Thurston-Mason Behavioral Health Organization (TMBHO)
Special Meeting with Health Care Authority

Date:	January 6, 2017	**Time:**	2:30pm
Location:	Health Care Authority 626 8th Avenue SE, Olympia WA		
Subject:	TMBHO Governing Board to meet with HCA to discuss Mid-Adopter or Late-Adopter options		
Staff Contact/ Author:	Tina Gehrig, Clerk 360-867-2509		
Attendees:	**Health Care Authority:** Nathan Johnson, Chief Policy Officer MaryAnne Lindeblad, Medicaid Director Alice Lind, Section Manager		
	Commissioners: Bud Blake, TMBHO Chair Terri Jeffreys, TMBHO Vice-Chair John Hutchings, Commissioner		
	Thurston-Mason Behavioral Health Organization: Mark Freedman, Administrator Joe Avalos, Chief Operating Officer Tara Smith, Fiscal Manager		
	Other Staff: Sherri Nehl, Kelli Kennedy		
Mid-Adopter or Late-Adopter Options Discussion	Commissioner Blake began the discussion with a brief description of some of the great things that TMBHO has recently accomplished and expressed excitement of working with HCA towards full integration. The discussion for today will center on the difference/flexibility in becoming a mid-adopter versus late-adopter (2020). Mr. Freedman spoke about the notion of increased flexibility for those who come on as mid-adopters. What does that mean? In SW WA (early adopter) the only role is that of crisis services. TMBHO recognizes that there are many additional services that would need to be maintained at the local level to impact the community in positive ways in addition to crisis services. What are those additional services that would be allowable for the BHO to manage? TMBHO has worked hard to establish services that most impact the high utilizers of jails, homeless persons, emergency departments, etc. and would like to continue in that role of management. Mr. Johnson spoke about the original intent of SB 6312 which was requested by the Governor and adopted in 2014. The integration of finances has occurred with the creation of BHOs, and clinical integration will happen soon with the move of DBHR to HCA. While there are many interpretations of what integration means, HCA maintains that the intent of the legislature in this decision was that all Medicaid funds would go to a licensed managed care entity, i.e., licensed by the Insurance Commissioner. In the Thurston-Mason region, there are five managed care health plans. Financial and service risk to plans and partner, maintaining oversight and monitoring.		

There are however, varying options for how the MCO's procure and manage the system. It's recognized and acknowledged that counties do play an important role in managing local resources.

In SW WA a Regional Advisory Committee was created that includes state and local representatives that meet semi-annually to provide oversight of a fully integrated managed care system for Medicaid individuals. SW does not have Access to Care standards and they believe that this has eliminated barriers for some individuals that have accessed care or received services that previously would not have been able to if they did not have a diagnosis, but were decompensating at the time. HCA would like to see more connections made in the prevention/early intervention stages rather than high risk persons later on.

While there is a difference in oversight and direct impact, each region has the ability to define that, but a single entity still has oversight over individuals being seen, whether for physical or behavioral health or both. Concern was expressed with the MCO's not having experience in dealing with the needs of this population.

The following services would not be included in the MCO contracts:

- Crisis services for all members of the community (includes DMHPs)
- State funded services for Non-Medicaid beneficiaries
  County funded for Medicaid and non-Medicaid (local treatment sales tax)
- Miscellaneous (Ombuds, Committees formerly led by BHO – WISe, CLIP, Behavioral Health Advisory Board, etc)

Plans also will not manage CJTA and state block grant funding. Previously state block grant funding was used to fill needs that Medicaid would not pay. TMBHO uses SBG for housing support services to Medicaid clients, but it's not a Medicaid allowable service. HCA's intent was to integrate as many services as possible, rather than try to carve out as many services as possible.

Thurston-Mason BHO currently has 2 providers that offer a physical and behavioral health integrated model. SeaMar has both a primary care and behavioral health clinic at their facility. BHR has a behavioral health clinic on the same campus as Valley View Health Center, a FWHC primary care provider.

Discussion occurred about capacity and Network adequacy. HCA maintains high standards around availability of providers and they look closely at wait times and availability of services. MCO's have the responsibility to have sufficient providers and that may include opening new facilities when the need arises.

Care coordination is a critical element of local treatment service provision. HCA noted that the MCO's receive lists of high utilizers in their regions and they are responsible for sending someone to connect with them. Once again the MCOs can do this directly or indirectly with subcontracts.

Cost reimbursement for providers is another area of concern, particularly for SUD providers who were underfunded for so long. This last year with the creation of BHOs, SUD providers were able to see a slight increase in reimbursement. How will that be maintained with MCO's having oversight?

	What's in place for measure quality management of MCO's? 1. External quality review. 2. Team monitoring (HCA Staff review standards to make sure that plan meets certain requirements and other components on a yearly basis, more often if needed). Plan loses 1% of premium and needs to show quality improvement over 7 measurements to receive back. What will happen to BHO owned facilities, i.e., 3 crisis triage facilities? The BHO was encouraged to have these discussions with plans collectively to maintain these services and how to be the most cost effective. How does a county become mid-adopter? The County authority would opt-in through a letter of intent and non-contracted entities would assist with the procurement process to avoid conflict of interest. Benefits of becoming a mid-adopter: 1) Time limited resources to assist in the implementation process. North Central is being provided $200,000 for implementation 2) 1115 waiver incentive – significant incentives available to those who are mid-adopters. Who administers? Through the Community accountability of community health structure (Cascade Pacific Action Alliance).

I certify this is a true and correct copy of the original document maintained in the Office of the Thurston-Mason Behavioral Health Organization.

ATTEST:

_____ *Date:* _____

Tina Gehrig, Clerk of the Board