Integrated Managed Care

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Current Siloed Medicaid Systems

Mental Health Services & Chemical Dependency for people who meet Access to Care Standards

DSHS administers benefits:

- County-based Behavioral Health Organization (BHO) contracts for Specialty mental health services and substance use disorder (SUD)
- State hospitals with which mange long-term psychiatric inpatient stays

Medical Services & Mental Health Services for people who do NOT meet ACS

HCA administers **medical** benefits (including prescription drug coverage) and mental health benefits for Medicaid enrollees who do not meet ACS

- Contracts with Healthy Options plans for medical and non-ACS mental health managed care services
- Direct contracts with providers for fee-for-service (FFS) enrollees

HCA administers **dental** benefits via direct contracts with providers.

Providers

Providers

Individual Client

Full Integration Basics

County Authority

- It is the decision of the county authority(s) in a Regional Service Area to move to an integrated model before 2020. In January 2020, the full State will transition per E2SSB 6312.
- In a multi-county region, all counties must agree.

Consumer Choice

- Each region will have a minimum of 2 Managed Care Plans, which will be selected through a competitive procurement process.
- No region will have more than 5 plans.

Collaboration

- No matter when a region goes forward, the implementation process will require a high degree of collaboration between providers, MCOs, county/BHO staff, and the State.

County/ BHO Role

- All regions will have the option to keep their BHO in the role of BH-ASO, which is an entity that manages the crisis system regionally as well as certain non-Medicaid funds.

- If desired, the county(s) can form a Interlocal Leadership Structure that that will lead the design & implementation from the local level

Medicaid Transformation Demonstration Opportunities related to Integration

- All ACH's are required to and will receive funding for clinical integration projects (see toolkit);

- All regions with implementation dates prior to 2020 will receive incentives to support provider transition:
  - First incentive on receipt of binding letter: by 9/15/17
  - Second incentive on implementation date: 1/1/2019

- The first incentive payment will be distributed upon approval of the ACH project plan – expected early 2018

Proposed ACH Waiver Incentive Amounts

** The below funding levels are pending CMS methodology approval.

Accountable Community of Health*	Regional Client Count	Eligible Incentives for Binding Letter of Intent	Eligible Incentives for Implementation	Total Incentives for Integrated Managed Care
Cascade Pacific Action Alliance	179,382	$3,382,000	$5,074,000	$8,457,000

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Integration Incentive Funds: Potential Uses

- Can be used to assist providers in the region with the process of transitioning to a integrated managed care business model, such as:
  - Implementing new billing technology
  - Technical assistance to learn new billing/encounter submission/claims reconciliation methods and train staff on medical billing
  - Technical assistance in moving to value-based purchasing payment methods
  - Technical assistance to implement a new EHR
  - Technical assistance to implement an integrated clinical model

- Funds can also be used to further support implementation of transformation projects

Next Steps

- September 15, 2017: Binding Letters of Intent Due to be "mid-adopter"
  1) January 2019 – full integration, no transition
  2) January 2019 – MCOs assume risk, 1 year transition period

- Default: Full integration by January 2020 (no Demonstration incentives and no binding letter of intent due)

Resources

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