Medicaid Behavioral Health Services in King County
Overview of Persistent System Vulnerabilities

• Large changes to payment structures
  ▪ 3 significant system changes in last 3 years
  ▪ Cash flow
  ▪ Case rate system does not incentivize retaining most difficult clients

• Infrastructure requirements
  ▪ Documentation
  ▪ Regulatory requirements

• Staffing
  ▪ Increased competition for staff
  ▪ Salaries
  ▪ Licensure costs
King County Medicaid Behavioral Health Sector

• ~ 30 Providers
  ▪ Only Mental Health services (approx. 8)
  ▪ Only Substance Use Disorder (approx. 6)
  ▪ Providers of both mental health and substance use disorder treatment (approx. 20)

• Experts in serving those with serious and severe BH conditions
Who and How We Serve Our Patient Population

• Patients:
  - Often *not* involved in healthcare elsewhere
  - Provider becomes medical home even without primary care services on site

• Typically have multiple social stressors needing intervention

• Extensive use of non-medical staff (social workers, case mgrs.)

• Requires flexibility to service models (outreach, non-clinic based services, walk-in care, etc.) to ensure people will be served.
Services within King County Medicaid BH:

- 24-hour crisis response
- interpreter services
- brief interventions
- case management
- psychiatric and medical services
- in-home services
- employment/vocational services
- peer support services
- homeless outreach and engagement
- housing/residential services
- day treatment
- individual and group therapy
- family therapy
- psychiatric consultation to schools
- medication management
- cultural consultations and culturally appropriate care
- education and training opportunities
- consumer/advocate run services
- High-intensity outpatient care (WISe and PACT).
- Case management

Reimbursement for these vary with modality (MH > SUD generally. OTP services bundled)
King County Medicaid Behavioral Health Sector

• Modalities in Mental Health Treatment:
  - Inpatient Hospitalization
  - Intensive Outpatient
  - Outpatient
  - Co-occurring (dual diagnosis with MH + SUD)
  - Crisis Response Services
  - Assertive Community Training (ACT teams)
  - Peer support
Modalities in Substance Use Disorder Treatment:
- Inpatient
- Intensive Outpatient
- Outpatient
- Opioid Treatment Program
- Detoxification (withdrawal management)
- Pregnant and Parenting Women
- Long term residential

- Office Based Opioid Treatment – counseling (Outpatient)
- **Not included**: peer recovery support
Not included in King County Medicaid BH:

- Homeless outreach
- Supported Housing (e.g., ShelterPlus Care)
- Legal assistance (help with ID, warrants)
- Employment training

- These are funded by county and city contracts
  - MIDD
1. Significant Changes to Payment Structures

• Pre-April 1, 2016:
  ▪ Single State Agency (SSA – SUD sector) or Regional Support Network (RSN – MH sector)
    Weekly billing/reimbursement
    Cash flows were dependable
    Provider focus on reimbursement rates, containing workload
1. Significant Changes to Payment Structures

• April 1, 2016: Behavioral Health Organizations
  ▪ Interim structure between SSA/RSN and Fully Integrated Managed Care (1/1/2020)
  ▪ Responsible for Medicaid payments

• 9 BHOs across state
  ▪ Fully independent from the other BHOs
  ▪ Governed differently
  ▪ Different relationships with providers (collegial to adversarial)
  ▪ Idiosyncratic operational requirements

• Several providers with multiple sites in multiple BHOs
1. Significant Changes to Payment Structures

• January 1, 2019: King County Integrated Care Network (ICN)
  ▪ Manages Medicaid payments between MCOs and BH providers
  ▪ King County Behavioral Health and Recovery Division partnership with BH providers
    Intended to help minimize additional disruptions to system
  Cash flows
  Authorizations, reimbursements, documentation
1. Significant Changes to Payment Structures

• Future:
  ▪ Duration of KC ICN?
  ▪ Changes to MCO contract relationships?
  ▪ Changes to reimbursement rates?
    Significant fear of:
    Reduced reimbursement rates
    Delays in reimbursements
  ▪ Changes to infrastructure requirements in order to remain competitive
    Fully integrated care
2. Infrastructure requirements

- Documentation
- Regulatory requirements
- IT infrastructure
  - Electronic medical records
- Efficiencies in billing and reconciliation
- Auditing requirements
- Meeting attendance with funders
- Managing a diversity of systems for payment/reporting
- *Increased administrative staff needs*
3. Staffing Challenges

- Increased competition for staff
  - Primary care system
  - Opioid crisis

- Salaries
  - Historically low
  - Independent nonprofit challenges competing with primary care, for-profit, tribal programs

- Licensure costs
  - SUD annual licenses more than doubled in 2019
  - 25% of licensed CDPs failed to renew license (e.g., loss of jobs)
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How can HealthierHere help?

• **Advocacy**
  - GB must determine importance of current BH sector
  - Advocate for protection/support at state, county levels
  - Help align reporting metrics with quadruple aim
  - Help providers navigate contracts with MCOs
  - Equity and parity on case rates vs primary care

• **Innovation**
  - Centers of Excellence for BH services
    - Current system => race to the bottom for minimal services
    - Rhode Island, Vermont examples (Medicaid waiver projects)
    - *Enhanced payment rates for providing excellent care.*
    - *Incentivize treating most challenging patients.*
How can HealthierHere help?

• **HH Governing Board:**

• Determine means by which BH providers can be strengthened
  - GB-focused workgroup for 6 months?
  - Keep BH system vulnerabilities explicitly in mind with decisions
  - Other options?