Healthier WASHINGTON

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FAQs

Physical and behavioral health integration

Continuum of care and county services

1. What will the new integrated structure look like for counties? How will dollars the BHO uses to support the counties in their stabilization and continuum of care programs flow? How will the administrative costs of running stabilization/human service programs be paid?

If the county is also a service provider, the county provider agency would be eligible to contract with the MCOs and/or BH-ASO to continue providing treatment services, just as any other behavioral health provider agency in the region. This is the case in Skamania and Grant counties already.

If the county provides allowable delegated functions or coordination functions on behalf of the BHO, and would like to continue providing those functions in the future, the MCO/BH-ASO could choose to continue that arrangement. If these functions are paid for by county dollars, those dollars stay with the county and are used at the discretion of the county.

2. Where are current county staff (providing care coordination and mental health outreach services) going to work? What about public health staff who work on prevention programs? Is the role of health and human services at the county level being eliminated or simply changing? What (specifically) does it look like in an integrated model?

Any county staff or functions that are funded by local funds, such as 1/10th of 1 percent, will not be affected at all by this transition. Counties maintain full control over local funds and 1/10th 1 percent funds. The prevention programs funded through DBHR/Substance Abuse block grant will continue to be funded through counties unless the county chooses not to maintain this role.

Care coordination and outreach would become a responsibility of the MCOs. However, that does not prevent the counties from continuing some/all of those functions through contracting with the MCOs or ASO.

3. What assurances do local jurisdictions have that this is not a cost shift or unfunded mandate? What assurances do we have that service levels will not be negatively impacted?

HCA will requires the same services be provided through contracted MCOs and BH-ASOs. HCA will monitor use to ensure that services will not be negatively affected. The Interlocal Leadership Group has the opportunity to provide input on the monitoring activities, early warning system, and performance measures.

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4. When will data be released on Southwest Washington's early warning system results for the past contract year?

HCA released a 90-day report on the Southwest Early Warning System.

While HCA has continued internally monitoring certain early warning system indicators after 90 days, we have not released a public report and we will not be able to do so before the decision deadline. We can tell you that the early warning system indicators showed a stable system with no significant change in any direction.

HCA would also direct the region to a letter from the Southwest Washington Behavioral Health Provider Alliance, which states: "the change to integrated managed care in Southwest Washington has been a success….access has been significantly improved and administrative processes have been greatly reduced and provider feedback has been a foundational component of the entire process."

Additionally, in August 2017, the Research and Data Analysis section of DSHS assessed first-year data of the early adopter region, concluding that the Southwest Washington region had achieved statistically significant improvements in 10 categories of measurement as compared to other regions of the state. On eight measures, they were measured as equal, and on one measure they were trending negatively. This measure (emergency department utilization) is mitigated by the fact that the region was already the second lowest in such utilization, and while the region has decreased its utilization, it has not decreased as much as other regions.

Crisis services

5. How will the funds for Crisis Services be "braided" after integration? Will MCOs be contractually required to provide Medicaid funds to partially support Crisis Services moving forward? What requirements will there be for MCOs to help maintain other services that require blended funding?

The MCOs are required in contract with HCA to establish a sub-contract with the BH-ASO to pay for Medicaid-covered crisis services for their members. This includes mobile crisis outreach and the crisis hotline and any short-term crisis stabilization activity that might occur during a mobile outreach visit, etc.

If a Medicaid client is committed to treatment as a result of their encounter with the crisis system, such as being committed to an E&T by a DMHP, the MCOs are contractually required to pay for that treatment service (the MCO pays the E&T directly). They are not able to do prior authorization or deny a service that has been court ordered.

The BH-ASO also has a contract with HCA funded by non-Medicaid funding sources. This covers the non-Medicaid crisis related costs, such as crisis services delivered to non-Medicaid individuals or court reimbursements for any individual who is involuntarily committed or the cost of a DMHP ITA investigation.

The braiding of funding really happens at the BH-ASO level, just as it does right now at the BHO level. The crisis providers should expect to be paid by the BH-ASO similar to the way they are today by a BHO. Providers will directly negotiate with the MCOs and BH-ASO a payment method that works best for them.

6. In the fully integrated managed care model, where does the funding come from and who pays for the court system costs related to E&T facilities?

The funding comes from the state-only funding contracted to the BH-ASO, and the BH-ASO funds the ITA court costs.

7. In the fully integrated managed care model, who pays the E&T costs and how is this determined?

Like any other provider, the E&T negotiates a contract with the appropriate payers, which will include the MCOs for Medicaid individuals as well as the BH-ASO for non-Medicaid individuals. The details of provider and payer contracts are proprietary and negotiated between the provider and payer.

8. Is there any legislation that requires counties to supply mental health, chemical dependency (SUD), and crisis services? If so, please provide all statutory citations.

No. Currently the responsibility is that of the BHO. If there isn't a BHO then it is the responsibility of the DSHS Secretary (RCW 71.24.035(16)). Under FIMC, the responsibility shifts to the MCOs and the BH-ASO.

9. In the FIMC model, who pays the state hospital bed allocation penalties for the region? What criteria is used to determine which health plan and/or BH-ASO is required to pay for bed allocation penalties due to over utilization of allocated beds?

In the integrated managed care model, the region's state hospital bed allocation is distributed to the health plans and the BH-ASO. Based on historical utilization of beds, the BH-ASO is assigned a bed allocation for the non-Medicaid population. The remaining beds are distributed between the MCOs based on their proportion of the region's Medicaid enrollees. When a non-Medicaid client enters the hospital, they are "assigned" to the BH-ASO. When one of the health plans members enters Eastern State Hospital (ESH) or Western State Hospital (WSH), they are assigned to the appropriate MCO. The MCOs and BH-ASO each employ a hospital liaison who is responsible for managing their census and coordinating discharge/placement, etc. for their assigned clients at ESH and WSH.

Under the current methodology, if the entire region remains under its regional allocation, no bed overage fees are assessed and none of the entities (MCOs/BH-ASO) are penalized. If the region goes over its allocation, the bed overage fee (as assessed and calculated by DBHR on a regional basis) is distributed amongst the MCO/BH-ASO entities based on their utilization of beds relative to their target allocation. This means that the entities who utilize more beds or go above their own allocation will be assessed the bed overage fee while those that remain under their allocation will not be assessed a bed overage fee. The utilization of beds at the individual MCO/BH-ASO level is calculated by HCA as a quarterly average of the daily census.

HCA is considering some minor adjustments to this methodology in the future and can share more information when final. HCA is open to input on ways to improve these processes and policies.

Maintaining and expanding treatment capacity

10. How will residential treatment be paid for, and what assurances are there that systems the counties are investing in will be utilized?

Residential treatment beds are paid for by the MCO, or for non-Medicaid clients, by the BH-ASO. The MCOs will have a portion of state-only funds that will allow them to pay the non-Medicaid room/board cost, just as the BHO's do today. Residential treatment services are Medicaid covered and therefore are paid for by the MCO's using Medicaid funds.

As the BHOs currently do, the MCOs will be required to provide medically necessary services, including treatment in IMDs that extends beyond 15 days.

If an individual is involuntarily committed to residential treatment or is otherwise authorized for residential treatment by the BH-ASO, the BH-ASO would pay for that out of non-Medicaid funds (state funds, block grant, proviso, CJTA - - as allowable and available).

In terms of assurances to the county regarding whether the beds will be contracted; there is a shortage of beds in the State of Washington. As Essential Behavioral Health Providers, the MCOs will need as many providers as are available. MCOs are responsible for the full spectrum of services, it behooves them to serve clients in the least restrictive manner possible, where clients are likely to succeed. This includes maintaining relationships with the communities in which the person resides.

11. What is the logistical process for bringing on more providers and increasing consumer access to services? What happens if the limitation for increased access is workforce? How will capacity be developed in order to keep people stable and out of crisis?

As noted in prior questions, the MCOs are held to requirements to have an adequate network of providers to meet the access needs of the population. If the limitation is workforce, the MCOs have flexibility and discretion to increase provider rates for certain types of hard-to-access services. Additionally, in Southwest Washington HCA is working on a capacity building process with the MCOs, BH-ASO, ACH and counties to collectively work towards increasing provider capacity in the region.

One of the benefits of this model is that the access to care standards and silos are removed, which allows new providers such as medical systems to obtain licensure for behavioral health (BH) services (if desired) and offer additional services or clinically integrated models that they have not previously delivered. If this occurs over time, it will improve access to services.

12. HCA has stated that in January 2019, all regions must eliminate the Access to Care Standards. What does this mean and what would it look like for a region that is a Mid-Adopter immediate, a Mid-Adopter transition, and a Late-Adopter?

When we say "Access to Care Standards must be eliminated," we mean that on January 1, 2019, the MCOs in the mid-adopter regions will determine whether to impose utilization review or prior authorization for services. Medical necessity decisions will be made by the MCO, or if delegated, will be delegated without regard to Access to Care Standards, and will instead be based on medical necessity criteria.

For regions that are not mid-adopters and choose to implement in 2020 Access to Care Standards will remain until 2020 implementation.

13. Does HCA's FIMC model affect counties' Developmental Disabilities programs, contracts, or the Division of Vocational Rehabilitation?

HCA does not anticipate this change will impact a count DD program or Division of Vocational Rehabilitation. If the BHO is funding any county employees in the DD program or the Division of Vocational Rehabilitation, let us know.

Coordination with public safety systems

14. Who is responsible for coordination with jails to ensure diversion services are working? What will counties do if they are not? Who is responsible for coordination with courts to ensure timely access to assessments and funding support and treatment access for Drug Court? How will the CJTA money be distributed?

The MCOs and BH-ASO all must coordinate with the criminal justice system and treatment providers to assure their members are engaged in treatment and diverted from jail whenever possible. The region should expect that the MCOs and ASO hire jail liaisons and are actively engaged in jail diversion activities.

In SW Washington and North Central, the BH-ASO receives the "jail transition" proviso funds and contracts those funds to the providers who have been providing jail transition services in the region.

The BH-ASO also receives the CJTA funds and contracts those to providers, primarily to support the non-Medicaid justice-involved population that is eligible for CJTA funded treatment. Many of the treatment services funded via CJTA are also Medicaid-covered and thus covered by the MCOs for their clients.

The use of CJTA funds is directed locally, by each region's CJTA panel. This does not change -the BH-ASO simply contracts the funds out in accordance with the priorities and parameters that are determined by the local CJTA panel.

Depending on how the Drug Court currently operates or is funded, HCA will work with the region during the lead-up to integration to ensure Drug Court continues.

15. Do all proviso dollars go to the BH-ASO, like a region's jail and E&T proviso dollars? If so, and the region is not the BH-ASO, will counties have any input on how the BH-ASO allocates those dollars within the region?

In Southwest Washington and North Central, proviso dollars typically go to the BH-ASO. In some cases, the MCOs also received a portion of these dollars to support Medicaid clients. E&T proviso dollars have not been allocated during the transition of SW Washington and North Central, so this would be a something discussed with the region, to determine the best approach for allocating these funds. The Interlocal Leadership Group should have input into this topic.

Workforce

16. Who will do advocacy for workforce needs and training? Who will identify future local needs and how will those needs be addressed?

This should be a topic for the Interlocal Leadership Group as implementation progresses.

Regional planning

17. What specific decisions should be made by a regional service area if they would like to remove all risk to the counties as part of the Mid-Adopter or Late-Adopter decision?

The counties will have no financial risk for behavioral health service if they do not choose to become the BH-ASO, and instead opt for a procured BH-ASO.

18. Who is responsible for regional planning on programs and services that need to be coordinated?

HCA would further discuss with the regional stakeholders and selected MCOs/BH-ASO how they would like this to look in their region, and how they think it can be most effective. This should be a topic for the Interlocal Leadership Group as implementation progresses.

19. With county involvement (BHO/BH-ASO) how will the above coordinating services be funded? What is the protection for counties that the system we are involved with will be adequately compensated and not require backfill with local county funds?

HCA would need more specific information on the type of coordinating services this question refers to. HCA has no ability to require the counties to "backfill" the cost of services in the Medicaid program. Strategies for ensuring the system of care within the region remains intact could be a task for the Interlocal Leadership Group.

20. The transition period will require additional demands on our local staff as well as additional staffing to do reporting and maintain Level of Services [LOS], how can this be funded?

SIM-funded technical assistance dollars to assist mid-adopter counties in the transition to 2019 are available, up to $200,000 per region. These funds should be used to support planning and implementation that will need to occur at the local level.

Also, the ACH has the ability to provide integration incentive funding to the counties to support implementation costs.

21. The BH advisory committee function is very important. Does HCA/DSHS provide funds to continue this important function during and after the integration period? If so, what entity is provided these funds by HCA/DSHS (county, BH-ASO, health plans), and does it vary depending on whether a region is a Mid-Adopter (immediate or transitional) or Late Adopter?

HCA agrees that this committee's function is important and does require that the function continue after integration. The funding structure would not alter based on implementation date but the entity that is provided the funds could vary by region. In SW Washington, this function is coordinated by the ACH. In North Central,

this function will be coordinated by Beacon. Designated funding will be provided to the entity that operates the Advisory Board.

22. Does any part of the 1/10 of 1 percent sales tax or the mental health/chemical dependency property tax collected by counties get dedicated or required to be used as part of the Medicaid funding for integration?

The 1/10th of 1 percent sales tax is a county funding source. It is entirely under the jurisdiction of the counties and the county decides how to expend county tax dollars. The state cannot place any requirements on local funds.

23. What role does the ACH play in the Mid-Adopter immediate integration option?

The ACH role remains the same regardless of whether the region chooses to pursue a transition year or not.

We expect that the focus of the mid-adopter incentive funds should be to build the capacity of the behavioral health providers as they transition to working with managed care organizations. The BHO and counties should be participating in the ACH and should have a voice to advocate for how funding should be distributed.

Client rights

24. What does a County do if a MCO or the local health care provider "fires" a client for things like "no-show," "behavioral issues," or simply not following medical advice? What happens if the client has a barrier to accessing care? Who is their advocate?

HCA MCO contracts include requirements regarding "involuntary disenrollment", including, e.g.

4.12.6.3 "HCA will not terminate enrollment and the Contractor may not request disenrollment of an Enrollee solely due to a request based on an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or behavioral health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b) (2))."

MCOs are required to provide access to care for clients, and provide assistance to them when providers terminate services. MCOs are required to provide information on grievances and appeals to clients. Additionally, the ombuds function will continue within the region and can assist the client, should they feel they have been wrongly terminated or denied services.

Preparing providers

25. Which partners need to be ready if the region decides to be a mid-adopter? Who is responsible for knowing if they can be ready in time? Who is responsible for ensuring that our healthcare systems are ready to take on behavioral health patients and/or that they have enough capacity to provide preventative care to the expanded population?

The initial change means that BH providers currently contracted with the BHO will need to contract with the MCOs/BH-ASO and be paid using more standard insurance payment/billing methods. Additionally, allied systems that coordinate closely with the BHO will need to transition to working with and partnering with the MCOs/BH-ASO. The MCOs/BH-ASO are required to develop an allied system coordination plan that clearly

outlines these partnership agreements, including with MOUs where appropriate. Best approaches for ensuring ongoing relationships with allied system partners could be discussed and developed further through the inter-local leadership. We think it could be a creative approach for this work to be delegated to the BH-ASO, as a single coordinating entity.

HCA has learned lessons from Southwest Washington, and has been working to develop tools that will assist with assessing provider readiness. This includes a survey tool to assess provider billing and IT capacity, that the Department of Health contracted practice coaches will be trained to use.

Additionally, DOH, through its Transformation Hub, is responsible for developing a full toolkit and "roadmap" that will complement the survey tool, to clearly define the MCO billing expectations for providers and provide guidance and clear timelines on what they need to do to be ready for implementation.

These tools should ideally be paired with hands-on technical assistance. For example, in North Central and SOUTHWEST WASHINGTON, HCA has devoted SIM grant dollars to bringing on consultants to provide hands-on TA to providers to configure their billing systems, implement new EHRs, and test billing/claims submission with MCOs. HCA is invested in finding solutions to assist providers with readiness. In mid-adopter regions we believe this type of work should be a priority use of Medicaid Transformation Demonstration incentive funds via the ACH.

Assessing "readiness" of providers is something that will require a very high degree of collaboration between HCA, the BHO, the selected MCOs and the ACH. It is not something one entity will be solely responsible for. We should discuss what you mean by "expanded population", since from our view the only new population for MCOs is the BH Services Only group.

26. Is it true that HCA expects providers and provider agencies to get loans from banks for opening new sites as part of the FIMC implementation (if they don't have sufficient reserves for doing so), and in subsequent years, to participate in the FIMC model?

No.

27. Who will pay the providers to upgrade their computer software/systems to meet the new data demands? Who will do the training on how to use the systems? Who will do compliance monitoring? Who will advocate for the providers so that they have the resources they need to succeed in providing care?

HCA would expect that ACH Demonstration incentive funds would be used to support provider IT infrastructure building. Additionally it would be an allowable use of BHO funds to support providers' transition to the MCO delivery system. As noted in prior sections, HCA would strongly encourage the provision of TA on IT/billing changes, which could be a good use of ACH integration incentive funds. The MCOs will also be very involved in the provider readiness.

Providers can also advocate for themselves and should. A best practice from SOUTHWEST WASHINGTON is the formation of a BH Provider Alliance, which the providers use to advocate for their needs.

28. Does HCA require the health plans to fund all contracted service providers at the same level they were funded by the BHO the first year? If not, what are HCA's funding requirements of the health plans to the service providers during the first year of FIMC? Are there any HCA funding requirements for the health plans in the subsequent years with the service providers?

HCA requires that the same providers currently contracted to provide BH services be offered contracts. The MCOs will receive the same level of funding (PMPM) provided to BHOs. Contracts are negotiated individually between MCOs and providers. In the SOUTHWEST WASHINGTON and NC regions the providers have negotiated the same funding level with the MCOs that they had under the prior system.

29. How do Federally Qualified Health Centers (FQHCs) fit into the FIMC model and what changes for them?

FQHCs that offer Outpatient Behavioral Health services under contract with the BHOs can continue to do so under FIMC by entering into contracts for behavioral health services with MCOs. FQHC's still receive their encounter rate.

30. HCA sets rates for the hospitals, how will this work in the FIMC model? Will HCA require that the funding needed to pay psychiatric inpatient hospital stays come from the behavioral health crisis service, behavioral health outpatient, and substance use disorder residential funding?

In general, HCA does not set provider rates and dictate them for the plans. An example of an exception is payment for admissions in a designated Critical access hospitals (CAH) when the client is in the HOBD eligibility program; then, HCA does continue to set the rate and reimburse for admissions.

Reimbursement for all other admissions are paid by the FIMC plan. The reimbursement rates for services are negotiated between the hospital and the FIMC plan. HCA pays the plan a specific amount "per member per month" (PMPM) to access and pay for the contractually required services. The PMPM is an actuarial derived amount based on the historical expenditures of all required services, including community inpatient psychiatric admissions.

31. Please clarify the definition of "providers" who would be eligible for Mid-Adopter incentive funds.

All incentive funds under the Medicaid Transformation Demonstration, including funds earned for integration milestones, are paid to the ACH and held by the Financial Executor. The ACH will determine funds distribution to partnering providers. There is no set definition of partnering providers, but these providers can include providers traditionally reimbursed by Medicaid (e.g. primary care providers, oral health providers, mental health providers, hospitals and health systems, nursing facilities), providers not traditionally reimbursed by Medicaid (e.g. counties, community-based and social organizations, corrections facilities, Area Agencies on Aging), tribes/ITUs, and other organizations identified as critical partners to fulfill objectives of the Demonstration. Guidance to ACHs has emphasized intended use to assist providers and the region with the process of transitioning to integrated managed care.

Integration incentive dollars

32. Where is the oversight on the state dollars from the local level in the integrated model, regardless of timing?

Final authority and oversight of state dollars is with the Health Care Authority, as the entity that contracts those funds to the MCOs and BH-ASO. The Health Care Authority is accountable to the legislature. Through an Interlocal Leadership Group structure, or another Regional Advisory Structure as desired by the region, local communities can provide a strong advisory role and can also work with the state and MCOs/BH-ASO to obtain information about how the state funds are being expended.

33. Could the mid-adopter incentive dollars be used to help providers make the necessary changes to their electronic record systems so that they can meet the new MCO requirements for data reporting and billing?

The ACHs are expected to use those incentive dollars for providers to better prepare them for integration, for example, developing infrastructure that supports clinical integration, etc. In order to maintain adequate networks within rural areas, the MCOs have a vested interest in ensuring that providers have the resources they need to continue providing services.

34. How can the Mid-Adopter incentive funds be used by an ACH in our region?

The Mid-Adopter incentive funds should be used by an ACH to assist providers and the region with the process of transitioning to integrated managed care. This could include using funds to assist with the uptake of new billing systems, or technical assistance for behavioral health providers who are not accustomed to conducting traditional medical billing or working with managed care plan business processes. Additionally the incentive payments can further support and build upon the region's work to implement integrated clinical models.

35. Does agreement to use 2019 as a transition year with some Medicaid services still contracted back to the BHO-ASO still qualify the region to receive incentive dollars?

Yes.

36. Does HCA have a mechanism to ensure the Mid-Adopter incentive funds provided to a region's ACH are NOT used for unintended purposes/providers? If so, what is that mechanism?

The ACH will report certain information to the Financial Executor in order to distribute funds. While the final details for what information will be required is still under development, the ACH is responsible for providing projected budget information through project plan submissions.

Partnering providers who are eligible to receive incentive funds must register with the Financial Executor through the web portal. In doing so, the providers will also sign a standard partnership agreement to participate in the Demonstration. The following list indicates the type of information needed from the partnering providers to register with the Financial Executor:

- Entities tax identification number
- Attestation that entity is not an excluded entity
- Acknowledgement that DSRIP funds are being paid based on achievement of a DSRIP objective

- Acknowledgement that the state and federal governments have a right to audit DSRIP activities and to take back any funds that were improperly paid.
- General Terms and Conditions similar to those included in the contract between ACH and HCA.

37. How does the ACH get the Mid-Adopter incentive funds?

Integration funds flow in the same manner as other incentive funds under the Demonstration. Once earned, funds are available to the ACH and partnering providers through the Financial Executor. This process can take a few weeks once the ACH is notified that it has earned the incentives. The process for ACHs to release funds to partnering providers through the Financial Executor is still under development with the design of the web portal.

38. Does release of the Mid-Adopter incentive funds require CMS and legislative approval? Has this approval already been given for our region to receive the Mid-Adopter incentive funds if we decide to be a Mid-Adopter region?

The 2017-2019 biennium budget proviso gives the Health Care Authority legislative approval for the DSRIP incentives, which includes the integration incentive funds. Additionally, CMS has granted approval for the integration incentives through their approval of the Special Terms and Conditions (STCs) and the DSRIP Funding and Mechanics Protocol.

39. What date will the first installment of the mid-adopter incentive funds be released to our region's ACH?

Integration funds for submitting a binding letter(s) of intent will be available in early 2018. These funds will be released to the Financial Executor at the same time as incentive funds earned for approval of transformation project plans.

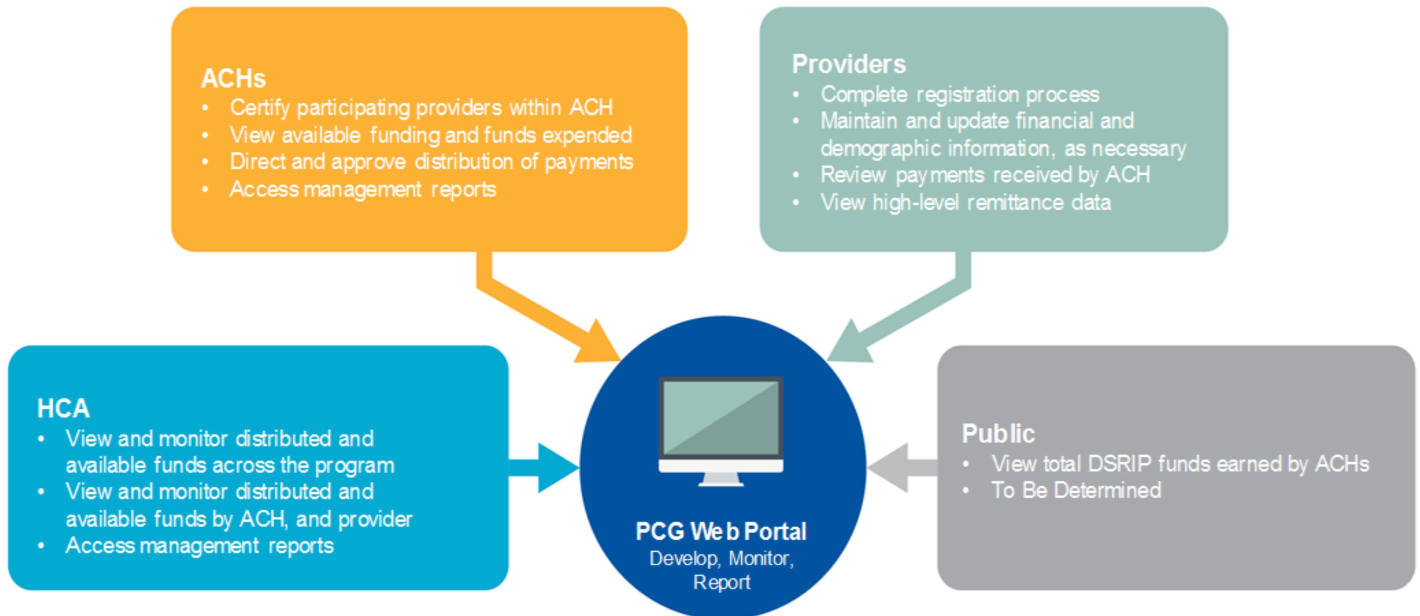
Here is an overview of steps to flow incentives, including integration funds, from HCA/CMS to ACHs and partnering providers:

1. ACHs will develop relationships with partner providers to accomplish the goals of specific projects
2. At the ACH's direction (from the application), providers will be asked to register in the Financial Executor's portal, providing banking and other necessary information.
3. The Independent Assessor determines how much DSRIP funding each ACH earns, and informs the Financial Executor.
4. Per the Independent Assessor's findings, HCA transfers the appropriate amount of money to the Financial Executor's accounts.
5. ACHs will log into the Financial Executor's portal and determine the amount of DSRIP money each entity should receive as part of their participation in projects.
6. Based on the ACH's payment distribution, the Financial Executor will distribute payments to the appropriate entities.

40. What oversight does HCA keep on the Mid-Adopter incentive funds once they have given them to the ACH?

The ACH will report certain information to the Financial Executor in order to distribute funds. While the final details for information that will be required is under development, the ACH is responsible for providing projected budget information through project plan submissions.

The web portal through the Financial Executor will also include reporting and monitoring capabilities:



BHO reserves

41. Does the BH-ASO obtain the non-Medicaid reserves remaining from the BHO? If the BH-ASO does not obtain the BHO's non-Medicaid reserves, what legal authority does HCA have to take non-Medicaid reserves, if the BH-ASO still has the burden of risk?

The unspent reserves must be returned to the state at the termination of the BHO contract.

If the BHO opts to transition into a BH-ASO, it would establish an entirely new contract and would become a new organization.

HCA is currently exploring options related to reserves. Options currently include whether as part of the BHO reserve spend-down process, the BHO could use non-Medicaid reserves to purchase a surety bond or be used to assist with transition costs in becoming the BH-ASO. Another option that would require legislative direction, could be to direct back a portion of the reserve funds to the BH-ASO after they have been returned to the state.

It is important to note that a very large portion of funds held in reserves by BHOs are not required reserves and they can be spent at any time at the discretion of the BHO. BHOs should be planning a spend-down of those reserves as any unspent reserves would need to be returned.

42. Who is the recipient of the BHO's Medicaid reserves and how will they be used in the future?

The federal portion of the reserves is returned to CMS; the GFS portion is returned to the General State Fund. The state would need explicit legislative authority to re-appropriate these funds.

43. Which state agency is the recipient of the BHO's non-Medicaid reserves and how will they be used in the future?

The reserves are contracted to the BHO for the duration of the contract. As mentioned above, when a contract terminates the non-Medicaid funds are returned to the General State Fund. The Medicaid portion is returned to CMS. No department/administration has the authority to spend the funds without explicit legislative authority.

44. What is the process for regions to spend down their BHO reserves?

DBHR is working on a template to provide to BHOs that will assist them with drafting spend-down plans. Spend-down plans will be reviewed and approved by DSHS. Additional information on this process and the template will be forthcoming.

45. Is the BH-ASO required to obtain a surety bond?

We recognize this is an issue and we are looking at options to assist. This includes exploring legislative options to allow certain reserves to fund these types of transition-related expenses.

46. If the regional service area decides they want to be the BH-ASO, can it use non-Medicaid state funding reserves from the BHO to pay for a surety bond to cover the BH-ASO risk?

DBHR does not have the authority to allow a BHO to give another entity its GFS reserves after the BHO contract ends and the BHO ceases to exist. As per the contract, GFS reserves must be returned to the state. These contract terms have always been in place and were acted on with the closeout of both Pierce County RSN and the Southwest Behavioral Health RSN. If the county chooses to become a BH-ASO, that will be a new entity.

47. If regional service area decides they want to be the BH-ASO and they cannot use non-Medicaid state funding reserves from the BHO to pay for a surety bond, will HCA provide funding to the region's BH-ASO to pay for the surety bond to cover the risk? If HCA won't fund the surety bond, what options are available to a region to pay for the surety bond?

We recognize this is an issue and we are looking at options to assist. This includes exploring legislative options to allow certain reserves to fund these types of transition-related expenses.

48. When the state says that all BHO reserves will be taken back, is this all BHO reserves in all categories?

All contracted funds that have not clearly been obligated for incurred expenses must be returned to the state.

49. Can any unspent dollars remaining at the end of 2018 be "redirected" with legislative approval to continue capacity building efforts that were begun before 2019, e.g., development of crisis and residential treatment facilities?

This would require legislative action and is something that will require additional discussion.

50. Is HCA planning to take back reserves from BHO contracted service providers as part of their FIMC plan?

No. Provider reserves are not subject to recoupment.

51. What is the timing of reserve fund relinquishment under the Mid-Adopter transitional option, Mid-Adopter immediate approach option, and Late Adopter option? Specifically provide detail on the following options:

a. If the regional service area decided to become a Mid-Adopter with the transitional one year option, what is the timing and when would HCA take back both the BHO's Medicaid and non-Medicaid reserves?

All mid-adopter regions will require the BHO to terminate as the BHO on January 1, 2019 and reserves will be relinquished with appropriate run-out period based on that date.

The Governor's office, the HCA and Department of Social and Health Services understand this concern and want to be helpful in achieving a resolution that allows counties to be successful as BH-ASOs should that be their desire. The Governor's office, OFM and the Departments have been meeting about the issue and believe legislative action will be necessary to fully resolve the issue. The Governor's office is exploring some possible actions to help achieve resolution. We expect some action in the next two weeks.

b. If the regional service area decided to become a Mid-Adopter and did not want to opt for the transitional one year option, what is the timing and when would HCA take back both the BHO's Medicaid and non-Medicaid reserves?

All mid-adopter regions will require the BHO to terminate as the BHO on January 1, 2019 and reserves will be relinquished with appropriate run-out period based on that date.

The Governor's office, the HCA and Department of Social and Health Services understand this concern and want to be helpful in achieving a resolution that allows counties to be successful as BH-ASOs should that be their desire. The Governor's office, OFM and the Departments have been meeting about the issue and believe legislative action will be necessary to fully resolve the issue. The Governor's office is exploring some possible actions to help achieve resolution. We expect some action in the next two weeks.

BH-ASO

52. What is the role of the BH-ASO? Can you provide examples of activities/programs?

The primary role is:

- Manage the crisis system regionally including mobile outreach, ITA investigations, DMHPs, crisis hotline, etc. BH-ASO contracts with existing crisis providers to do this, and then will work overtime to expand services if desired by the community.
- Pay for BH services for non-Medicaid clients, including services if a client is involuntarily committed, or other BH services as funding allows.
- Manage the FYSPRT, BHAB, block grant project plan writing process, and any other regional committee or convening structures focused on planning or coordination efforts.

- Administer CJTA funds and other non-Medicaid funding sources in accordance with CJTA Panel Plan and locally developed block grant project plan
- Employ the regional BH ombuds
- Manage discharge planning for non-Medicaid clients out of the state hospital
- Other centralized functions as agreed upon by BH-ASO/MCOs, etc.

53. If the county does not want to become the BH-ASO for the region, but another county in the region does, can that county become the BH-ASO for the region? Are there any new or different BH-ASO requirements for that county? Can more than one county become the BH-ASO within the same region, such as if multiple counties want to be the BH-ASO for their county only?

The BH-ASO is a region-wide entity. The counties can organize the BH-ASO management any way they want, but all counties must agree to have a county-based BH-ASO for the region. If all counties do not agree, the state will procure a BH-ASO, as has been the case in Southwest and North Central.

54. Will the BH-ASO be allowed to bring ombuds back in house after integration occurs? Is this something the BH-ASO could contract back with the MCOs to perform after full integration?

Currently, the BH-ASO contract requires the BH-ASO to contract for an independent ombuds, which is not an employee of the BH-ASO but is an independent contractor (the same way it works in BHO regions today). HCA does not have any plans to allow the ombuds to move "in-house", we are supportive of an approach that allows the ombuds to continue operating independently in the region. HCA provides the BH-ASO with an allocation of state-funds that supports the provision of an ombuds. The MCOs do not have any part of the ombuds contracting.

55. Does the BH-ASO contract with HCA or is it a sub-contract with the MCOs?

Both. The BH-ASO has a contract with HCA that is funded by multiple non-Medicaid funding sources (State General Fund, SAMHSA Block Grant, proviso, CJTA, etc.).

Additionally, the MCOs are REQUIRED to contract with the BH-ASO to reimburse for Medicaid covered crisis services. HCA has encouraged the MCOs to contract on a capitated basis with the BH-ASO. They are essentially passing through the portion of the PMPM that is for crisis services, and delegating the administration to the BH-ASO.

56. Will HCA require all the health plans and the BH-ASO to contract with all the behavioral health service providers that are contracted with a BHO at the time of the implementation (1/2019 - Mid-Adopter immediate and transitional, 1/2020 - Late-Adopter)?

It is HCA's expectation that during the RFP process the MCOS will offer contracts to all the existing BHO-contracted providers. It is the decision of a provider whether or not they want to negotiate a contract with an MCO. HCA cannot compel providers to contract with payers.

During the RFP network review and again during the readiness review process, HCA closely reviews network submissions, which includes signed contracts with providers. During these reviews, HCA monitors to determine if all BHO-contracted providers are in-network and if not, HCA would work closely with the health plan to

attempt to resolve the issue so a provider can be brought in-network. However, as stated above, HCA cannot compel a provider to contract with a health plan.

The goal is to replicate the existing behavioral health network 100% and then begin to add new providers and expand the network over time. This goal was achieved in Southwest Washington and in North Central. 100% of the previously contracted providers have been brought into the MCOs networks, and all crisis providers and other applicable BH-ASO providers are contracted with Beacon Health Options.

57. Can certain delegated functions continue beyond 2019 if the MCOs and BHO develop a plan for limited delegation of functions? See attached diagram of possible functions for a BH-ASO. Delegation to BH-ASO?

Potentially – yes. If you choose to use the 2019 transition year, delegation would be allowed. This role identified in the attached document is similar to the existing BH-ASO role, with some additional services such a PACT being fully managed by the BH-ASO. HCA is open to working on this model further with the region. Beyond 2020, delegation is limited by contract language.

58. If the Medicaid money is going to the MCOs, what is the funding mechanism for the BH-ASO? How will it work for a smooth transition? What is the best way to guarantee adequate funding for a BH-ASO?

MCOs are required to sub-contract a portion of Medicaid funds to the BH-ASO for crisis services to Medicaid Clients. Additionally, a large portion of GFS dollars and other grant and proviso funds also go to the BH-ASO.

59. Can counties make recommendations regarding contracting between HCA and the health plans, and health plans and the service providers?

Counties can make recommendations about the RFP, including how many plans would be appropriate for the region and question or considerations to include in the RFP to make sure it's localized. The counties do not get to determine which plans are selected, this occurs through the RFP scoring process. Health plans may ask counties about recommendations about provider contracting and about how contracting is done by the BHO, but they are not required to do so.

60. What entities are involved in the contracting between HCA and health plans?

HCA and the health plans are the entities that are involved in the contracting, and the contract is held between HCA and the health plan. HCA also works with DSHS on contractual requirements and is happy to consider any suggested changes from stakeholders.

61. What entities are involved in the contracting between health plans and service providers?

Contracts between providers and payers are proprietary and are negotiated between the health plan and the provider.

62. What ability do the locally elected officials have to influence contract negotiations in the Mid-Adopter (immediate and transitional approach) and Late-Adopter options, as it relates to health plans and service providers?

As noted above, mid-adopter counties have the ability to have input into the number of plans in the region and in region specific questions that might influence the outcome of the RFP. Contracts between health plans and providers are proprietary. Providers negotiate the terms of the contract and rates for services directly with the health plan.

63. Does HCA's plan with the health plans allow or require FIMC health plans to contract with county behavioral health agencies?

The services county agencies provide qualify them as "essential behavioral health provider types" meaning they must be included in the MCO network.

County behavioral health agencies are treated the same way as any other licensed behavioral health agency. County behavioral health agencies are able to negotiate contracts with the MCOs and/or the BH-ASO.

In Southwest Washington, both Clark and Skamania counties operate licensed behavioral health agencies that have contracted with the MCOs and/or the BH-ASO. In North Central, Grant County operates a behavioral health agency that is contracted with the MCOs and the BH-ASO.

64. Is the BH-ASO responsible for the costs and services for non-Medicaid individuals from their region that are treated in E&Ts, crisis stabilization facilities, and community hospitals outside their region?

Generally speaking, yes, although there are sometimes exceptional or complicated cases.

The BH-ASO is expected to establish contracts with a provider network to serve the non-Medicaid population, which could include providers inside or outside the region. In some cases the BH-ASO may also need or desire to pay out-of-network providers using a single case agreement.

65. Will there be any chance the state will release a portion of the 10% they keep for admin to the BH-ASO after integration occurs?

This is a fair question and HCA certainly understands this concern. We are having further discussion about this internally. There may be opportunities to examine this in the agency integration (DBHR, HCA) effort that is underway. Currently, none of these admin funds have been released or made available to Beacon Health Options for this purpose in the early adopter regions, and they have been able to administer the block grants in addition to other non-Medicaid services and Medicaid crisis services. HCA can commit to working through these issues with regions that choose to become a county-based BH-ASO.

66. How does HCA intend to allocate these resources between the BH-ASO and the MCOs?

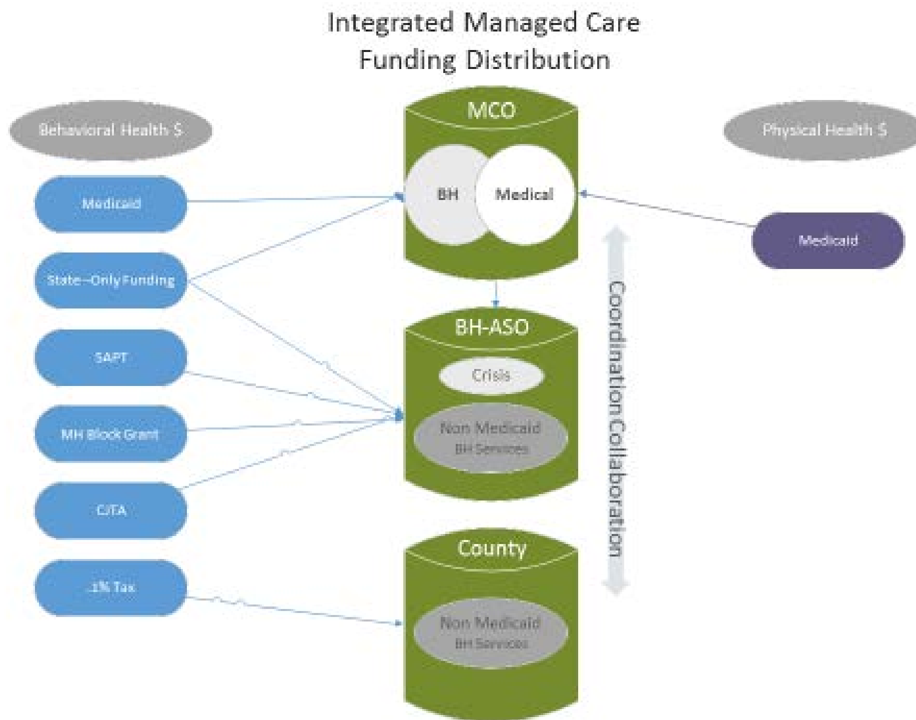
HCA divides the funds based on an analysis of prior expenditures and service utilization in the region, which provides an estimate of how much non-Medicaid funding is expended on the Medicaid population (distributed to the MCOs) and how much non-Medicaid funding is expended on the non-Medicaid population (distributed to the BH-ASO). The analysis also looks at the ITA-related non-Medicaid expenses (court reimbursements for ITA, etc.)

and provides those funds to the BH-ASO, because those costs are borne by the BH-ASO for the full population (not just non-Medicaid people).

67. Are mid-adopter regions able to select the number of health plans and have input on the selection of the health plans for their region during the RFP process?

Mid-adopter regions can provide input to HCA on how many health plans are recommended for the region. HCA will make the final decision on the number of health plans. There must be at least 2 due to CMS regulations, and there will not be more than five.

68. What is the funding model and how does it work between the state and the BH-ASO, and between the health plans and the BH-ASO?



Value-based payments

69. If a region pays a higher capitated rate to some of their contract providers to cover additional risk, how would that work in Value Based Payment arrangements? Are service providers paid per individual served? How is the expected savings achieved by service providers?

The state is interested in increasing value-based payment arrangements and has set targets for MCOs. It does not mandate what those arrangements are between MCOs and providers. They are free to negotiate. Many different arrangements can be made under value-based purchasing principles. Arrangements would be worked out between the provider and the MCO. The main difference is that some portion of the payment must be tied to provider performance. This can work under fee-for-service, capitated payment, or global

payment models. Savings are achieved overall when unnecessary services are avoided, such as emergency department and re-hospitalization.

70. How does HCA see Value based Payments working for behavioral health providers?

Similar to medical provider payments structures, VBP payments could include: incentives in addition to FFS base-payments for providers achieving performance levels; downside risk if performance levels decline; or both.

71. How will "Value Based Payments" compare to the "capitated contracts" some behavioral health providers receive now or the "per patient" contracts providers have had in the past?

MCOs are free to negotiate contracts with providers that include any arrangements that providers are willing to accept, within the contractual and regulatory limits set by the state and CMS.

72. Will or can the RFP for the health plans and BH-ASO specify how Value Based Payments will work or how that will be addressed in the future?

Yes, HCA is in the process of updating the VBP Roadmap. That revision may include implications for MCO contracts and the RFP. This is also a good opportunity for regions to work with HCA on the questions they would like to see included in the RFP.

a. If not, how does HCA plan to implement and monitor progress in the future on value-based payments and integrated services on both the patients and the providers' ability to deliver adequate services?

Value-based payments are monitored through performance measures and purchasing approaches which are called out in contract.

Transportation and other non-Medicaid support services

73. Some of the support services to persons receiving Medicaid funded treatment are paid for entirely with non-Medicaid funds, e.g., transportation from SUD residential treatment facilities and "flex" funds for outpatient providers. How will transportation issues and costs in general be addressed if services are regionalized and who will be responsible for connecting patients with the network of providers?

For transportation, if the client is being transported to a Medicaid-covered treatment service, the providers can access HCA's transportation broker service to obtain Medicaid-covered transportation. This applies regardless of whether the treatment provider is in the region or out of the region. If there is concern with access or timeliness of access to the broker services, please notify HCA and we will work with you to resolve this issue.

The flex funds proposal is a very interesting idea for transportation costs not covered by Medicaid. We would expect the MCO's/Beacon to replicate at least initially in their provider contracts, and assuming it is something that continues to be viewed as a value-add, it's likely that type of contracting arrangement could continue, as agreed upon by providers & payers. The MCOs are provided some GF-S dollars to support these type of wraparound supports.

74. What is HCA doing to prevent health plans from developing more comprehensive networks in population centers, including specialty services, and leaving those residents living outside of the population centers to rely on Medicaid Transport (inadequate), public transportation (often non-existent), their own vehicle (if they have no vehicle and/or no money), or natural supports which are all barriers to serving high needs individuals?

In order for a plan to be awarded a Contract with HCA, the plan must demonstrate their network has the capacity to serve 80% of the Medicaid eligible population in a given service area. No single plan will have 100% of the Medicaid population like the BHO does today because coverage for the population is distributed amongst multiple MCOs. However each plan must achieve at least 80% network coverage. This means if you have between 3-5 plans with 80% network coverage, the region will have coverage for much more than 100% of the Medicaid population.

Network adequacy is calculated not only by number of providers within the service area but also by proximity of the providers to the possible enrollee. This means that all eligible proximity locations within a service area are taken into consideration when calculating the capacity of a plan to deliver services to all eligibles including those outside of the population centers. This measurement is completed through Geocoding.

In other words, network adequacy is measured in both urban and rural settings and is monitored using Geocoding. MCOs would not be able to meet network adequacy without meeting distance standards, which prevents MCOs from concentrating their networks only in urban areas.

Transitional year option

75. Regarding the Mid-Adopter transitional approach option, HCA states that the "MCOs assume risk for Medicaid services, subcontract an agreed upon set of service and or functions to the BHO for 1 year." What are the "agreed upon set of services?

Many services or functions could be delegated by the MCOs during the transition, including network management, utilization management, quality of care monitoring, etc. The decisions would be made during 2018 and this would be a focus of the Interlocal Leadership Group. This will be a negotiation between the MCOs and the former BHO, and HCA will approve delegation agreements.

a. If the Regional service area decided to become a Mid-Adopter with the transitional one year option, what are all the functions that HCA allows the health plans to contract back to the BHO, beyond the BH-ASO functions?

HCA is open to discussion on what could be delegated in 2020 and beyond, but the central tenet is that we do not want a bifurcated system of BH/PH or specialty BH separated from the BH delivered through traditional medical managed care. When we say "access to care" standards will no longer apply, we mean that we want holistic care all the way up to holistic administration of the benefit package. We would be open to discussing delegation agreements focused on service-oriented approaches, such as the delegation of WISe team management, PACT teams, programs for services in schools, or care management.

76. If the Regional service area decided to become a Mid-Adopter with the transitional one year option and decides after the one year transition period to become the BH-ASO for the region, what is the timing HCA requires of the non BH-ASO functions moving from the BHO to the health plans and how would this transition work?

As has been stated in prior meetings, mid-adopter regions (transition year or no transition year) should plan to decide in January, 2018 whether they want to be a county-based BH-ASO, or whether they want HCA to procure a BH-ASO.

In the scenario described above, the “non-BH-ASO functions” will transition to the health plans by January 1, 2020 when the transition year ends.

The exact details of what is delegated to the former BHO by the MCOs during the 2019 transition year will be established during 2018, including clear milestones for when and how those functions/services transition to the health plans by January 2020. HCA intends to do a rolling readiness review process during 2019 to ensure that the functions are transitioning and milestones are being met in preparation for the transition year to end on January 1, 2020.

The details of this transition year and milestones will be a strong focus of the Interlocal Leadership Group.

77. What role does the ACH play in the Mid-Adopter transitional integration option?

ACHs are in a regional convening and coordination role and are ready to support and explore opportunities to ensure providers are supported, regardless of the option selected. Specifically, ACHs are responsible for making decisions about allocating integration incentive funds for their region, regardless of the option selected. In addition, each ACH is required to design and implement an integrated physical and behavioral health project as part of the Medicaid Transformation Demonstration. This project provides additional opportunities to consider the needs of providers during the transition to integrated managed care.

It’s very important that the counties and BHO participate in the ACH and we strongly encourage you to do so. This is the primary avenue to influence decision-making regarding the mid-adopter incentive funds, and BHO/county input should be a critical component of that decision-making.

78. If the Regional service area decided to become a Mid-Adopter with the transitional one year option, and after the one year transition period, the region decides not to become the BH-ASO for the region, what is the timing HCA requires of the BH-ASO functions moving from the BHO to a BH-ASO health plan?

HCA would like this decision to be made by January 2018 and will be sending a formal communication asking all counties to notify HCA of their decision in January, 2018. If a region changes its decision from becoming a county-based BH-ASO to contracting it out, HCA must know 9 months prior to January 1, 2020. In that event, the Contractor that will be selected as a result of the upcoming BH-ASO procurement will expand its service area to include the entire region, and that entity will need approximately 9 months to transition and establish contracts with providers, etc. HCA intends to structure the upcoming procurement to allow for this type of service area expansion if-needed.

a. **Is there any penalty to regional service area's counties for deciding to not become the region's BH-ASO after the transition year?**

No.

Late adopters

79. What happens on January 1, 2020 for the Late-Adopters -- is it actually a one-day transition from BHO to health plans as a FIMC model with contracts between HCA and health plans, and health plans and service providers to follow? How are individuals served and providers paid during the time period contracts are being negotiated and executed?

For all regions regardless of mid-adopter status there is a cut-over day. The actual transition and implementation leading up to the cut-over day is a significant operation that will be worked on for months before the cut-over occurs to ensure it is smooth.

On the cut-over day, the BHO contract will end and the MCO/BH-ASO contracts begin. Providers will have negotiated their contracts with the MCOs and the BH-ASO months before, and those contracts will be executed with an effective date of January 1, 2019 or January 1, 2020. Providers negotiate contracts with the MCOs/BH-ASO during the RFP process (approx.… 6 months before go-live) and HCA checks that those contracts are in place again during readiness review (3-4 months before go-live). For all services rendered prior to the cut-over day, those are billed to the BHO. For all services rendered after the cut-over day, those are billed to the MCOs/BH-ASO.

There will be significant work that will occur between the providers and MCOs to ensure that the providers are able to bill MCOs starting on the cut-over day, with claims testing occurring in the months before go-live. Providers should be able to begin billing MCOs on the cut-over day.

There is no time in which a provider does not have a contract for services rendered – they will maintain the BHO contract until the cut-over date.

Enrollees will also transition to having MCO coverage for BH services on the cut-over day. Their enrollment is processed in the system approximately 6 weeks prior and becomes effective on the cut-over day. They will receive notices and a communications plan is deployed so that clients are fully aware of the change. They will receive new benefits booklets and insurance plan cards, etc. in advance of the cut-over day. The transition is intended to be seamless for clients, they should be able to continue to see their provider with n0 interruption of services.

In Southwest Washington our experience was that the transition for clients was very seamless and there were no reported access issues for clients – clients maintained full continuity of care.

80. What leadership is involved in the transition on January 1, 2020 for the Late-Adopters -- does it include county, BHO, HCA, provider agencies, and health plans?

Regardless of the timeframe for adoption, BHO staff, counties, HCA, provider agencies, the Apparently Successful Bidder MCOs, and the ACH would all be involved in the transition.

Rural health and behavioral health care

81. What is the significance of a critical access hospital, or having no significant healthcare system in place? How will the integrated model look in counties (or rural areas of counties) if there is an unwillingness, or inability, of the primary healthcare system to deliver service? What happens if they are prohibited from delivering certain services because of their hospital designation? How will that gap be filled? How will those patients be diverted to another system and who will pay for that diversion?

This transition will most significantly impact the BHO-contracted providers and behavioral health services paid for by the BHO. This transition should not result in any significant changes to the critical access hospitals or primary care providers that already operate in the medical system. The Managed Care Plans will continue to be held to network adequacy requirements that require them to maintain a network of medical providers (including primary care, hospital, specialty, etc.) that meet time and distance standards, etc. If providers are unwilling or unable to contract with managed care plans, or choose not to serve Medicaid patients, the managed care plans must find new providers to contract with, otherwise they will be out of compliance with network adequacy which will result in an enrollment stoppage, or additional corrective actions.

82. What tools does the integrated model have to improve access (notably in rural areas) that the current system does not have? What happens if providers refuse to improve access (for whatever reason? What are the MCOs commitment to the local communities, especially small rural ones, in funding for full integration?

As noted in prior questions, if behavioral health services are delivered in new settings then this will lead to increase penetration rates and access.

While not the same as BHO standards, the MCOs are required to adhere to access standards in rural areas, and also have care coordination requirements specific to rural and frontier regions. Through network adequacy standards, time and distance standards will also be required for BH services. We would be happy to discuss better aligning standards through the Inter-local leadership.

Rural and frontier providers will play a critical role for MCOs in their ability to meet these network standards. Commitment to supporting these communities will be critical to these efforts. This is also why HCA does not plan to have less than 3 plans in any region.

83. How do Critical Area Designated Hospitals (CADH) fit into the FIMC model and what changes for them? For instance, currently when a CADH bills Medicaid patients and the hospital loses money in the end, the federal regulators make the hospital whole if there is a loss. Will this still continue in the FIMC model?

MCOs enter into contracts with CADH facilities today to provide Hospital Services to Medicaid (Apple Health) Members. This will continue under the integrated managed care model. The mechanism for Federal back-end payments to CADH providers for Medicaid services does not change under integrated managed care.

84. What is HCA going to monitor as we move toward FIMC adoption, both directly with the health plans and expect the health plans and BH-ASO to monitor with the service providers? Does it vary depending on whether a region chooses Mid-Adopter immediate, Mid-Adopter transitional, or Late Adopter? If so, in what ways?

For transitional periods, monitoring will be determined according to several issues that are currently unknown: the delegation arrangement between MCOs and former BHO, the measures chosen for the Early Warning System, etc.

In general, for mid-adopter or late adopter implementation, HCA will monitor MCOs for readiness according to the contract requirements throughout the pre- and post-implementation period. Performance measures such as HEDIS and CAHPS are collected annually. In addition, DSHS RDA will continue to calculate the performance measures agreed to under the 1519/5732 legislation.

85. Can County Commissioners influence HCA's monitoring parameters as we move forward?

There are many different monitoring systems for the FIMC managed care plans. Some systems are governed by federal and state statute, and as such have minimal room for input or variation.

There are two main avenues for influencing the monitoring parameters: 1) through requesting that certain measures be added to the early warning system, which will begin at implementation and continue for at least one year; and 2) by establishing an Interlocal Leadership Group, composed of elected officials, and described in the proposed amendment to HB 1388 in last year's legislative session. Through that body, monitoring parameters could be requested and reported.

86. How often does the HCA plan to meet with a region that decides to become a Mid-Adopter region? Does it vary whether the region chooses the Mid-Adopter immediate or transitional option? If so, in what ways?

HCA plans to make every attempt to meet with the region as frequently as the region feels is necessary. This could include in-person meetings or conference calls, and will likely be a combination of both. In both SOUTHWEST WASHINGTON and NC, HCA held weekly conference calls with key stakeholders and also travelled to the region an average of 2-3 times per month. A benefit to mid-adoption is that there will be less regions implementing simultaneously, therefore allowing for HCA and the MCOs to focus resources towards those regions. Resources will be stretched further amongst regions implementing in 2020. That said, regardless of the implementation date you select, HCA is committed to working with regions to achieve successful statewide integration.

87. Please explain how HCA plans to improve the physical and behavioral health of non-Medicaid individuals (e.g. income level at or below the 220% federal poverty level, not Medicaid eligible, or uninsured) within the context of implementing the FIMC model throughout Washington State, like HCA is expecting for the Medicaid eligible individuals. This is particularly important to regions' decisions about becoming the BH-ASO since this is the target population served?

HCA's initiatives and goals for a Healthier Washington extend beyond just the implementation of the FIMC model. Efforts include population health initiatives, development of other VBP private-payer models, and implementation of Demonstration Projects through the ACHs.

Additionally, by establishing a designated payer (the BH-ASO) that is responsible for the non-Medicaid population's behavioral services, via their available grant funding and non-Medicaid funding sources, the FIMC model ensures that the non-Medicaid population is managed and their services are prioritized through a network of BH-ASO providers.