Washington State Department of Social & Health Services

Transforming lives

DSHS Response to Questions from Chelan/Douglas RSN Released May 23, 2014

Regional Service Area (RSA) and Behavioral Health Organization (BHO) Questions

1. Define what the nature of the financial risk will be for the counties who assume the responsibility of the Behavioral Health Organization

   Think of this as insurance. The BHO receives a premium payment for each Medicaid enrollee to cover all medically necessary services. It's the same payment for an enrollee who accesses many services as it is for the enrollee who doesn't. When you, as a BHO, accept payment you are responsible for covering all services even when the payment is not sufficient to cover certain individuals who use many services. In balance, that same payment will be much more than is required to cover many other individuals who do not use many services. BHOs will be responsible for all inpatient, residential, and outpatient mental health and substance use disorder medically necessary services.

2. Clarification around the threshold of Medicaid covered lives to support full financial risk. Is this actual Medicaid enrollees, or total population of the potential RSA?

   The threshold refers to the population of Medicaid enrollees, not the general population. The number of covered lives is most important for the sustainability of BHOs. Based on our actual recommendations a larger pool moderates the risk to the BHO in terms of the impacts of "high use" versus "low use" individuals, as described above. In general, the smaller the number of Medicaid covered lives, the greater the administrative burden. The cost of administration decreases as expenses are spread over a larger volume of enrollees. The Department and the Authority are recommending a minimum of 60,000 to 65,000 in a BHO.

3. What is the benefit package relative to Chemical Dependency service for Medicaid enrollees, and what are the access standards?

   The benefit package for chemical dependency will be all of the services under the current State Plan. BHOs are responsible for all medically necessary mental health services for all Medicaid clients meeting Access to Care Standards, and for substance use disorder enrollees screened through American Society of Addiction Medicine (ASAM) criteria for patient placement into substance use disorder services.

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4. If the final recommendation for our RSA has Chelan and Douglas Counties included with other counties that currently comprise an RSN, will both RSNs within the new RSA have the opportunity to apply to be the BHO for the region?
   No. We are accepting one BHO per region. Therefore, we are accepting one detailed plan for each region.

5. Once it is determined what the regional service area (RSA) will be, how long of a transition will it be to either complete a merge, or develop a plan to become a BHO?

   It is assumed that regional service area designation will occur by Oct 1, 2014. Guidelines for state expectations of detailed plans will be issued by July 15, 2015, and submission of detailed plans to the Department from BHOs by October 31, 2015. These will include a description of the BHO organizational structure. The time it takes for each BHO to develop a project plan will be different, but these dates offer a sense of thresholds that will dictate progress toward final implementation of services in April 2016.

6. Section 5, Paragraph 2(a) references BHO applicants needing to demonstrate the "ability to maintain and management adequate reserves." How will "adequate reserves" be determined?

   Adequate reserves are calculated by an independent actuary as part of the rate setting process. These reserves will be established using the same process used to determine reserves for the Regional Support Networks with the addition of CD services. The risk reserves on average are 10 percent of the general operating budget in the region. They may be a little higher or lower depending on the size of the region.

7. What would happen if with a multi-county RSA some counties want to be early adopters and others do not? The law seems to require that all of the counties must agree to be early adopters.

   Early adopter regions need to include all of the counties in the Regional Service Area.

   The legislative intent of 6312 with regard to the "early adopter" approach is that all counties within a particular regional service area are jointly adopting the option.

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8. If the State were to contract directly with an MCO for behavioral health service within an RSA (e.g. early adoption), how might current provider agencies be impact?

   The Counties are in the current position of choosing the early adopter option including what counties to align with based on the needs of their population. In planning for this option they also have the ability to influence the impact of the decisions on the future delivery system and use of existing providers. Regardless of the financing approach, we strongly expect existing behavioral health provider to be utilized by the contracting entity (BHO, MCO or otherwise). This seems necessary from a network adequacy and overall delivery system capacity perspective.

9. Chelan and Douglas Counties are in a position that we need to decide to invest in and provide "diversion beds" at our Parkside facility. We also will be investing funds to do tenant improvements to house our current provider, Catholic Family & Child Services, at Parkside. How can we be assured that this investment will provide the long needed services that we have addressed locally?

   Current valuable relationships with providers will translate into the new world of BHOs. They will be needed in 2016, just as they are needed today. Investments in community needs will retain their value. Further, the community will continue to have needs identified now as the BHOs evolve. The importance of strong community partnerships is core to the success of our behavioral health system in the future.

10. How will non-Medicaid services and/or consumers be funded in the BHO model?

    In addition to contracting for services to Medicaid enrollees, BHOs will also hold contracts with the state for general fund and block grant services to non-Medicaid consumers and for non-Medicaid services.