without MAGI
FY 2011 Monthly Average
2012 by Month
2013 by Month
2014 by Month
2014 Service Hours Without MAGI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8000
7000
6000
5000
4000
3000
2000
1000
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JAN
FEB
MAR
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JUNE
JULY
AUG
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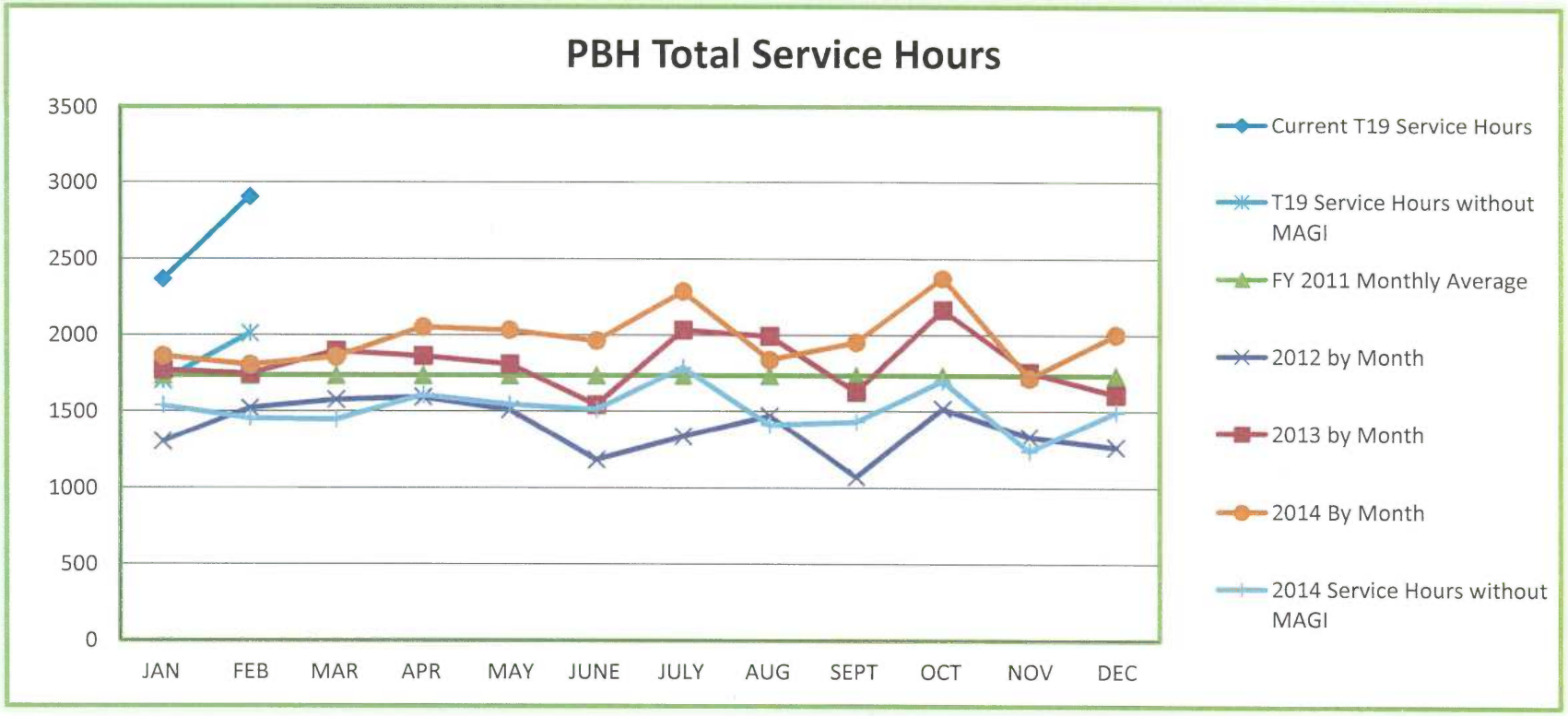
DEC
Current T19 Service Hours
T19 Service Hours Without MAGI
FY 2011 Monthly Average
2012 by Month
2013 by Month
2014 By Month
2014 Service Hours Without MAGI


PBH Total Service Hours
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2500
2000
1500
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500
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JAN
FEB
MAR
APR
MAY
JUNE
JULY
AUG
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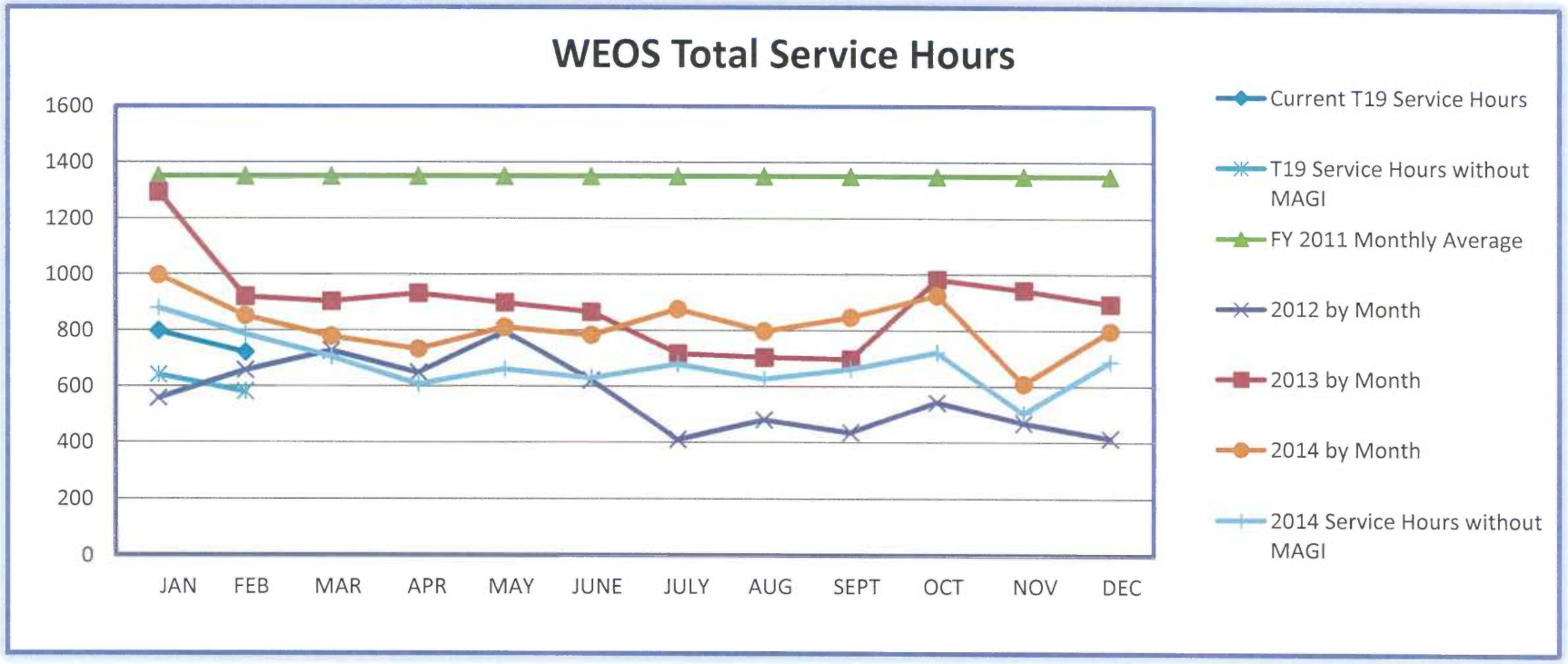
DEC
Current T19 Service Hours
T19 Service Hours without MAGI
FY 2011 Monthly Average
2012 by Month
2013 by Month
2014 By Month
2014 Service Hours without MAGI


WEOS Total Service Hours
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1400
1200
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800
600
400
200
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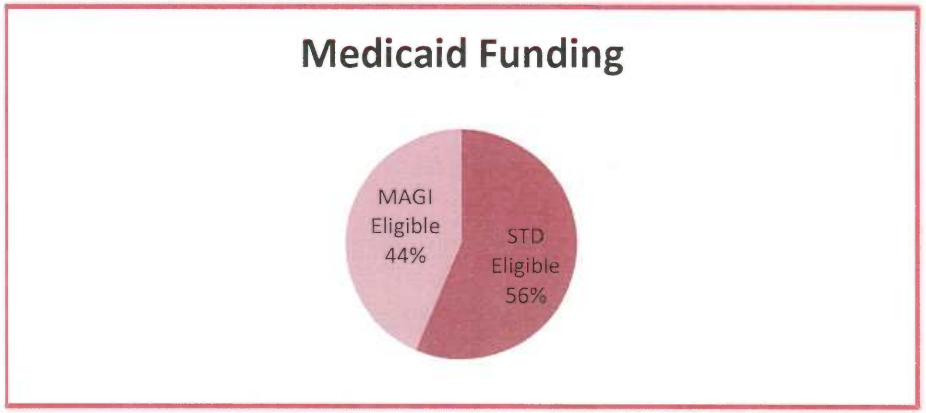
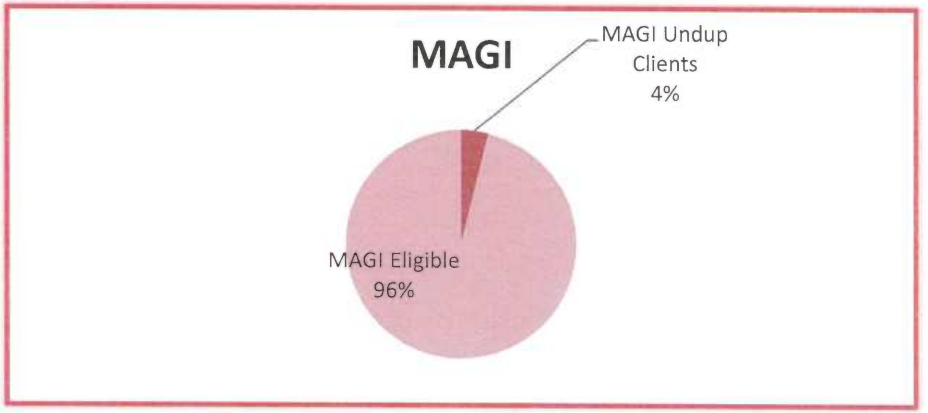
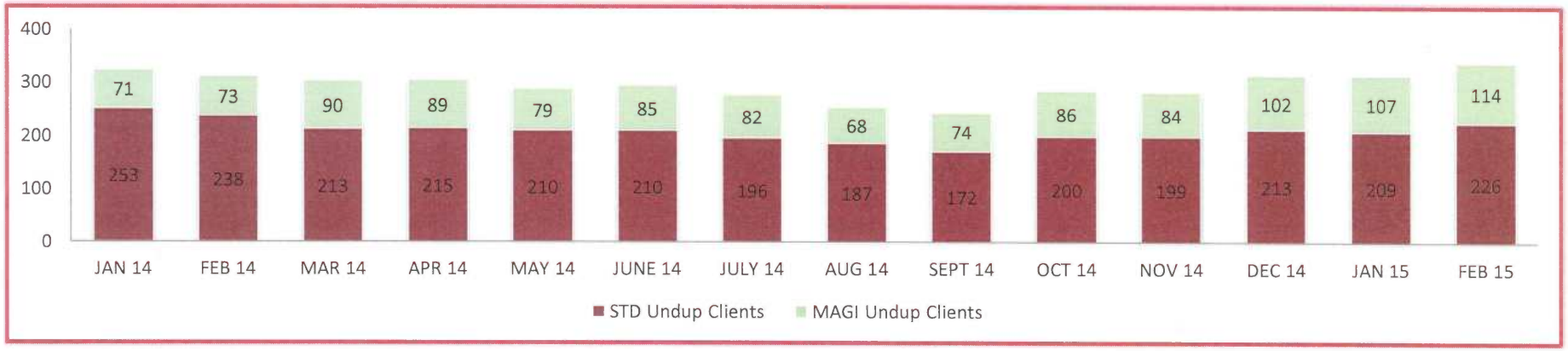
JAN
FEB
MAR
APR
MAY
JUNE
JULY
AUG
SEPT
OCT
NOV
DEC
Current T19 Service Hours
T19 Service Hours without MAGI
FY 2011 Monthly Average
2012 by Month
2013 by Month
2014 by Month
2014 Service Hours without MAGI

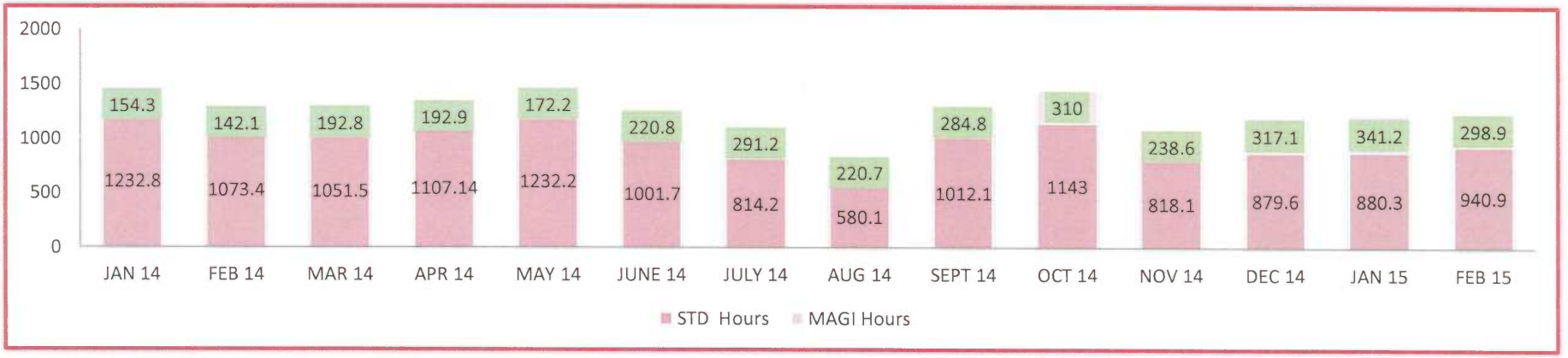
JMHS

Attachment 7.f.2

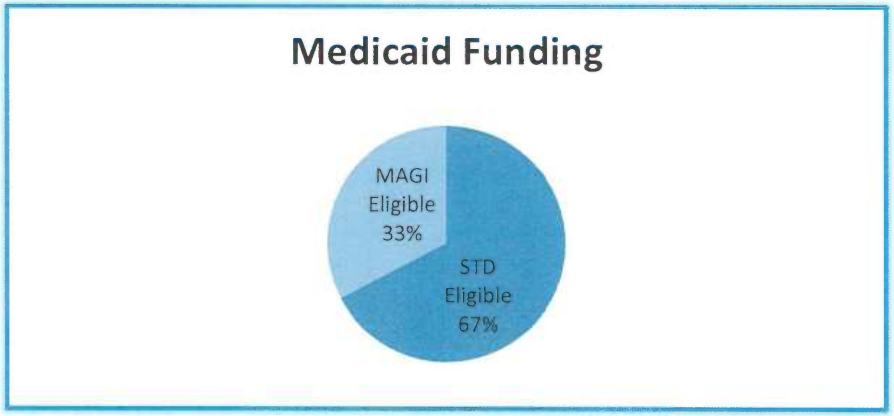


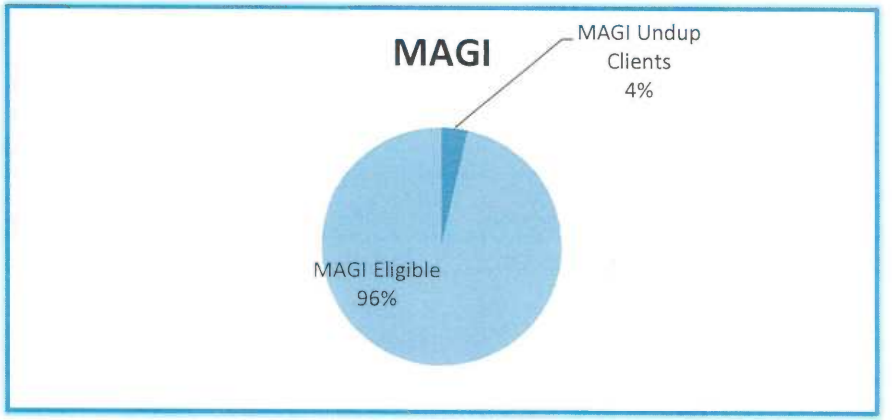


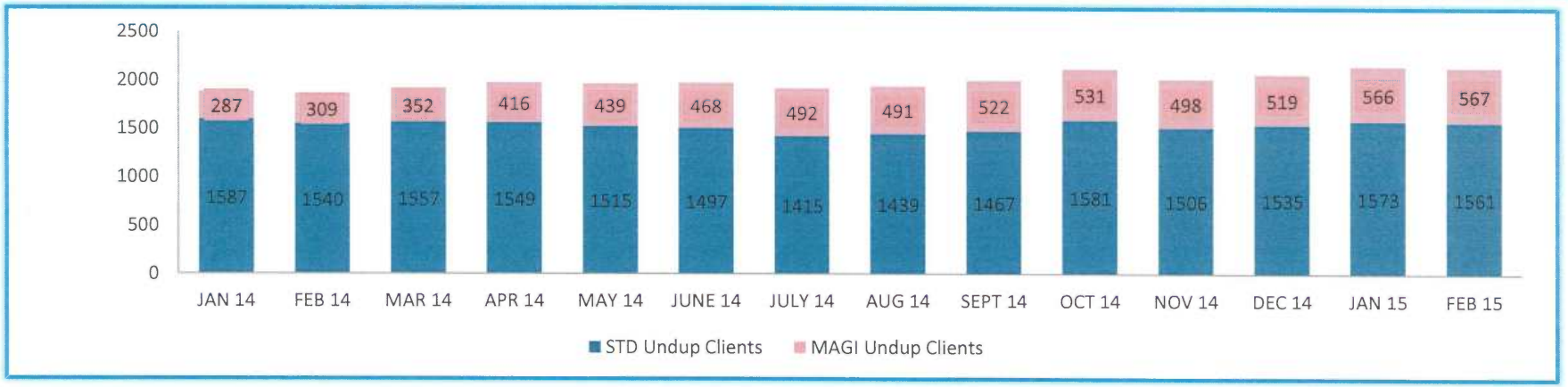




KMHS


Medicaid Funding
MAGI Eligible 33%
STD Eligible 67%


MAGI
MAGI Undup Clients 4%
MAGI Eligible 96%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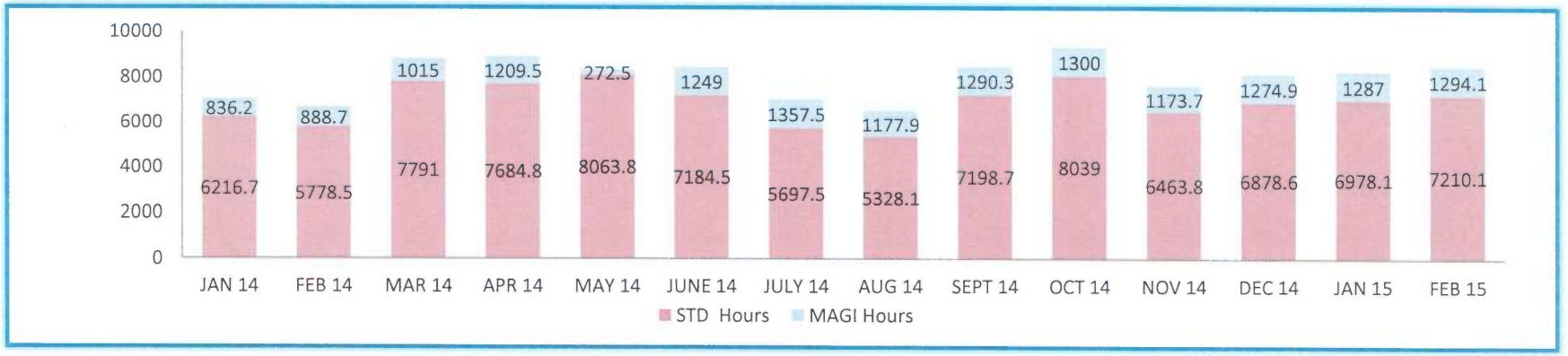
STD Undup Clients
MAGI Undup Clients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6216.7 5778.5 7791 7684.8 8063.8 7184.5 5697.5 5328.1 7198.7 8039 6463.8 6878.6 6978.1 7210.1
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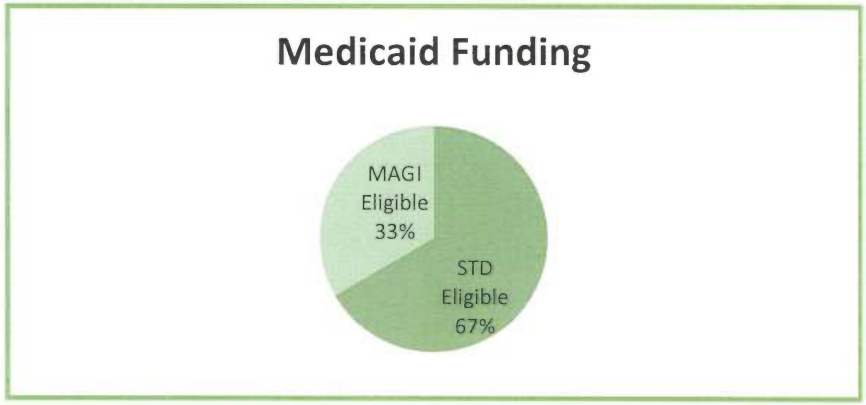
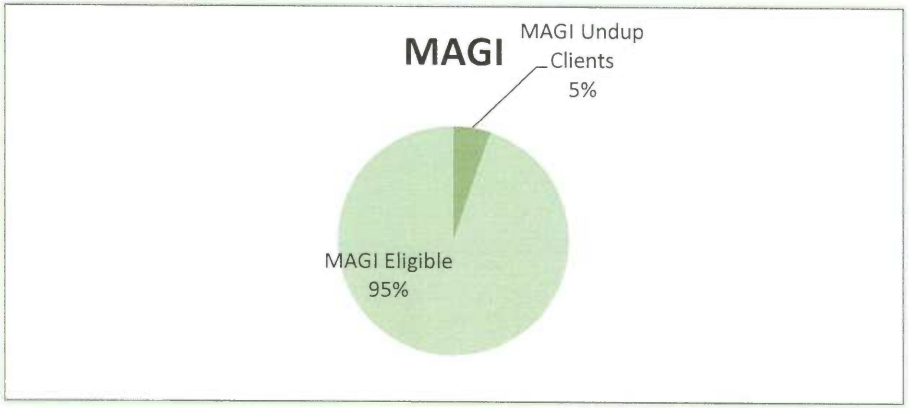
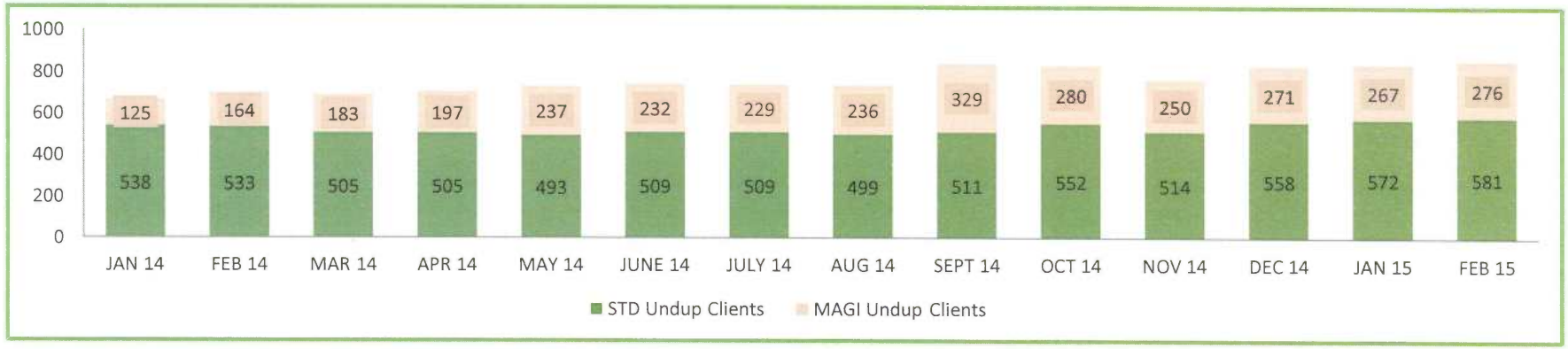
STD Hours
MAGI Hours

PBH


Medicaid Funding
MAGI Eligible 33%
STD Eligible 67%


MAGI
MAGI Undup Clients 5%
MAGI Eligible 95%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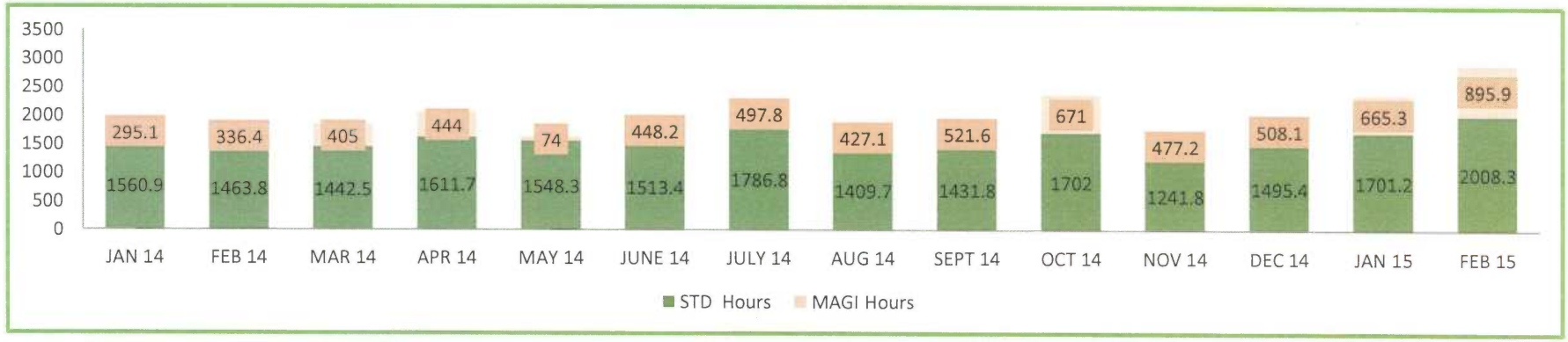
STD Undup Clients
MAGI Undup Clients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1560.9 1463.8 1442.5 1611.7 1548.3 1513.4 1786.8 1409.7 1431.8 1702 1241.8 1495.4 1701.2 2008.3
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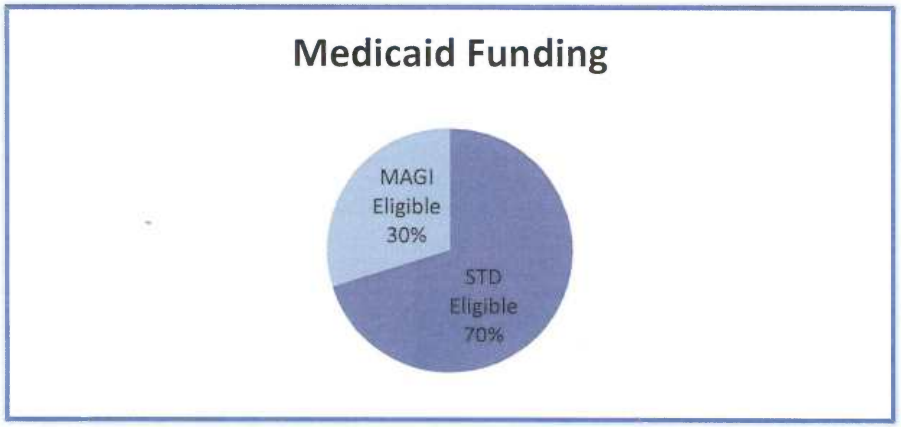
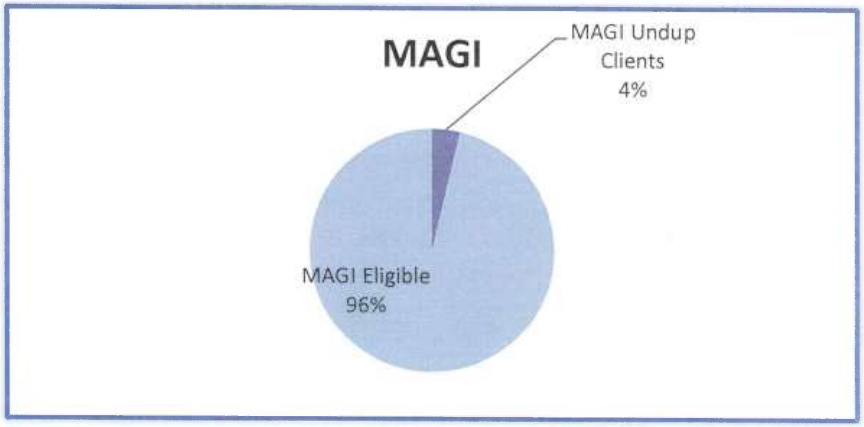
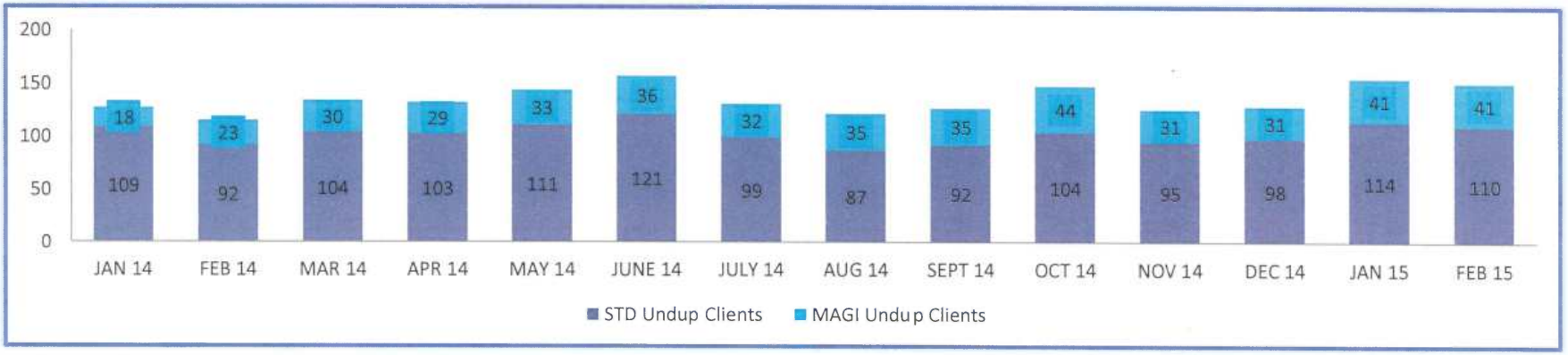
STD Hours
MAGI Hours

WEOS


Medicaid Funding
MAGI Eligible 30%
STD Eligible 70%


MAGI
MAGI Undup Clients 4%
MAGI Eligible 96%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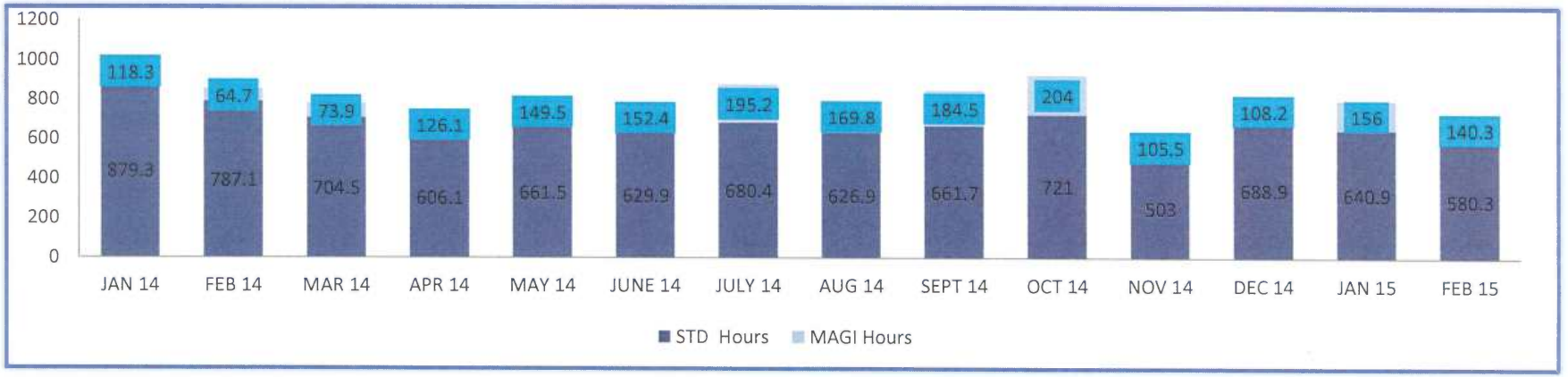
STD Undup Clients
MAGI Undup Clients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879.3 787.1 704.5 606.1 661.5 629.9 680.4 626.9 661.7 721 503 688.9 640.9 580.3
STD Hours
MAGI Hours