This document was received from the Chemical Dependency Integration Work Group on November 10, 2014

Adult Behavioral Health Systems Task Force
Chapter II – Integration of Chemical Dependency (CD) purchasing with managed care contracts
Chemical Dependency Integration Work Group

The CD Integration Workgroup appreciates the opportunity to present a summary of their findings to the Adult Behavioral Health Taskforce that need consideration prior to behavioral integration in April, 2016. The Chemical Dependency Integration Workgroup has met five times and has cross sector and geographic representation from both substance abuse and mental health areas of focus. The group consists of providers, counties, plans, and state agencies. The workgroup has worked in accordance with the two other Behavioral Health workgroups and appreciated their cooperation.

Vision statement: True clinical integration is where multiple care providers who are working with a client (patient) utilize a "shared treatment plan" where in each clinician shares clinical needs, treatment goals/objectives, client progress/challenges in order that all have an understanding of the total persons clinical plan. Integration is not simply co-location or blending funding.

Tasks:

- **A.** Identify key issues which must be addressed DSHS/DBHR and HCA to accomplish integration of CD (chemical dependency) purchasing with managed care contracts;
- **B.** Recommend whether BHO managed care contracts should mandate purchase of specified CD (chemical dependency) services;
- **C.** Identify effective means to promote recovery and prevent harm associated with mental illness and CD (chemical dependency);
- **D.** Review detailed plan criteria developed for county authorities wishing to serve as BHO's.

Findings:

- **A.** A Comprehensive Chemical Dependency Benefit is integral to an integrated behavioral health system
    - a. The foundation for a treatment system is what services are allowed and compensated for. A service package that is not comprehensive will not allow for services to be provided that will benefit an individual fully and will keep services as is. In an integrated behavioral health system under the Affordable Care Act it is imperative that parity in mental health and substance abuse occur.
        - i. The workgroup has been in concert since the first meeting that the benefit package should include.
            1. Outreach/ engagement
            2. Pre-treatment/ interim services

3. Integrated crisis response services
4. Case management/care transitions (care coordinators/ navigators)
5. Peer services
6. Recovery supports
7. Withdrawal management*
8. Outpatient treatment*
9. Intensive outpatient treatment (IOP)*
10. Residential treatment (Short and Long Term)*

*These modalities should include Medication Assisted Treatment

The more comprehensive the Medicaid benefit is, the cheaper it will be for the state, due to the federal portion of the match. For newly eligible people, which are a majority of substance abuse populations, this is covered by the federal government currently at 100%.

ii. In addition to Medicaid funding, the state needs to maintain Grant in Aid to cover current non-Medicaid activities, i.e. sobering, outreach, childcare, detox and residential treatment in IMD facilities and services to new immigrants, undocumented individuals and others not on Medicaid.

B. Actuarial Rate Study

a. State agencies should openly share information about actuarial rate development and be open to feedback from stakeholders. It is imperative that state agencies not base actuarial rates on artificially capped, historically low rates, but they taking into consideration a fair and accurate wage to be able to enhance our work force and the cross training that will need to take place to have a functioning integration.

C. Laws and Regulations

a. The state should collaborate with stakeholders to undertake a detailed comparison of MH (mental health) and CD (chemical dependency) regulations, and recommend standardization where appropriate.
b. The state should collaborate with the Washington State Attorney General's Office and stakeholders to develop standardized privacy guidelines under HIPAA and 42 CFR part 2 that facilitate bi-directional care coordination.

D. Integrated Data Collection System

a. The state should create (or purchase) an integrated data reporting system for MH (mental health) and CD (chemical dependency) providers that combines the strengths of the existing data systems. Input into the system design should come from stakeholders representatives that would utilize the system.

E. Proposed Budget Cuts

a. DSHS should provide an analysis of the impact of proposed budget cuts on behavioral health integration.

Additional Considerations:

It is our recommendation that we take into consideration the people that we serve and the providers that will be providing the services. Integration needs to be manageable and able to navigate during transition so that those that need the services can access them and those that will be providing them are able to do so in a seamless manner.

We would also like to echo the recommendation of our colleagues in the Public Safety/Involuntary Treatment Act Work Group that the legislature adequately fund involuntary chemical dependency treatment, including secure detox and residential facilities. We also recommend that the legislature determine what changes to the chemical dependency ITA system are needed to ensure that chemically dependent individuals who are gravely disabled or a danger to themselves or others can receive lifesaving treatment.