10749

08/27/99

Introduced By: Larry Gossett

Phase III IP motion
DS 08/27/99

Proposed No.: **1999-0333**

MOTION NO. **10749**

A MOTION adopting the inpatient and outpatient mental health service integration plan of the department of community and human services mental health, chemical abuse and dependency services division.

WHEREAS, the state Medicaid program for mental health services offers regional support networks the opportunity to manage inpatient and outpatient mental health services for Medicaid-eligible adults and children, and

WHEREAS, the King County mental health division assumed financial risk for its eighty million-dollar managed care mental health program for outpatient services in 1995 through Motion 9399, and

WHEREAS, the state mental health division will require King County, beginning October 1, 1999, to assume a phase-in of financial risk for inpatient services of approximately twelve million dollars for publicly funded persons, a risk that the state currently holds, and

WHEREAS, King County will assume full financial risk for inpatient services by July 1, 2000, and

WHEREAS, the mental health service system must be modified to ensure appropriate management of the inpatient risk, and

WHEREAS, the inpatient and outpatient mental health service integration plan dated June 1, 1999 and included as Attachment A to this motion, proposes modifications to the mental health system that provide reasonable financial safeguards while continuing to seek further benefit for consumers; and

WHEREAS, the mental health, chemical abuse and dependency services division has prepared addenda to the inpatient and outpatient mental health service integration plan to more specifically address provider roles, system oversight and performance expectations and the promotion of recovery and to revise implementation timelines;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

The inpatient and outpatient mental health service integration plan dated June 1, 1999, as amended by addenda 1 through 4 dated August 31, 1999, and included as Attachments B through E to this motion, is hereby adopted.

PASSED by a vote of 12 to 0 this 7th day of September, 1999.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

Louise Miller
Chair

ATTEST:

Clerk of the Council

Attachments: A. Integrated System Management: The Proposed Model for Inpatient and Outpatient Mental Health Service Integration in King County, dated 6/1/99

B. Addendum 1: Provider Roles in Partnerships with the King County Mental Health, Chemical Abuse and Dependency Services Division, dated 8/31/99

C. Addendum 2: System Oversight and Performance Expectations, dated 8/31/99

D. Addendum 3: Promoting Recovery in Public Mental Health Systems, dated 8/31/99

E. Addendum 4: Revised Timeline, dated 8/31/99

INTEGRATED SYSTEM MANAGEMENT:

The Proposed Model for Inpatient and Outpatient Mental Health Service Integration in King County

Prepared by
King County Department of Community and Human Services
Mental Health, Chemical Abuse and Dependency Services Division
June 1, 1999

KING COUNTY MENTAL HEALTH, CHEMICAL ABUSE AND DEPENDENCY SERVICES DIVISION
INTEGRATED SYSTEM MANAGEMENT
June 1, 1999

INTRODUCTION

The King County Mental Health, Chemical Abuse and Dependency Services Division (KCMHCADSD) recommends a change in the publicly funded mental health system in King County. The change is that a single managed care entity provide inpatient and outpatient mental health services to eligible persons in King County and that the entity bear financial risk for providing those services. (See Attachment A, Risks Associated With an Integrated Inpatient and Outpatient System of Care, for a description of types of risk.)

The proposed model is one of two system change models developed by the KCMHCADSD and released for public review and comment. (See Attachment B, Two Models for Inpatient and Outpatient System Integration, for a description of each model.) The single entity model was overwhelmingly preferred by participants in the review and comment process (Attachment C, Public Comment).

The KCMHCADSD is recommending the change because of a new risk that cannot reasonably be managed in the current structure. By July 1, 1999, the KCMHCADSD will be required to sign a contract with the state Mental Health Division (MHD) to assume the financial risk for inpatient services for publicly funded persons, a risk the state MHD currently holds[1]. Although risk must be fully transferred during the 1999-2001 biennium, the state MHD has agreed to phase in the transfer. The KCMHCADSD will assume full risk by July 1, 2000. See Attachment D, Financial Plan, for the anticipated fiscal impact of the risk transfer. The projections are that the restructured system will be able to operate within budget, both before and after July 1, 2000.

Not directly related to the need for system change to manage additional risk but adding a positive planning dimension is the recent decision by the Metropolitan King County Council to administratively merge the former King County Mental Health Division and the King County Division of Alcohol and Substance Abuse Treatment Services into the KCMHCADSD. The merger was effective June 1, 1999 and, although budgets and funding priorities will continue to be separately established, it does provide the opportunity to develop integrated mental health and chemical abuse/dependency services for populations with a dual need using a more coordinated approach than might be possible with two separate divisions.[2] A single managed care entity

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[1] The financial risk is for voluntary and involuntary inpatient psychiatric services at community hospitals. It does not include state hospitals or local psychiatric evaluation and treatment facilities.

[2] These integrated services would supplement, not replace, already existing mental health and chemical abuse/dependency services. The capacity to provide discrete mental health or chemical abuse/dependency services to individuals not in need of integrated care would be preserved. Attachment G, Populations and Service Needs shows the different populations by system of primary responsibility.

model is a good fit for this coordinated planning because it provides a single point of accountability and communication.

In order to approach the proposed system change as thoughtfully and carefully as possible, the KCMHCADSD worked with consultants who are national experts in mental health managed care[3]. The initial consultation process resulted in the development of the two integrated system models described in Attachment A. The consultants also provided information about national trends in mental health managed care that established a general context for model development.

TRENDS IN PUBLIC SECTOR MANAGED MENTAL HEALTH SERVICES

States, counties and community-based providers have been responsible for planning, funding, and delivering mental health services to public beneficiaries since the inception of the community mental health movement. During the 1990s, there has been a successive shift of financial responsibility for mental health services from the federal government to the states and, when possible, from the states to counties. In an effort to manage this shift, and with waivers from the Health Care Financing Administration (HCFA) for selected Medicaid requirements, states and counties have increasingly moved toward implementing public sector managed care. The models used have varied, but the majority have relied, at least to some degree, on the private commercial sector. In the private commercial sector, specialized organizations for the management of mental health and substance abuse benefits began in the early and mid-1980s, proliferating in the late 1980s and early 1990s. States and counties sought to capitalize on this experience and, as a result, major entrance of the for-profit sector into the management of services for public sector beneficiaries started in the early 1990s. In the brief period since these models began to be implemented, there have been shifts in purchasers, models, and funding.

Phase One: 1991-1994

Examples of states beginning operations during this period were Massachusetts, Iowa, Nebraska, and Ohio. The primary characteristics of this period were:

1. state Medicaid divisions as the predominant purchasers with varying influence and involvement by state mental health departments;

2. contracts and responsibility covering the entire state but only for a specific sub-population of state's responsibility;

[3] The consultants, who both provided information and drafted portions of this document, were: Sheila Baler, Ph.D., Menninger Care Systems (project lead and overall consultation); Patricia Jordan (inpatient integration); and J.B. Bixler (chemical abuse/dependency and mental health integration). Prior to the development of this specific proposal, Ron Manderscheid, Ph.D. Chief, Center for Mental Health Services, provided consultation about system structure options and contracting.

3. partial to full financial risk assumed by the vendor (usually a for-profit managed care organization);

4. full implementation of the contract required on the first day of operation; and

5. a significant reduction by some states in the moneys spent on mental health services.

In part because of the design characteristics in general, there were major service, administrative, and political problems in first year and beyond. These included:

- a continuation or even increase in the fragmentation of the service system with resultant cost shifting to non-covered services or programs;
- litigation over Request for Proposal (RFP) issuance and/or contract awards, due in part to the lack of experience of public purchasers in procurement processes; and
- major objections by traditional providers of care to both the selected vendors and the systems.

Phase Two: 1995-1998

During this period, some states were new entrants (for example, Tennessee, Pennsylvania, Washington, Colorado, and Kansas) while others were revising their initial models (for example, Massachusetts). This period was marked by the following:

1. an acceleration in the number of RFPs issued for management of mental health services;

2. a change from statewide to county/regional RFPs in many states;

3. at the county/regional level, RFPs issued for administrative services only provided through and Administrative Services Organization (ASO);

4. the development, in Philadelphia, of a non-profit managed care entity that includes management of physical health care and whose Board of Directors was appointed by the county;

5. disasters in Tennessee and Montana that illustrated the need to: allow adequate time for system change; ensure funding appropriate for eligibility and benefit/coverage requirements; reduce possible antitrust issues related to provider-sponsored networks; and allow the managed care vendor to exert reasonable control over services and network management;

6. some consolidation in the same contract of responsibilities for Medicaid populations and indigent populations not covered by Medicaid;

7. experimentation with structural partnership models between for-profit and non-profit organizations, especially in "community mental health franchise" states such as Colorado and Kentucky;

8. profit lids for managed care organizations and requirements that savings above those lids be reinvested in the publicly-funded system;

9. attempted development of public sector, provider-sponsored networks and/or managed care organizations, with very mixed results; and

10. continued litigation over contract awards, although contracting itself became more sophisticated.

Phase Three - 1999-2000

It is anticipated that the next phase of reform will be marked by the following:

1. upon re-bid, continued change from one statewide contract to regional/local contracts with the same or different vendors;

2. increased insistence that the managed care vendor profit be based on the achievement of performance measures;

3. purchaser-set capitation rates;

4. an increase in RFPs jointly issued by more than one categorical department, for example, child welfare and mental health, or substance abuse and mental health; and

5. an increased use of level-of-care tools and best practice models for clinical quality management.

THE MANAGED MENTAL HEALTH CARE SYSTEM IN KING COUNTY

The KCMHCADSD's current managed care system for outpatient services, the Prepaid Health Plan (PHP), began operations on April 1, 1995. At the same time, the KCMHCADSD assumed inpatient authorization responsibility, but not financial risk, for voluntary child and adolescent inpatient admissions. The inpatient authorization responsibility for voluntary adult admissions was added during 1996.

At the present time, the KCMHCADSD has retained the financial risk for outpatient services, although it has not yet accepted the financial risk for inpatient services. The KCMHCADSD has chosen to contract for the administrative service functions of administrative and clinical management with a national managed behavioral health organization, United Behavioral Health (UBH). As the ASO, UBH holds the contracts with community provider organizations, manages

the inpatient authorization and length-of-stay extension functions, and negotiates and manages a number of contracts for programs not now included in the PHP.

While the KCMHCADSD, in collaboration with other stakeholders, has revised certain aspects of the system in the last three years, the basic model, structure, and financing have remained stable. Because of this stability, the KCMHCADSD has developed several important assets related to current operations, staffing, and tools. These include:

- a reliable and accurate vendor payment system;
- a functional information system which can be used to operate, monitor, and plan;
- a core group of seasoned county mental health staff with experience in the system and skills in the use of the databases for management;
- continuity of care from the state hospital and local inpatient units to the community, particularly for residential placement;
- effective centralized crisis response; and
- ASO strengths in provider contract management, operations of the billing and reimbursement system, and clinical concurrent review.

At the same time, there are several targets for improvement. These include:

- the administrative and paperwork burden, particularly for line staff case managers;
- the number of policies and procedures made necessary by a system focused on process rather than performance;
- the implementation of clinical best practices and individualized care, particularly for the difficult-to-engage/serve client, in order to improve outcomes; and
- the coordinated service requirements of clients with the dual diagnoses of mental illness and substance abuse.

Although the above areas for improvement are important, the KCMHCADSD would not be seeking system change at this time if it were not for the requirement to assume financial risk for managing inpatient services. This responsibility represents a significant addition to the basic

work of the PHP and the system must be redesigned to accommodate it.[4] A benefit of the proposed system redesign is that it also provides the opportunity to systematically address the areas for improvement.

GOALS FOR INTEGRATED SYSTEM MANAGEMENT

The KCMHCADSD has the following goals for the redesigned system:

1. To assume both financial risk and management of inpatient services with enough administrative control so that the transition will be clinically and financially successful.

2. To continue to improve the quality of care for the populations served by the KCMHCADSD.

3. To improve the quality of life for the clients served by the KCMHCADSD and for the community that surrounds them.

4. To assure culturally appropriate services.

5. To move to a performance-based system rather than a service-monitoring system.

6. To continue the process of system and policy simplification in order to achieve greater administrative efficiencies.

7. To maximize the amount of funding available for direct services by reducing administrative costs and achieving system efficiencies.

8. To coordinate and integrate mental health and chemical abuse/dependency services for those clients with dual treatment needs.

THE CURRENT SERVICE MODEL AND THE INTEGRATED SYSTEM

As stated previously, the KCMHCADSD currently is the health plan and purchases clinical and administrative services from UBH, its ASO. Much discussion has ensued about whether this model could be adapted to accomplish the new responsibilities and goals. Adapting the model has some appeal because:

[4] As one example, the KCMHCADSD has no experience with inpatient rate setting and contracting, and would either need to hire and train staff (with the assistance of consultants) to do this, or purchase the experience through either the ASO or a managed care vendor.

- it would involve minimal changes for all concerned (clients, vendors, and the KCMHCADSD and UBH);
- it would retain the identified assets of the current system; and
- it would maintain a single, countywide mental health system.

Unfortunately, keeping the current model does not address existing system inefficiencies and does not provide the range of tools and flexibility needed to fully manage the increased financial risk for inpatient management. Specific issues that indicate the current model is not an option include:

1. The KCMHCADSD continues to retain primary financial risk. Vendors in the current network have consistently argued that creativity, ingenuity, and therefore performance are stimulated when risk is passed down. This occurs because of increased flexibility in the use of funds and the immediately felt necessity of using those funds effectively. Clinical creativity, ingenuity, and improved performance are values the KCMHCADSD supports and intends to encourage.

   The ability to assume risk, however, requires that the potential client base covered is large enough and varied enough to balance clients who have high cost service needs with clients who have lower cost service needs. Actuarial analyses suggest that, at a minimum, a risk-bearing entity must cover 80,000 lives. The 1998 Medicaid enrolled population in King County was about 158,000[5]. The current system includes eighteen vendors; the King County population is not large enough to support either individual vendors or two managed care organizations as risk-bearing entities.

2. If risk cannot be transferred, the ability to achieve integrated system management goals is restricted. Examples include:

   - Because there is no cost to be born for the use of voluntary psychiatric inpatient services[6], UBH and outpatient providers have little incentive to assist in managing that cost. If a client wishes to be hospitalized, there is little incentive to find other appropriate but lower cost treatment alternatives. The KCMHCADSD in the current system, therefore, has limited administrative or clinical control to assure that the transition will be clinically and financially successful (Goal 1).

[5] The capitated funding the KCMHCADSD receives from the state MHD is determined by the number of Medicaid enrollees.

[6] There currently is some risk attached to management of the state hospital census where the majority of patients are on involuntary commitments.

- Because financial and service incentives are not aligned by financial risk sharing, the processes by which services are delivered are managed rather than performance (Goal 4).

- Because individual vendors have different approaches to clinical care management, it is difficult to implement system-wide quality-of-care measures (Goals 2 and 3), unless there is a significant increase in policies and procedures (Goal 5).

Transferring financial risk means that the KCMHCADSD can focus increased attention on assuring the accountability and performance of the entity. This ultimately means increased assurance that persons served by the system receive quality care.

3. An ASO model is a less powerful change agent than models in which vendors are a voluntary part of a risk-sharing managed network. An ASO is the administrative arm of the purchaser; it represents the purchaser's interests. Because no risk is shared with the vendors, change occurs largely through administrative, rather than vendor, initiative and vendors have little investment in the consequences. When they elect to join a risk sharing managed network, vendors assume a direct investment in system changes that maximize their performance.

4. Vendor reimbursement in the current system is through case (tier benefit) rates. According to vendors, the case rate approach limits flexibility. They suggest that capitation is the reimbursement strategy that allows the greatest flexibility, and therefore the greatest opportunity for clinical creativity and innovation. As with risk sharing, successful capitation requires the ability to distribute costs over an adequate number of covered lives. Because the population of covered lives is insufficient to support risk for eighteen vendors, the current system cannot move toward capitation.

CARVEOUT SERVICES

In 1998, programs that were contracted separately (carved out) from overall PHP case rate funds represented about 36% of service dollar expenditures (Attachment E, Carveout Programs). It is not anticipated that this will change in 1999. These carveout programs represent innovative responses to clients' needs and responses to legislative and governmental mandates. They have served clients and the system well, and the goals they achieve are valued. Two issues affecting carveout programs must be addressed, however, as the planning for the integrated system proceeds. These issues are: (1) the site of management accountability for each carveout program; and (2) whether each specific carveout continues to receive targeted funding or whether the funds are folded into the overall PHP case or capitated rate.

The first issue, management accountability, is relatively clear. The intent is to have the entity be accountable for all service related programming. The exceptions will be primarily for those programs where federal or state contracting restrictions apply. At the present stage of planning, the KCMHCADSD is intending to continue to hold the contracts for:

- Ombuds Service,
- Mentally Ill Offender—Community Transition Program, and
- the federal Children and Families in Common Grant.

In addition, the KCMHCADSD will continue to provide Crisis and Commitment Services. Management and accountability for all other carveout programs will be the responsibility of the entity.

Because of the complexities of the planning process, this assignment is still draft; final assignment of accountability will be determined before the release of the integrated system RFP.

The second issue, continuation of carved out funding, is more challenging. Having over a third of available service dollars restricted in use limits the flexibility needed to creatively and effectively manage overall client service needs.[7] Flexibility is achieved when more dollars support the overall PHP case or capitated rate. The intent, therefore, is to gradually fold the funding for a majority of carveouts back into overall PHP case rate or capitated funding.

At the present stage of planning, the KCMHCADSD has identified the following carveout programs to continue to receive targeted funds, at least for the first year of the entity contract:

- Emergency Telephone Services;
- Outreach and Engagement Services;
- Crisis Triage Unit;
- Older Adult Crisis Outreach;
- Children's Crisis Outreach; and
- Evaluation and Treatment Facilities.[8]

These programs were selected because they represent services available to all King County residents without respect to income and because they are time-limited, not ongoing, interventions. Rolling the remaining carveouts into overall PHP funding would add about $25 million to the current outpatient service budget.
As with management accountability, this selection is still considered to be draft. The KCMHCADSD is continuing to engage in consultation that will result in final decisions about system structure. As these decisions are made, the above list may change. The final decisions will be stated in the integrated system RFP.

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[7] The majority of public mental health managed care systems have few specifically carved out programs because of the demands for simplicity and flexibility. Service requirements are built into performance measures and contract terms.

[8] Evaluation and Treatment Facility funding will actually be split: the amount that represents use by persons not enrolled in the PHP will continue to be carved out; the amount that represents use by persons enrolled in the PHP will be included in the capitated rate.

In order to protect the intent represented by carveout programs that move into the PHP case or capitated rate, carveout-specific performance measures will be included in contract language. For example, performance measures for the Intensive Case Management for Juvenile Offenders program could include the program requirements for eligibility, intensive case management services, and working relationships with the Department of Youth Services, juvenile probation officers and the police, and outcomes of: decreased total days in detention; decreased new referrals to juvenile court; increased days in school; increased days employed; and improved functioning in school, home, community, behavior towards others, mood regulation, self-harm behaviors, substance use, and cognitive skills. Performance measures for residential services could include the program requirements for eligibility screening and core services, and outcomes of: stable or improved functioning; no increased use of inpatient or crisis services; no increase in incarcerations; parity for ethnic minority populations and older adults; and transition to less restrictive environments.

Service provision and performance will be closely monitored and financial incentives and sanctions will be attached to ensure that the goals represented by the carveouts continue to be addressed.

SAFEGUARDS FOR CITIZEN AND MINORITY PARTICIPATION

Advocates and representatives of ethnic, sexual, and other minority populations have expressed concern about the assignment of responsibilities formerly held by the KCMHCADSD to a managed care entity that is not part of County government. This concern points to the need for mechanisms that safeguard the impact that clients, family members, advocates, minority population representatives and other stakeholders can have on the system. As part of the integrated system planning process, mechanisms will be developed that provide these groups access to information and a role in policy development[9], at both the county and the entity level. The goal is to ensure a client voice that is meaningful and representative of the different populations in King County.

THE SINGLE MANAGED CARE ENTITY MODEL

Given that system change is essential, the KCMHCADSD recommends that a single managed care entity be the model through which that change is accomplished.

Features of the Model

In the single managed care entity model, the KCMHCADSD is the purchaser while the single entity is the health plan as delegated by the KCMHCADSD. The entity will be responsible for

[9] Currently the King County Mental Health Board, Quality Council, Mental Health Ombuds Service and Quality Review Team provide avenues for client voice. These groups will continue in the integrated system although there may be some changes in function depending on system design.

ensuring coverage for services to King County residents. The KCMHCADSD will be responsible for assuring overall system viability, entity accountability, and quality of care for persons served in the system.

The entity will have a centralized administrative structure responsible for risk management, coordination of care, and accountability for the delivery of appropriate and effective services by an affiliated network of outpatient and inpatient providers. The entity must ensure the availability of both mental health and chemical abuse/dependency services expertise. The entity will be the point of communication with the KCMHCADSD for financial, utilization management, and other administrative issues. In order to accomplish this, the entity must have a centralized management information system that is able to transmit data to the KCMHCADSD information system[10].

Managing inpatient risk is a new responsibility for the KCMHCADSD. The entity, therefore, must bring a history of and current experience with inpatient rate setting, contracting, and management of inpatient provider networks. In order to assure that inpatient and outpatient care is coordinated, the entity must be able to demonstrate experience in effectively managing outpatient provider networks and in performance-based contracting. Because the KCMHCADSD is passing on financial risk, the entity must have risk reserves that are sufficient to protect the entity's solvency in the event that inpatient and/or outpatient costs exceed the available funding. The risk reserves must be separate from, and not contingent upon, PHP funding, that is, they must be from a source that is not related to PHP funding. The integrated system RFP will specify the amount of risk reserves necessary.

The entity must have experience in assuring that culturally relevant services are available and provided and must ensure that the interests of ethnic, sexual, and other minority populations are represented in service-related system decisions.

Finally, the entity will be required to reinvest in community-based services. The KCMHCADSD anticipates two funding streams for community reinvestment. The first is that a percentage of overall funds will committed to reinvestment as a basic cost of doing business. The second is that a profit lid will be negotiated and any savings above that lid will be reinvested.

The single managed care entity model does not include an ongoing ASO role. When the integrated system is fully functional, the entity will be responsible for managing the functions for which the ASO is currently responsible. The ASO contract will be continued through the initial start-up period in order to prevent unnecessary system disruption.

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[10] This does not mean that there will be two identical information systems (ISs). The entity IS will support entity business such as claims payments. The KCMHCADSD IS will support system planning and accountability. Currently the KCMHCADSD IS support the business functions of the ASO. Because these functions will be the entity's responsibility, the KCMHCADSD IS will no longer be required to support them. This will mean a reduction in IS costs for the KCMHCADSD.

In order to further limit disruption for clients during the first contract period, the entity will be required to offer contracts to all credentialled PHP vendors in the existing system who have signed contracts with the ASO (UBH) in place on January 1, 2000. In subsequent contract years, the entity may contract or not at its discretion. The criteria used to make credentialling and contracting decisions, however, must be reviewed and approved by the KCMHCADSD and the entity must be able to meet all of the service requirements, including requirements for culturally appropriate services.

As a steward of public funds, the KCMHCADSD will continue to be responsible for establishing the system clinical and financial goals, purposes, and outcomes for which the entity will be held accountable. The KCMHCADSD will also identify populations in need and ensure that these populations have access to responsible and appropriate services. Finally, the KCMHCADSD will continue to protect the County's interest in priority populations.

To establish accountability, the entity will be required to meet both clinical and administrative performance measures. The achievement of these performance measures will be monitored by the KCMHCADSD and will be financially backed through incentives and sanctions. The integrated system will be based on performance; the entity's contract will be developed and managed to support this.[11]

The Strengths of the Single Managed Care Entity Model

The single managed care entity model:

- provides a defined point of accountability for clients, advocates, the community, and the KCMHCADSD, and maintains a single, countywide mental health system. Because there is a single point of accountability, the entity contract can be structured to be a strong performance management tool.

- promotes efficiency through provider/service integration and the standardization of administrative procedures;

- facilitates the integration of currently carved out services into the PHP basic funding structure;

- provides the tools to manage inpatient costs and care effectively and efficiently because of the required expertise of the entity; and

[11] Performance measure details will be released as part of the integrated system RFP.

- facilitates the establishment of capitation rates because a single entity is responsible for all covered lives in King County.

INPATIENT AND OUTPATIENT INTEGRATION

Because integration of inpatient services into the PHP involves management of a new financial risk, it is a focus of current planning and will be a central part of entity business. The estimated budget for inpatient psychiatric services for King County residents is about $12 million compared to about $76 million for outpatient services. Attachment D, Financial Plan shows projected inpatient and outpatient revenues. Attachment F, Inpatient/Integrated System Planning Timeline, outlines the timeline and tasks for both inpatient and integrated planning.

As the KCMHCADSD prepares to take on the financial risk of managing publicly funded inpatient psychiatric services, it will be important to effectively manage clinical and administrative services that can minimize risk. There are five commonly accepted system attributes necessary for effective inpatient management. These are: (1) responsive and skilled crisis services; (2) shared risk for use of inpatient services by inpatient and outpatient services providers; (3) a range of inpatient alternatives; (4) clearly specified performance measures; and (5) tightly managed inpatient contracts.

The first of these attributes, responsive and skilled crisis services, is a feature of the current system and will be maintained in the new system. By requiring that the entity have experience contracting for and managing inpatient services, the KCMHCADSD is ensuring that the remaining system attributes will also be provided, once the new system begins. Because the new system will not begin until July 1, 2000, however, the KCMHCADSD must take interim steps to ensure that inpatient losses do not accrue. These interim steps constitute the inpatient management pilot project negotiated with the state MHD.

Two concepts are central to the KCMHCADSD's interim inpatient management proposal. The first is phased-in assumption of financial risk; the second is the development of a limited number of alternatives to inpatient services.

1. Phased-in Financial Risk

The state MHD has agreed to allow the KCMHCADSD to phase in risk in two stages. These are:

July 1, 1999 – June 30, 2000	The KCMHCADSD has responsibility for inpatient authorization, length of stay extensions, and inpatient quality management. Financial risk, both savings and losses, will be shared with the state MHD. The KCMHCADSD has proposed a risk corridor approach

	as the strategy for shared risk management. In this model, the state MHD would retain savings greater than a negotiated percent, and would absorb losses greater than a negotiated percent.
July 1, 2000	The KCMHCADSD assumes full financial risk for inpatient management.

2. Inpatient Alternatives

Central to successful inpatient management is the ability to divert from inpatient treatment those persons whose treatment needs can be safely and therapeutically addressed in less intensive settings. Inpatient alternatives can be used both to divert initial admissions and to shorten length of stay. According to data collected by UBH as part of their inpatient authorization reviews, 29% of inpatient admissions and 42% of length of stay extensions could be diverted to alternative resources.

The KCMHCADSD currently has in place three alternatives to divert initial inpatient authorizations[12]. These are: inpatient diversion beds for children, inpatient diversion beds for adults, and a crisis triage unit for adults. The initial planning intent was to immediately develop a range of additional inpatient alternatives to extend diversion capacity. Public comment, however, suggested that this might not be an effective long-term strategy. The argument was that, in order to manage risk successfully, an entity will develop a coordinated system of care; inpatient alternatives implemented independently of the entity's system of care might not be an efficient fit. This argument, plus the agreement by the state MHD to initially limit the risk the KCMHCADSD will bear, resulted in the decision to manage inpatient risk between July 1, 1999 and June 30, 2000 by tightening current inpatient utilization management procedures and implementing two inpatient alternatives.

The two inpatient alternatives to be implemented are:

1. converting one of the current children's inpatient diversion beds to a multiple-use bed. A multiple-use bed can be used either for initial inpatient diversion, or as a "step-down" for a child on an inpatient unit who no longer needs the inpatient level of care but who still requires more intensive supervision and treatment than can be provided in community settings. All currently funded beds are located in residential treatment settings with therapeutic services and 24-hour staffing, so would provide the level of support and supervision needed. The equivalent of one children's inpatient diversion bed was not used in 1998; this capacity could be converted to multiple-use with little or no additional funding.

[12] In addition to the previously mentioned crisis services.

The annual savings, based on 1998 actual children's voluntary inpatient use, are estimated to be $203,658. For further detail, see Attachment D, Financial Plan.

2. funding staffing and physical plant enhancements at the County-funded detoxification facility (Detox). The purpose of these enhancements would be to enable clients whose primary problem appears to be substance abuse or dependency, but who are suicidal or depressed because of or secondary to substance use, to go to Detox instead of being admitted to an inpatient psychiatric unit. The cost of this enhancement is estimated to be about $250,000. The annual savings, based on 1998 actual adults' voluntary and involuntary inpatient use, minus costs, are estimated to range from $87,592 to $316,947. For further detail, see Attachment D, Financial Plan.

The projection is that the implementation of these two alternatives would be sufficient to prevent any losses related to inpatient management between July 1, 1999 and June 30, 2000. The following table, also contained in Attachment D, Financial Plan, shows the projected inpatient financial management plan for second half 1999 (2H99) and first half 2000 (1H00), the period for which the KCMHCADSD holds financial risk:

	2H99	1H00
Inpatient Capitated Revenue	6,363,698	6,458,466
Inpatient Expenditures	6,052,616	6,001,129
Inpatient Savings	311,082	457,337
Administration	303,186	303,186
Risk Sharing Agreement	3,948	77,076
Risk Reserve (July, 2000)		64,585
Inpatient Savings less Administration	3,948	12,490

CONCLUSION

Because of increased risk and responsibilities, change in the publicly funded mental health system in King County is both necessary and appropriate. The KCMHCADSD is committed to informed and planned change that will accomplish risk management within a structure that supports increased accountability for quality of care and outcomes for clients who use the system, their families, and their communities. The recommendation to proceed with a single managed care entity model is a formal statement of that commitment. The single entity model supports clinical and administrative creativity that will result in improved care for clients within the pragmatic restriction of available funding.

ATTACHMENT A

10749

Risks Associated with an Integrated Inpatient and Outpatient System of Care[13]

Financial Risk	Description of Risk	Indicators of Risk*
Population	More people are eligible for service than projected	▪ Accuracy of projections of eligibles ▪ Accuracy of financial projections
Penetration	More eligibles seek service than projected (includes voluntary and involuntary hospitalization, outpatient and WSH)	▪ Parity ▪ High service utilizers ▪ Homeless ▪ Non-Medicaid ▪ Engagement of hospital discharges
Utilization	More intensive/expensive services are provided/required	▪ Risk corridor ▪ Length of stay in hospital ▪ Pre and post hospital services ▪ Hospital linkage for unenrolled
Case Mix	Case mix contains disproportionate share of high need clients	▪ Variance from projections ▪ Accuracy of tier placement
Cost of Direct Service	Cost of business outweighs payment	▪ Productivity ▪ Medical loss ratio ▪ Profit/loss and solvency
Coordination of 1st and 3rd party resources	Ability to maximize funding including Medicare, Healthy Options	▪ 1st and 3rd party resources ▪ Non-Medicaid conversion
System Collaboration	No direct control over all players	▪ Implementation of working agreements ▪ Links to residential care ▪ Vocational programs
Technical Competence	Inability to provide efficient and effective services	▪ Legal structures ▪ Transition/disaster plans ▪ Specialty services ▪ Interpreter services ▪ Staff qualification ratios ▪ MD reviews ▪ Accuracy of diagnosis ▪ Accuracy and completeness of data
Resource Management	Capacity for cost shifting if funding and responsibility are not linked	▪ Detention/incarceration rates ▪ WSH census ▪ Primary Care Linkage ▪ CDMHP contacts for enrolled clients ▪ Spend down
Continuum of care	Insufficient array and capacity of appropriate services	▪ Core services
Direct care for clients	Quality of care does not meet minimum standards Services are not provided in the least restrictive environment	▪ Level of functioning ▪ Housing ▪ Employment ▪ Age appropriate activities ▪ Individualized Tailored Care Plans ▪ Intersystem coordination ▪ Suicide rates ▪ Satisfaction

*Indicators of Risk will have incentives and sanctions applied to their performance standards

[13] Risk sharing is not synonymous with accountability nor does it replace accountability.

ATTACHMENT B

10749

Two Models For Inpatient and Outpatient System Integration

The two models considered for integrating the inpatient and outpatient mental health services are:

1. two risk-bearing entities (non-geographically based); or
2. one risk-bearing entity.

Option 1. Two Non-Geographically Based Risk Bearing Entities

In this model, the KCMHCADSD is the purchaser, with two entities being the health plans as delegated by the KCMHCADSD. Both entities would be required to ensure services are available to clients living anywhere in King County; there are no service area restrictions for either entity. The estimated KCMHCADSD administrative costs and staffing for this model in 2000 would be $3,337,793 and 30.75 FTEs.

Although previous iterations of this model have not been successful, as for example in Tennessee[14], this model is the proposed model through which managed public sector mental health services will be provided in the greater Dallas area. The Dallas model will become operational July 1, 1999.

Pros:

- Competition between the entities may produce financial and/or service benefits over time.
- Competition between entities may broaden opportunities to develop and implement clinical best practices.
- Contracts with entities could be based on comparative performance and outcomes.
- If one entity withdraws for any reason, the second entity can assume responsibility for those clients and services.
- Clients may choose an entity as well as a provider.
- Because of the complexity of managing two health plans, it supports a strong presence of the KCMHCADSD and direct involvement in system policies.
- It allows the KCMHCADSD to continue the planning direction taken before the state MHD provided the opportunity to develop an inpatient management pilot project.

Cons:

- Because each entity would be responsible for serving all of King County, client assignment and entity accountability for that client, entity size, funding, adverse selection, provider affiliation, and distribution of carveouts become complex problems. Because they are

[14] This model caused difficulties, confusion and increased costs in Tennessee and, because of both legal and administrative challenges, has been restructured.

- complex problems, the time it takes for appropriate administrative and management procedures to be implemented and tested will be lengthy. Until this management stabilization occurs, administrative and financial efficiencies are unlikely to occur.
- Competition between entities could lead to increasingly disparate services and programs available to clients, resulting in two mental health systems in King County rather than one (as happened in Tennessee). Unless the plans are allowed to develop differently, however, there appears to be no justification for having two.
- Competition may result in increased costs as each entity tries to outdo the other in service diversity and innovation.[15]
- In order to minimize health plan disparity and to meet the HCFA "one regional managed care organization requirement,"[16] there would be an increase in policy mandates.
- Because there are two health plans, with no geographic boundaries, there is the potential for client/community confusion about the system and its accountability.
- It requires that two entities, as well as the KCMHCADSD, maintain risk reserves. This reduces dollars available for services.
- It creates the risk of cost shifting of difficult clients between entities.
- It sets up duplicative fixed costs for information systems and claims payment unless the KCMHCADSD provides these services.
- If providers join both entities, there could be an increased administrative and paperwork burden, even at the line staff level, because of differing requirements.
- Because there are no restrictions on service area, both entities must maintain service coverage throughout the county, duplicating mental health resources and increasing overall service costs.[17]
- It adds complexity in the long-term delegation of the carveouts, unless the KCMHCADSD administers them. If the KCMHCADSD administers the carveouts the number of KCMHCADSD staff would increase. If one of the two entities manages one or more of the carveouts, that entity would hold an unfair competitive advantage. If both entities manage the carveouts, there would be increased community confusion about whom to call. For the smaller carveouts, services could be inadequate because the service dollars have been cut in half.
- Regardless of carveout distribution, it requires an increase in KCMHCADSD staff for contract and performance management of two entities.
- Because of the complexity of carveout management, it delays the transition of funding attached to the carved out services into the capitation rate.

[15] In the health care field, this is manifested in the examples of hospitals in the same areas competing to provide MRIs and CT scans. This practice ultimately had to be regulated because of costs.
[16] The HCFA waiver requires that the KCMHD maintain a governance structure that allows the PHP to function as one regional managed care organization.
[17] One of Tennessee's requirements for its new system is that it avoid duplication of mental health resources.

Option 2. One risk-bearing entity

In this model, the KCMHCADSD is the purchaser while a single entity is the health plan as delegated by the KCMHCADSD. The entity would be responsible for ensuring coverage for services to all

eligible citizens of King County. The estimated KCMHCADSD administrative costs and staffing for this model in 2000 would be $3,335,793 and 29.75 FTEs.

Pros:

- It simplifies the current system and provides a single point of accountability for clients, advocates, the community, and the KCMHCADSD.
- It provides incentives for further provider/service integration and therefore administrative efficiencies.
- It facilitates integrating currently carved out services into the PHP basic funding structure.
- Issues of client assignment and entity accountability for clients, entity size, funding, adverse selection, and distribution of carveouts disappear.
- Providers are part of only one entity. This could reduce the administrative and paperwork burden.
- It maintains a single, countywide mental health system.
- The entity contract can be structured to be a strong performance quality improvement tool.
- Because of the expertise of the managed care organization, and because there will be only one authorization source, it provides tools to manage inpatient costs and care effectively and efficiently.
- It facilitates establishing capitation rates because one entity is responsible for all covered lives in King County.

Cons:

- Clients cannot choose the entity (plan), only the provider.
- It reduces competition after award of contract. If the single entity is not performing, the KCMHCADSD has to start over.
- There is no competition to stimulate identification and implementation of clinical best practice.
- It is a new direction from the one the KCMHCADSD initially proposed before the state MHD provided the opportunity to develop an inpatient management pilot project.

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ATTACHMENT C

Public Comment

KING COUNTY MENTAL HEALTH BOARD

Public Hearing on Phase III Mental Health Reform
Sponsored by the King County Mental Health Board

Tuesday, April 13, 1999
King County Courthouse
Snoqualmie Room
516 Third Avenue
Seattle, WA
4:00 PM – 6:00 PM

Present:	Willair	St. Vil, Chair	King County Mental Health Board
	Anthony	Collis	King County Mental Health Board
	Katherine	Halliburton	King County Mental Health Board
	Ken	Anderson	United Behavioral Health
	Marc	Avery, M.D.	Valley Cities Counseling & Consultation
	Trish	Blanchard	Seattle Mental Health
	Lillian	Borrego	Children's Hospital Medical Center
	Ann	Brand	Mentor Health Northwest
	Mark	Brandow	Northwest Behavioral Services
	David	Cousineau	Seattle Children's Home
	Sandy	Forquer	ValueOptions
	Yoon Joo	Han	Asian Counseling and Referral Service
	Shirley	Havenga	Community Psychiatric Clinic
	Sue	Holbink	Harborview Medical Center
	David	Johnson	Highline West Seattle Mental Health Center/ West Seattle Psychiatric Hospital
	Denise	Lewis	Mentor Health Northwest
	Harriet	Markell	United Behavioral Health
	Ann	McGettigan	Seattle Counseling Services For Sexual Minorities
	Steve	Morton	Northwest Behavioral Services
	Michele	Munro	Seattle Counseling Services For Sexual Minorities
	Jaci	Oseguera	Consejo Counseling & Referral Service
	Eleanor	Owen	Washington Advocates for the Mentally Ill
	Rick	Ries	Harborview Medical Center
	Kathleen	Southwick	Crisis Clinic
	Perry	Wien	Transitional Resources
	Bob	Yost	ValueOptions
	Joanne	Asaba	King County Mental Health Division
	Shelle	Crosby	King County Mental Health Division
	Sherry	Hamilton	King County Department of Community and Human Services
	Laurie	Rasmussen	King County Mental Health Division
	Karen	Spoelman	King County Mental Health Division
	David	Wertheimer	King County Department of Community and Human Services

Tony Collis: We want to welcome everybody to this public hearing. My name is Tony Collis. I'm on the King County Mental Health Board, and in a moment I'll introduce other Board members. But first, I just want to say what a pleasure it is to be here, and also to welcome you to this opportunity to express your thoughts, ideas and opinions related to Phase III. We're eager to hear them; this is an opportunity for you to speak to the public process and to use it in a way that is most beneficial to our County, which is really the goal and the essence of this opportunity to get together. I would like to just introduce my colleagues and then I have a couple other things that I'm going to say. Clifford Thurston is also on the Board, and Katherine Halliburton, and Willair St.Vil, who is the Chairperson of the King County Mental Health Board. Willair and I will be working with you as we go through the rest of today.

We have a couple of hours. From what I see here, while we have people signing in, we have so far two people who are wanting to make public statement. We want to encourage people to make public statement if you so desire. In addition, you're welcome to provide a written document, and Laurie will take the written document...I'm sorry Joanne...we're just checking things out here...so, you are welcome to make a written document, make a public statement. We will be recording your public statements, and we're going to ask you to come and stand exactly where I am, so you can speak into these two microphones, and this is not karaoke, *(general laughter)* so you may not wander around singing and doing other such things. And, related to what you may do and what you may not do, as stated, this is a hearing, and it is an opportunity for you to voice your opinion. This is not a dialogue nor a discussion, so while many of you may want to have the opportunity to hear what other people are thinking, that is in fact not the purpose of today's time together. So, we're going to ask that as you come up and make your statement, that you simply make your statement, and you'll have up to two minutes, and I will wave...we have a one-minute warning; we have a 30 second warning; we have a 2 minute warning; and we have a 'your time is up – please be seated' warning, so we have options along the way. But we certainly will have enough time, and again welcome and thank you, and we can proceed. Willair, if you will...

Willair St. Vil: We're going to start with Dr. Rick Ries from Harborview.

Dr. Rick Ries: Thank you. It's an honor here. Dr.Richard Ries from Harborview Medical Center. Wanted to make a few remarks, and I'm talking for myself, not actually from Harborview. Wanted to say that I certainly agree with the one-entity view and I think that's most efficient, and the two-entity view would provide endless strife and confusion in the area. I wanted to agree with incorporating inpatient and outpatient risk together in the combined view of things, but I wanted to make some very stern comments about the future, and some warnings to people, and to tell you some things that you may or may not know.

For one, Seattle is already at the bottom of large urban areas in the United States in terms of the inpatient-outpatient ratio. Meaning that, in terms of how much money we spend on inpatient versus how much money we spend on outpatient, we're at the bottom of the list. No other large urban center in the United States that we can find spends *less* on inpatient care. Okay? Just for comparison, for example, in other counties which have in fact had tightly managed care much longer than Seattle has...in San Diego, they've managed to get their ratio all the way down to 45 percent of their budget spent on inpatient care. Do you know what the figures are in Seattle? Who knows? Why don't you know? I mean, if you're gonna go at this and you decide you're gonna make diversion from inpatient dollars to outpatient dollars, you should know that. Depending on how you measure it, Seattle spends either 13 percent or as much as 22 percent on inpatient care. This is less than half of any other major urban area in the United States we can find. San Francisco spends 40 percent; New York spends 50 or 60 percent; Massachusetts after about six years of aggressive managed care spends 40 percent on inpatient care. So the Seattle area has already managed its inpatient care more efficiently than any other urban center in the United States as far as we can figure out.

Second, in terms of inpatient systems, at least at Harborview, it's the only inpatient system in the United States that carefully measures outcomes, has patient details and has the largest database of any other inpatient center in the United States. Lastly, I think overly zealous attempts to manage inpatient care or to create, quote, "diversions" to save more money, since we're already at the bottom of the barrel, will likely hurt patients. You know, if you're already at the bottom of the barrel, if you divert more patients or don't admit people, you have to be very careful; making that last few percents of saves is liable to hurt patients that really do need care. So, we're in favor of this kind of model, but I think its...people need to be very realistic in learning, and that's why the County was actually resistant into taking over inpatient risk, because a study that they did, as well as an independent auditing firm, said in fact there's no money to be made; you may even lose money. So, be careful in thinking just how much is to be gained by taking over the risk for inpatient care. You're already doing about twice as good as any other place in the United States. Thank you.

Willair St. Vil: Okay...Eleanor Owen?

Eleanor Owen: My name is Eleanor Owen. I'm Executive Director of Washington Advocates for the Mentally Ill, and also with Mental Health Association of Washington. I, too, support the single-entity system. I think that, just as Dr. Ries indicated, a two-entity system would bring about much confusion, we'd lose money on all of it, it would be much more chaotic, and the reason that I support the single-entity is based upon a model that we have in this state. I think Pierce County is a model single-entity system, and on the basis of that, I believe that I want to see the County itself be the predominant entity in handling the risk. I personally feel that as an advocate for the client himself, or herself, that that

client is best assured optimum care when we remain...when the control remains in the public sector.

I feel very, very strongly about this. I think that when we say, 'well the client won't have a choice,' I think that we have choices of insurance companies, we have choices of pharmaceutical companies, and we have choices of banks, and the public is not well served by any of those entities. So, as long as we as advocates have *some* control over the public dollar, we are in control. I also think that the...I have a lot of criticism of forever changing; once we get something established, we're forever changing. It's a little bit like fixing the plumbing in your house while the water is turned on full-bore. So, I would say, let's try to stick with the model that we have, either in Pierce County or even in King County, but just giving more control to the public sector. Thank you.

Willair St. Vil: David Johnson?

David Johnson: I'm David Johnson, and I'm CEO of Highline West Seattle Mental Health Center and West Seattle Psychiatric Hospital, and I'm speaking today, though, as the Chair of the King County Mental Health Providers Association, and I'm giving you a letter signed by *all* members of the King County Mental Health Providers Association. There were four members who couldn't sign until we had arrived in the room today, and so you'll see some names missing, but on the original document, all people have signed this, and we, the members of that Association unanimously support a single-entity plan. We believe that the single risk-bearing entity should manage as much as possible control and manage the risk. In order to do this, we believe that all dollars should flow via capitation to the greatest extent possible, even though certain programmatic elements will always best be served as carve-outs.

When we thought of some of the objections, some of the cons that were listed in the proposal by the County, some of the reasons not to go with a single risk-bearing entity, we didn't have those problems. First, we're very much committed to client choice, and it's our belief that within that single entity, that many providers within the entity, there is choice for consumers about which provider to seek services from. Secondly, there was a possible concern about what happens to competition if you have a single entity. Yet, we noted that nationally what's happening is the bringing together of various competing partners for 'co-ompetition;' so that there are...it is perhaps erroneous to believe that simply by approaching competition in a "dog-eat-dog" way, you're gonna end up with the best practices possible. Indeed, there's a lot to be said for bringing players together, to cooperate in what they provide.

I also...one of the possible exceptions raised in the paper is that the County had been preparing its Board, had been preparing the State, for going for a two-entity system, what would it be like to switch to advocating a single-entity system. We think it's a real strength when further investigation, further exploration surfaces a better idea, so we don't see that as a drawback. One caution that we raise is in the timing of how this is implemented. The County

is planning to let an RFP this summer for alternatives to inpatient treatment, and though I know its immensely awkward to think of changing the timing on that, we would really advocate looking at the timeline as a whole. It might make sense not to do that ahead of time for a couple of reasons. First, you might really impact the outcome of the RFP for the single entity if you've done that piece first, and there might be other ways to look at services, so I know that's hugely problematic, but we really encourage that you look at that timeline. And I'm gonna leave this with you...

Willair St. Vil: We have reached all individuals who wanted to speak on the issue. Is there anyone who would like to say any more at this point...*(inaudible voices)*

Tony Collis: Eleanor, if you're...Eleanor, you're welcome to make a comment, but actually there's somebody over here who'd like to say something, and we will ask that people speak into the microphone.

Steve Morton: The reason I asked for some time is specifically...yes, my name is Steve Morton. I'm with Northwest Behavioral Services...specifically in reference to the RFP for the inpatient alternatives. Like some more clarity about that. I realize not today, but in some response to this hearing. Particularly when we're trying to integrate the system, what does it mean to have separate RFP for the development of inpatient alternatives? How would that be coordinated with the outpatient system, and how would that be integrated? Likewise, the plan itself has distributed doesn't have a lot of detail about how either model would function. There is a comment in there that after the outpatient system stabilized, that inpatient risk would be handed to the end consumer...not verbatim, but a comment of that nature.

So, there's a sense of organizing the outpatient system first and then bringing in the inpatient piece. Not clear about how that plan, how the plan projects that type of integration. Clearly the notion of putting providers at risk financially for providing quality care, whatever the client needs, regardless of the level of care, is the way to save dollars and provide the most streamlined and effective care for clients. When we have the type of separate funding mechanisms that have evolved over time, clinicians don't have the opportunity of full array of resources when trying to develop treatment plan. So, that it's not clear to me in the plan how that we're achieving integration, I'd like to see more detail about that. Thank you.

Sherry Storms: Hi, I'm Sherry Storms. I'm the Mental Health Ombudsman for King County, and I wanted to say that my office, or at least I, since its my office, it's my business, I definitely support the one-entity plan. I can just see two entities now in trying to figure out who does what. So, I support the one-entity plan. As long as we have a sufficient number of providers to choose from and the right for consumers to change providers, case managers, doctors, therapists and so on, as they have now, I think that the average consumer will be quite satisfied with that. As far as choosing a plan, once you're on Medicaid or medical coupons, you're kind of used to doing what the State tells you to, and

it's just wonderful to be able to have choices within a system, so the one-entity plan is fine. I'd also like to say that I support capitation program over the tier level as it is now. I think if we gave money to agencies per consumer and allow the agencies to be flexible within that capitation thing, it would probably work out a little bit better, and I'm not saying I'm an expert in this; I've been listening to other people and that's... The dream we had envisioned five or six years ago, when I was on what was called the Ad-Hoc Committee, when Carol Hernandez was in charge, was that you would take money, give it to an agency and the agency could do anything they wanted with it, as long as they provided good services. And so the closer we get to that, the happier I'm probably going to be.

And, I was...just to address upon about the one-entity provider...the provider, I think choice is enough, anything's not that crisis. The no competition...I think that's where the consumer and family advocate groups are going to have to come in, we're just going to have to watch and advocate for the consumers, and agencies should expect that if a consumer or an advocate for the consumer feels that there's an issue, we're going to come and tell you. And hopefully we can all work together to make that system better, so it'll stay a good system and get better, 'cause I do think it's a pretty good system right now, even though some of you have met me and might not think I think so. And, I am not quite clear about directions and monies and proposals. My major concern is to see that the consumer has choice, that the consumer is satisfied with their treatment plan, and the agency works in a respectful and cooperative and mutual plan for consumers, and that's my opinion. Thank you.

Willair St. Vil: I will acknowledge Eleanor Owen, and then again I ask anyone who'd like to speak before we close this process.

Eleanor Owen: I just wanted to add that I would like to see King County...my name is Eleanor Owen, and I'm the director of Washington Advocates of the Mentally Ill and Mental Health Association of Washington...I would like to see King County explore integrating not only inpatient, outpatient and the Substance Abuse and Mental Health, but also voluntary and involuntary inpatient. I think that there is much to be gained by; again just from the breadth of that care, we would be able to see a much more responsive system, and I think it would in fact be monetarily advantageous as well. I will be submitting written testimony because I think that a lot of the cons, I think, are based on false assumptions.

Tony Collis: Do we have anybody else who wishes to make a public statement? Anybody? Then with that, what I will do is draw this public hearing to a close, and there may be some people who would like to have some discussion, and I'll turn that over to Willair.

********** END OF TRANSCRIPTION **********

We, the members of the King County Mental Health Providers Association, unanimously support ***Option 2: One Risk – Bearing Entity.*** Such a risk-bearing entity should be given maximum ability to control and manage risk.

- In order to do this, all programmatic dollars should flow to the entity via capitation to the extent possible, even though certain programmatic elements will always be best managed by carve-out from capitation.
- To effectively manage risk and assure the delivery of integrated services, we support the intent of the Option 2 description to give management of many of the carve-outs and captitation revenues to a single entity.

In addressing the perceived drawbacks of Option 2, we offer the following:

- Since we are, of course, committed to the value of client choice among providers, we believe that choice of a provider truly enables the connection between client choice, client goals and individualized treatment planning.
- We are all committed to the success of managed mental healthcare in King County. Such success is only possible if there is efficient and effective management within the entity to assure the best possible client outcomes. Through cooperation, including cooperative competition within the entity we can maximize our strengths. The contract should define performance measures at significant junctures as well as provide for an ongoing and incremental process of quality improvement.
- In regard to implementation of clinical best practices, the best role model is that demonstrated by the Institute for Healthcare Improvement, which has been bringing together competing healthcare providers to agree upon and implement best practices in the service of all consumers of care. We commit to a shared quality improvement model, which includes best practices.
- We don't consider it a "con" that the King County Mental Health Dvision has further developed its

proposed model for healthcare delivery and should not be a reason to not move forward with Option 2.

We do have some questions about the sequencing of activities and how that aligns with the concept of creating a single entity. Once the decision has been made to go with a single entity, we all need to revisit the timeline to assure that it supports the future vision. For example, by letting an RFP for the alternatives to inpatient treatment prior to the release of the integrated system RFP, the KCMHD could inadvertently affect the outcome of the overall system by awarding a subset of it in advance.

- April 12, 1999

Asian Counseling and Referral Service
Diane Narasaki

Children's Hospital and Medical Center
Lillian Borrego

Community House Mental Health
Chris Szala

Community Psychiatric Clinic
Shirley Havenga

Consejo Counseling & Referral
Jaci Oseguera

Crisis Clinic
Kathleen Southwick

Downtown Emergency Service Center
Bill Hobson

Betsy Kruse

Evergreen Community Home Health
Betsy Kruse

Sue Ellen Holbink

Harborview Mental Health Services
Sue Ellen Holbink

David M. Johnson, M.D.

Highline/West Seattle Mental Health Center
David Johnson

Ann K. Brand

Mentor Health Northwest
Ann Brand

Steve Morton

Northwest Behavioral Services, Inc.
Steve Morton

Seattle Children's Home
David Cousineau

Ann McGettigan

Seattle Counseling Services for Sexual Minorities
Ann McGettigan

David Stone

Seattle Mental Health
David Stone

DAVID JOHNSON FOR Norm Johnson

Therapeutic Health Services
Norm Johnson

Perry Wien

Transitional Resources
Perry Wien

Marilyn LaCelle CEO

Valley Cities Counseling & Consultation
Marilyn LaCelle

DAVID JOHNSON FOR Jill Rand

YMCA Mental Health
Jill Rand

Mental Health
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APR 2 2

April 15, 1999

APR 2 2 1999

Shelle Crosby, Ph.D.
King County Mental Health Division
700 5th Ave., Suite 3800
Seattle, WA 98104

Dear Shelle,

The Mental Health Ombuds Service supports the single entity model for the proposed integrated mental health system.

The reasons for this are adequately addressed on page 10 of KCMHD's own description dated 4/7/99.

Complexity is, in my opinion, the antithesis of integration. I see integration as a method of incorporation as many necessary services with as few obstacles as possible for all concerned. The longer stabilization and efficiency takes, the more detrimental to the system.

The more freedom and creativity providers are allowed in developing service diversity and innovation the greater are the potential benefits to consumers. The greater the number of policy mandates the less system flexibility there can be.

I will respond to the cons on page 12 as follows.

The consumers of mental health services I have encountered almost always perceive treatment choices as being connected to the provider, with very little, if any, awareness of a "plan" or "entity" concept. Although competition can be a very good thing, especially within a capitalist system, it is not necessarily so. If KCMHD keeps track of what works and what does not work with any entity it engages a basic infrastructure for service provision can develop. If the single entity engaged does not perform well KCMHD may need to issue an RFP for a new agency but not necessarily start from scratch.

Identification and implementation of clinical best practice can be stimulated in ways other than direct competition. In King County we have a number of respected schools and colleges and the University of Washington. Education and educational research can be a great stimulus for clinical best practice, if given the opportunity.

The Mental Health Ombuds Office supports:

1. Capitation
2. Increased flexibility for providers to implement diverse and creative treatment options.
3. Increased consumer participation in all areas, including contract negotiation and the design and development of treatment options.
4. Consumer directed clubhouses and drop in centers.
5. Increased respite beds.
6. Outreach to homeless people with recognition of differing needs for different populations of the homeless (i.e. youth and young adult, elders, Native Americans etc.).
7. Shelter beds, transitional and permanent housing. Home ownership, cooperatives and communes.

My only concern with UBH being phased out would be how the PHP Grievance Committee would be organized under the new system.

Sincerely,

Sherry Storms

Sherry Storms
Executive Director

Cc; Joanne Asaba, Manager, KCMHD

King County Quality Review Team
Phase III – Consumer Forum Report

In collaboration with staff from the King County Mental Health Division, the King County Quality Review Team (QRT) conducted Consumer Forums throughout King County to discuss the Phase III planning process, answer consumer questions and elicit their feedback regarding this process. In preparation for these forums, QRT members Erin Sullivan, Lenore Meyer, and Shannon Greene sent letters and distributed announcements to all provider agencies notifying all concerned parties about these forums.

Five locations throughout King County were selected to host these forums. These sites were chosen on a geographical basis to ensure that widest number, and most representative sample of consumers could be reached. A total of 44 consumers attended these forums. The following is a list of sites, dates and attendance at each of the locations.

1) **Valley Cities Counseling and Consultation, April 12, 1999 – 0 in attendance.**
2) **Highline – West Seattle Mental Health Center, April 14, 1999 – 0 in attendance.**
3) **Mentor Health Northwest, April 15, 1999 – 7 in attendance.**
4) **Community Psychiatric Clinic, April 15, 1999 – 25 in attendance.**
5) **Seattle Mental Health, April 16, 1999 – 12 in attendance.**

Quality Review Team members opened the meetings with an introduction of their program, including an explanation as to the role that the Quality Review Team plays within the publicly funded mental health system within King County. They also discussed what their role would be throughout the Phase III planning process.

Following the introduction by the QRT, King County Mental Health Division staff, Shelle Crosby and Jean Robertson presented additional information regarding the Phase III planning process including:

1) An explanation as to why the Division is proposing changes to the current system.
2) A brief discussion regarding the two proposed Phase III plans currently being considered.
3) A presentation of the Division's current understanding of possible service improvements to be made under the new plan/s.

A question and answer period followed the presentation. During this time many questions were asked and concerns expressed. The following is a brief summary of the various comments and concerns we received from consumers at these forums. These

comments fall into two categories – 1) comments about the proposed reorganization, and 2) general services concerns.

SUMMARY OF COMMENTS FROM CONSUMER FORUMS

Comments about Proposed Reorganization:

- Change usually means cuts for us (consumers).
- Will there be any way for consumer problems to be heard and addressed?
- We don't have a voice in the direction our treatment programs take.
- We like the clubhouse model and the ICCD standards. Will there be support for that type of program?
- How do consumers know whether they are getting quality service? Where is the accountability?
- A two-entity model doesn't make any sense because they might not have comparable services. The one entity model sounds better.
- Case manager paperwork burdens are too great. The new system should decrease the time staff have to spend doing paperwork.
- Make sure that there is a brochure explaining the new system, whichever model is selected.
- Don't prescribe things like other insurance plans, for example, the number of specific types of services a client can receive.
- Overall health is important. Needs to be tied in with medical, dental, chiropractic services. It's imperative that people remain healthy, that their teeth remain healthy. It's much less costly to the government if people are healthy. Smoking cessation classes should be offered, as well as weight management classes. In general, initiate health groups within the mental health programs.
- These changes might affect our Medicaid benefits, that this might affect the cost of services provided to us.
- Overall, we want these changes to improve quality.

General Comments about Services:

- Case managers have too large of caseloads. There is not enough staff to deal with people with unique problems, including managing aggression and tumult.
- Three case managers provide service to all day treatment. There is no opportunity for private meetings with a case manager.
- No individual therapy is available, only group therapy.
- Case managers only have time to respond to problems and crisis management, rather than on what we want most - better case management.
- Day treatment is too much like work and is too boring. We used to have a van and go on outings. The van was eliminated and we were told to go on outings on our own.

If you don't have a car, the social skills or the money, it's just not possible. Organized activities with other people are more important.

- They changed day treatment to vocational training and got rid of everything recreational that we enjoyed – the pool table, the Ping-Pong table, games and even painted over our mural on the wall. Now it is just a sterile, boring room. I don't need a job. I need someplace "to be".
- There is not enough psychiatrist time available. Fewer and fewer community psychiatrists are willing to take coupons.
- Whenever we get used to something, they (the agency or County) changes it.
- Vocational opportunities are too short term and not career oriented. Employment programs have gone downhill. Need basic work skills – spelling, grammar, math, typing and computers.
- We want to eventually go back to work and be able to make more money working than we get on SSI.
- If we go to work, we lose our med coupons and can't afford medications that we need.
- Some services and benefits used to be available but aren't anymore. These improved consumer's quality of life. They included outings and camping trips, the groom room, and dinners at the clubhouse.
- Medication costs are a concern. The agency used to pick up the cost of some of the meds, but doesn't now. Is there a way to get more med samples from drug companies?
- The consumer aide program is a really good program. Is there a way to expand this?

QRT PHASE III PLANNING RECOMMENDATIONS
(Based upon Consumer Forum feedback)

1) Entity/entities must establish a viable, accountable consumer grievance process within each provider site.
2) Entity/entities must establish resource libraries and provide more educational materials to consumers regarding neuro-biological disorders. This would include creating a library, Internet access to mental health sites, and provide educational trainings on best practices in providing mental health services, the latest research on, and the newest medications used in the treatment of mental health disorders.
3) Entity/entities must provide or create an innovative recreational/social activities program that is available to **all** consumers at each provider site.
4) Entity/entities must establish, or greatly improve upon current consumer vocational programs, including access to vocational counseling.
5) Entity/entities must reduce case manager caseloads to a level that meets best practices guidelines. Our recommendation is for case managers to care for no more than 30 consumers, less for more difficult to serve populations.

6) Require that the entity/entities provide individual therapy to consumers who, as defined by best practices guidelines, are required to have, and will greatly benefit from this type of treatment (major depressive disorder, bipolar disorder, etc.).
7) Throughout the Phase III process, consumers must have input and be notified of all proposed changes. This could be accomplished by the distribution of materials, consumer forums, site visits, postings on the Internet, case manager mailings that they could use to educate their consumers, etc.

QUALITY REVIEW TEAM IDEAS FOR FUTURE PROJECTS

The Consumer Forums generated a great deal of discussion on the Phase III planning process and concern about services that are currently provided to consumers. Based on the feedback that we were given during these discussions, the QRT has developed a list of 10 potential areas that warrant future research and that are potential future QRT projects.

1) Comparative study of services that are provided by each provider within King County. This would include caseload size, recreational activities provided by, quality of meals, vocational programs, housing concerns, educational opportunities, etc.
2) Investigate grievance/advocacy programs within specific agencies and Countywide.
3) Types of vocational training provided to consumers – Is it geared toward career oriented employment, or toward more common types of work such as janitorial or dishwashing.
4) Ways in which the County and provider agencies can work to reduce the stigma of mental illness.
5) Investigate hospital diversion practices. Under the current system, are these practices helping or hurting consumers? Could new partial hospitalization programs be established which would save money, while improving services for consumers?
6) Consumer housing – Is it safe, stable and reasonable?
7) Do consumers exercise self-government within their agencies? Do they have the opportunity to do so?
8) Do SSI and SSA allow for a fair and livable compensation? If not, what steps need to be taken to correct these inadequacies.
9) Currently, Medicaid and Medicare penalize consumers that return to work by discontinuing payment for medications and medical appointments. What can be done to bring about a change to the system?
10) Survey consumers as to the amount of help the system currently provides to them. Ask consumers whether or not they feel that their mental health and coping skills have improved under the current system. Find out what is working, what isn't, and what changes need to be made.

CRISIS CLINIC

APR 2 1 1999

April 19, 1999

To: Shelle Crosby, King County Mental Health Divison
From: Kathleen Southwick, Executive Director, Crisis Clinic

Re: Comments on Integrated Systems Planning Proposal

Thank you for the opportunity to participate in the planning process prior to the development of the RFP. We appreciate being able to give input related to the role of emergency telephone services.

The Crisis Clinic supports the single entity model as compared to the dual model and we have signed the letter of support developed by the providers. However, I believe that more discussion and planning needs to take place regarding the transfer of current "carve out" services.

We believe it is very important for emergency telephone services to remain under the direction of the County as is proposed for crisis and commitment services. Crisis services are designed to benefit the entire community—not just the publicly funded client—and the county needs to assure that these services are adequately funded for effective response. Our current system of crisis response services including triage, next day appointments, etc. works extremely well and should be retained.

The primary focus of the entity will be on improving services to the publicly funded client, although they will give attention to specialty populations. Crisis response has not been a priority area for them. Given that emergency telephone service receives a small amount of funding in relation to out-patient funding, over time it will be very easy to chip away at the funding necessary to provide adequate emergency telephone response.

Second, while the County is concerned with an effective structure for mental health services, emergency telephone services is in a unique position of being an integral part of the safety net of the human services system in King County. King County is a national model for the effective integration of 24-hour crisis response service and community resource information. Both the mental health system and the County's community service's system benefit from the cost-effective integration of these services. The Mental Health Division needs to assure that the entire human system works together effectively, just as you are doing with the alcohol and substance abuse systems. By moving emergency telephone services away from your direct control, you may be contributing to the slow unraveling of a system that is exemplary.

1515 Dexter Avenue North Suite 300 Seattle WA 98109 Telephone 206 461 3210 FAX 206 461 8368 www.crisisclinic.org

The integration of the 24-hour Crisis Line and the Community Information Line, both supported by our comprehensive resource data base, is a very cost effective way to assure outstanding response not only to people in crisis, but those in emotional distress and seeking basic needs services. As you know, United Way is also a major funder of the 24-Hour Crisis Line, as well as our other services. A majority of municipalities also fund both services. We have created an exceptional "safety net" for this community. We are concerned that over time, an entity whose primary concern is the publicly funded client, will not value the system integration that has occurred and a series of minor decisions and reductions in funding will begin to erode the exemplary model of service we currently have.

The Mental Health Division has a responsibility to assure its services are well coordinated with other social service systems. Just as you have made crisis and commitment services a priority to remain under direct County control, we strongly encourage you to include telephone emergency services in that group.

Shelle, I will be sending you a copy of these comments in the mail. Thank you for the opportunity to share our concerns.

Administrative Offices
4319 Stone Way North • Seattle, WA 98103

(206) 461-8385
FAX (206) 634-3596

APR 19 1999

April 12, 1999

Shelle Crosby, Ph.D.
King County Mental Health Division
700 Fifth Avenue, Suite 3800
Seattle, WA 98104

Dear Ms. Crosby:

We, the members of the Board of Trustees of Community Psychiatric Clinic, join with the King County Mental Health Providers, to support the implementation of one risk-bearing entity of providers in the next phase of reform. Both as taxpayers, and volunteers on a non-profit board, we fully support a system of care that maintains a single, countywide mental health system which can provide incentives for further provider/service integration and administrative efficiencies. Our clients, advocates, and the community would benefit from a simplified system that provides a single point of accountability. Furthermore, one risk-bearing entity responsible for all covered lives in King County would facilitate the establishment of capitation rates and allow maximum ability to control and manage inpatient and outpatient risk.

We appreciate the opportunity to support the King County Mental Health Providers in the recommendation of a single risk-bearing entity.

Sincerely,

The Board of Trustees of Community Psychiatric Clinic

John Corapi, President
Randy Barker, Secretary/Treasurer
Michael Garrett, First Vice President
Sharon Rosse Fowler, Third Vice President
Kathy Brown, Member
Bill Kiskaddon, Member
Kay Nelson, Member
Ron Reichter, Member
Stephen Yamada-Heidner, Member
Nancy Coyle, Member

STATE OF WASHINGTON

APR 22 1999

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

N17-21 • 400 Mercer St., Suite 500 • Seattle, WA 98109-4641

April 20, 1999

Ms. Joanne Asaba, Manager
King County Mental Health Division
Dept of Community and Human Services
Key Tower
700 Fifth Avenue, Suite 3800
Seattle, WA 98104

Dear Joanne,

Thanks for the opportunity to review your April 7th memo on Integrated Systems Planning.

At this time I have no comments on the issue discussed in your memo. Our concern is that appropriate mental health services are provided for the children and families we serve. You are in a better position than we are to pick the best and easiest model to manage.

Sincerely,

Paula C. Oppermann by CJK

Paula C. Oppermann, Deputy Regional Administrator
Region 4 Division of Children and Family Services

cc: Ms. Shelle Crosby, Ph.D., King Co. Mental Health

UNITED WAY
KING
COUNTY
Your Community
Safety Net

April 29, 1999

APR 3 1 1999

Ms. Joanne Asaba, Manager
King County Mental Health Division
700 Fifth Avenue, Suite 3800
Seattle, WA 98104

Dear Joanne:

As the King County Mental Health Division is considering changes to the structure of the provision of mental health services, I would like to share my concern that whatever structure is developed, it not erode the effective provision of emergency telephone services, as offered by the Crisis Clinic, a United Way of King County partner agency.

United Way is in a unique position to see how the various social service systems work together to support eachother. By any standard, King County has an excellent model of social service delivery. Central to our "Community Safety Net" are the Crisis Clinic's 24-hour crisis line and its community information line. Our community derives a great benefit, including cost efficiencies, from having these two services provided by a single organization. Both mental health clients and others in need benefit from the joint expertise of staff and volunteers providing these services.

Moving emergency telephone service away from the direct control of King County opens the door to a potential erosion of these services. As a major funder of the Crisis Clinic, United Way of King County has a strong interest in its continued efficient and effective operation as a hub of the human service delivery system.

I strongly encourage the Mental Health Division of King County to retain direct control of emergency telephone services as a separate funding agreement.

If you have any questions, please do not hesitate to call me at (206) 461-3634.

Sincerely,

Jaime Garcia, Vice President
Community Services

cc: Joanne Harrell, President and CEO, United Way of King County
Ron Sims, King County Executive
Larry Gossett, King County Council
Shelle Crosby, KCMHD

107 Cherry Street • Seattle, WA 98104-2266 • Phone/TDD 206 461-3700 • FAX 206 461-4872
13010 N.E. 20th Street • Suite B • Bellevue, WA 98005-2034 • Phone/TDD 425 869-0980 • FAX 425 869-0602
United Way Good Neighbor Center • 305 South 43rd Street • Renton, WA 98055-5785 • Phone/TDD 425 226-0210 • FAX 425 226-0211

United Behavioral Health

April 25, 1999

Joanne Asaba, Manager
King County Mental Health Division
Key Tower
700 Fifth Ave., Suite 3800
Seattle, Washington 98104

Dear Joanne,

Thank you for this opportunity to submit comments regarding the recently released Integrated System Planning document. These comments will be brief and limited to significant structural issues related to the two models that are proposed. We realize that there are yet many details to be worked out and I will resist the temptation to ask numerous questions regarding the operationalizing of these models.

Both options discuss the establishment of "risk bearing entities". It is unclear, and perhaps needs further review, as to the legal status or structure that will be required of these entities. In order to assume risk it is generally required that some level of net liquid assets or reserve be established so as to assure the economic viability of the entity and protect the long term public interest of a stable service delivery system. Can risk based contracts be passed on to some sort of linked or affiliated provider network or will there be a requirement that only a recognized insurance entity take on this risk? This is an important question for the current set of King County providers as they continue to meet and plan for this significant system change.

Option 2 (one risk-bearing entity) has many advantages over the two entity option that are well articulated in the planning document. Of particular importance is that it will require fewer carve out services and logically reduces the total level of administrative services necessary to operate the system. We clearly favor and support a plan that gives the risk bearing entity(ies) the greatest degree of flexibility for managing the fullest possible range of the service system. This ensures a proper alignment of incentives and encourages innovation and creativity in service design and resource management. The key question here though, as referenced in the planning document, is HCFA's interpretation of the Balanced Budget Act requirement for consumer choice. On the physical health side they are clearly requiring the establishment of two or more risk bearing entities to protect the consumers choice. It remains somewhat ambiguous as to their application of this requirement to behavioral health services. Clearly there will be a

700 5th Avenue, Suite 3800 • Seattle, WA 98104-5038 • Tel: 800-790-8049 • Fax: 206-205-5459

choice of providers in both Options as well as the continuing need for a disenrollment process. Some states are referring to mental health services as a specialty service thus requiring only a provider choice rather than a plan choice. It is unclear if the assumption of risk (because of the shift in incentives) impacts this decision and requirement. Hopefully the County (or the State) will have some satisfactory response to this prior to the release of an RFP if Option 2 is the eventual direction that is approved.

The third large structural question relates to the assumption of risk for acute inpatient care and costs. To fully align incentives for the risk-bearing entity(ies) this is a critical area. With the County still negotiating with the state MHD regarding inpatient risk assumption much remains unknown in this regard. The design for this will have a significant impact on the risk bearing entity(ies) structure and operations. There will be a need for considerable clarity on this for the eventual RFP and system requirements.

As I indicated previously we have many other questions regarding the operations and expectations of the risk bearing entity(ies) but recognize that those answers are perhaps premature and that an initial structural direction must first be settled. As the County's ASO we of course will continue to assist your planning efforts in whatever ways as may be beneficial or helpful to you in this process. Please don't hesitate to contact Harriet or myself in this regard.

Sincerely,

Ken Anderson (hdm)

Ken Anderson
Assistant Vice President
United Behavioral Health

ValueOptions

More Choices. For More People.

April 19, 1999

Shelle Crosby, Ph.D.
King County Mental Health Division
700 Fifth Avenue – Suite #3800
Seattle WA 98104

Dear Shelle,

ValueOptions is pleased to offer you comments regarding your models for Integrated System Management to change the publicly funded mental health system in King County. We hope you find this information valuable in your RFP process.

We were prepared to submit a lengthy discussion paper strongly encouraging the King County Mental Health Division to accept the one risk-bearing entity model. However, in your April 7th document, the King County Mental Health Division has thoughtfully considered both the merits and the potential drawbacks associated with each model for Integrated System Management within the county. The thoroughness of your research is commendable. The results clearly point to the benefits of one-risk bearing entity model; your document provides multiple benefits that are associated with that model. We also felt that many of the public comments and written submissions presented at the Public Forum on April 13, 1999, confirmed overall support for the one risk-bearing entity model.

We would like to comment on a few additional areas in your document. Please find below some lessons we have learned through our implementation experiences that we hope will be useful as you enter into the design phase of your RFP process.

Impact of Multi-Entity Strategy on Administrative Functions/Implementation

Your document clearly indicates that the County is quite familiar with the problems faced by several states (Tennessee, Texas and Arkansas), in awarding multiple entity contracts. Your document refers to the recent Dallas NorthSTAR project. As one of the Behavioral Health Organizations (BHOs) selected for that project, we have found that the County must take a very strong managerial approach to ensure that communications are distributed and interpreted in a consistent manner by both BHOs. Subtle differences in policy interpretations and credentialing/clinical criteria among the two behavioral health care organizations can have a definite impact on outcomes and the overall achievement of the State's programmatic goals.

Arkansas' statewide Medicaid carve-out program was originally intended as a multi-entity award, but the State rescinded its original RFP and revised its program to select only a single-entity. The State of Arkansas determined that a multi-entity program would result in increased administrative costs that would divert funds from care. We strongly suggest that you consider the additional administrative and infrastructure costs incurred in managing two BHOs.

Contracting with multiple entities requires a greater coordination effort among the County, vendors, agencies, providers and facilities to provide a system of care encompassing a total treatment system for all members. The enrollment process becomes far more complex and more difficult when dealing with two BHOs. Enrollment fairs, marketing strategies, and County approval of these impact on the transition time and the costs of these activities. Under a single-entity system, time and expense spent in marketing and enrollment development would be eliminated and those resources would be focused on providing consumer education and outreach immediately. Multiple entities can prolong and complicate the transition process.

It is noted that one of the assets of the current operating system is a functional information system to operate, monitor, and plan for the expansion of the county's ability to bear the risk for inpatient mental health services. However, one of the areas targeted for improvement is the administrative and paper burden for case management staff. Some key points to consider:

- One would want to consider whether your current information system has sufficient capacity to support expanded clinical case management functions.
- If Metropolitan King County Council Proviso mandated the integration of services for the dually diagnosed, would the system be able to handle the complexities of service coordination requirements for these clients?
- Should these functions be delegated to one or two risk-bearing entities, what requirements are there for interfacing with their information systems and would your system be able to meet the demands required by two vendor systems?
- Do your clinical case management or claims payment systems have the capabilities of generating back-end reports regarding utilization by diagnostic categories or HEDIS quality of care indicators for individual providers/facilities?
- Is there the capacity for tracking specified performance measures that would maximize your progress towards sharing the risk for inpatient management?

Affect of a Multi-Entity Strategy on Consumers

Most importantly, King County must examine the benefits that a multi- vs. single- entity strategy provides to its behavioral health care consumers. A **1997 University of South Florida Impact Analysis Report** on child and adolescent services was used by Chris Koyanagi of the Bazelon Center for Mental Health Law in raising questions about the workability of HCFA's suggested changes for providing consumers with choice by

adopting a multi-entity strategy. In brief, the report indicates that in states where stakeholders had the choice of using multiple Managed Care Organizations (MCOs) the result was:

- Stakeholder and organizational confusion concerning issues, such as service authorization, service delivery, billing, credentialing, reporting, medical necessity issues, and level of care criteria;
- Increased administrative costs;
- Loss of chosen providers;
- Fragmentation of services;
- Decrease of prevention activities;
- Duplication in administrative services;
- Difficulty in monitoring quality of service; and
- Lack of specialized services.

Transitioning to Another Managed Care Organization

ValueOptions has extensive experience in successfully transitioning established programs from a previous vendor in its Massachusetts and Arizona projects as well as in several large commercial accounts. There are lessons learned from these transitions that we would like to submit to you as recommendations for King County. Both Massachusetts and Arizona involved large projects with issues related to continuity of employment, service delivery, the smooth transition of management information systems, billing processes, eligibility and enrollment procedures, and policy and procedure changes.

We strongly recommend that you refer to the Maricopa County RFP for a framework for structuring a transition plan and its benchmark requirements. Very important in this design was the recognition that upon contract award, the new vendor or entity required funding to successfully "turn off" one system and "start-up" a new one. A second design feature was the establishment of a transition Steering Committee comprised of high-level State executives, *ValueOptions* executives, and ComCare (outgoing vendor) executives who met weekly in a public forum. The public forum was done "fishbowl" style, allowing for public comment at the end of each meeting. These meetings provided an opportunity for all to measure our progress in meeting our objectives and target dates prior to the required systems test. Advocates, consumers, family members and providers were welcomed at these meetings. While the model used in our Massachusetts project was somewhat different, there were several keys to its success that are applicable in any transition:

- Active involvement of the State/County;
- Early and ongoing communication with the outgoing vendor;
- Clear communication to providers regarding procedures for authorization of care and submission and payment of claims;
- Comprehensive training; and
- Early coordination with high-risk members.

The third design feature we would like to highlight was that there was a contractually established "go live" date at which time (12:01 a.m. on a given day), the *ValueOptions* system replaced the outgoing vendor. We strongly recommend that King County adopt this strategy to avoid some of the San Diego implementation pitfalls reported in Mental Health Weekly earlier this year. Clean cut-off and start-up dates from one system to another are essential in both controlling implementation costs and maximizing efficiencies.

In both programs we hired many staff from the out-going vendor. This action can significantly add to the knowledge base of the incoming staff, eases transition issues, and adds continuity and consistency in relationships with consumers.

Issuing an RFP for Inpatient Alternatives

At the public hearing, it was recommended that King County consider combining the Inpatient Alternative RFP with the Integrated System RFP. We concur with this recommendation. If the Inpatient Alternative RFP were awarded to an entity other than the one awarded the Integrated System RFP; many of the problems associated with a two-entity system would reappear.

Integrating Substance Abuse Dollars into RFP

Another lesson learned from experience is that the more the program funding remains segregated, the more difficult it is to successfully treat co-occurring disorders in an integrated and timely fashion. King County is uniquely situated right now to "blend" funding with this initiative. Already you have received authorization from the State to proceed with blending inpatient and outpatient funding; we strongly recommend you also blend the substance abuse dollars as part of your overall integration mandate. The maintenance of separate funding streams, particularly given the prevalence of co-occuring disorders, is one of the greatest barriers in providing effective care.

We have reviewed the March, 1999 paper *"Promoting Excellence: A Plan for an Integrated Continuum of Mental Health, Chemical Abuse and Dependency Services in King County"* and concur with many of the concepts and vision statements in that document. Specifically, on page 5 it states, "Increasingly, however, individuals with multiple disorders (both a mental illness and a drug/alcohol problem) represent a population that is not being treated as effectively as possible and, as a result, consume significant public funds in multiple systems while not achieving positive treatment outcomes." Those clients are referred to as "High Impact Offenders" and represent 750 to 1000 individuals each year in King County. This population would greatly benefit from coordinated efforts by those programs/agencies that have had a history of success in King County and the integration of some of the successful programs we have initiated in other parts of the country under a managed care framework.

On page 9 of *"Promoting Excellence"* it states, "For example, mental health providers must continue to learn about the power of self-help recovery groups, just as chemical dependency providers must continue to learn about the opportunities provided by carefully prescribed psychotropic medications to treat serious and persistent mental illness." In Colorado and many other locations, ValueOptions has been instrumental in the introduction of self-help groups run by and specifically geared toward the dually diagnosed client. These types of programs have successfully expanded to include self-help groups within the penal system. With limited financial resources (primarily used to train peer leaders), groups such as these could have a tremendous impact on the target populations described in the *"Promoting Excellence"* document.

ValueOptions has found that blending funding streams is an effective tool for integrating services and revenue maximization. Blending funding for mental health and substance abuse services yields both financial and quality improvements. It has become clear that data and protocol-driven service management across these service delivery systems is one of the most powerful ways to accomplish goals such as the following:

- Eliminating gaps in services,
- Increasing cost-effectiveness,
- Identifying duplicated services,
- Modeling and predicting the outcomes of groups of services, and
- Managing global resources efficiently.

Comments on the Timetable for the RFP, Contract Negotiations, and ASO Transfer of Functions

We would like to respectfully share with you some observations on your proposed timeline. The observations are based on our extensive experience in the area of responding to RFPs, contract negotiations, and adequate timeframes for vendor to vendor transitions.

In our experience, most States and Counties allow 45 to 90 days for receipt of the response to the RFP. We would like to support an October 1, 1999 RFP release date and advocate for a December 15, 1999 due date, thus avoiding the holiday crunch. This would allow for approximately 75 days to prepare and submit a proposal response. This would seem appropriate given that this is the millennium year. You may also want to reconsider the amount of time you have given yourself to review the submitted proposals. We would suggest that you allow at least six weeks. A two-month contract negotiation window is sufficient if working sessions between representatives of the County and the winning vendor are scheduled immediately following contract award.

The distinction between May 1, 2000 and July 1, 2000 as start date is not clear. There appears to be a two-month period (May – June 2000) that has been differentiated from the July – December 2000 ASO transfer of functions to the new vendor. Based on our vendor to vendor transfer experiences in Massachusetts and Maricopa County, Arizona,

we would recommend that the full eight months be dedicated to the implementation and transfer activities, including administrative readiness testing.

We would also suggest that the County be very clear about what it expects with regards to the transfer of risk for this population. We would strongly urge the County to consider the merits of a one-time transfer of all risk as opposed to a phased in approach that necessitates multiple transfers of risk for certain levels of care. The transfer of risk to the new vendor is best managed when all levels of care are transferred simultaneously, otherwise, if the most expensive level of care is transferred first, the vendor could find itself with a cash flow problem. Transferring risk twice for the same level of care within an eight-month timeframe would also present some administrative challenges

We thank you again for the opportunity to respond to your document. We would be available to discuss any issues mentioned in this letter, or provide additional information if you think it would benefit the process. If you have any further questions or comments, please contact Bob Yost, at (800) 804-5040.

Sincerely,

Sandra L. Forquer, PhD

Sandra Forquer, Ph.D.
Senior Vice President / Strategic Development

Robert Yost

Robert Yost, MA
Executive Director / Development and Provider Relations

ATTACHMENT D

Financial Plan for PHP Phase III Integrated Model

Fund 000001120 Dept. 0924
Community & Human Services / Mental Health Fund

Prepared By: **Rachel Solemsaas, Chief Financial Officer** T

Category	1998 Actual	1999 Adopted	1999 Projected 5	2000
	10,586,563	10,824,299	14,900,574	
Base Revenues:				
*PHP outpatient funds	51,875,805	51,307,666	50,553,149	
*PHP inpatient funds2	633,359	719,487	636,691	
*Federal Grants	3,207,238	2,689,385	2,501,391	
*State	18,901,125	19,604,633	20,746,076	
*Local government	2,871,845	2,728,728	2,881,809	
*Current Expense	308,950	421,950	421,950	
TOTAL BASE REVENUES	77,798,321	77,471,849	77,741,066	
Base Expenditures:				
Integrated Services				
* **Entity Payments**				
* PHP outpatient	44,077,028	48,191,009	47,110,561	
* PHP Residential & Crisis Services	14,663,053	15,373,873	14,964,615	
* PHP Hospital alternatives	7,205,131	8,379,816	8,733,073	
* PHP Specialized Services	2,485,545	2,573,949	24,426,241	
* Administration[4]	3,591,794	3,854,070	3,701,759	
* One time development costs	483,034	1,514,778	1,095,105	

Category	1998 Actual	1999 Adopted	1999 Projected 5	20
Mentally ill offenders-adults				
*Jail Alternative Services	447,914		-	
*Comm Treatment Program	160,878	415,000	465,000	
*Mental Health Court Liaisons	3,099	151,232	170,465	
*Crisis Triage	295,529	1,212,647	1,170,904	
Mentally ill offenders-juveniles				
*DYS assessment project	15,000	100,000	100,000	
*DYS Youth Offender with MICA	209,785	188,085	188,085	
*DASAS-1st time youth offender	180,920	180,920	180,920	
TOTAL BASE EXPENDITURES	**73,818,710**	**82,135,379**	**80,306,728**	
Other Fund Transactions(adj from Budgetary to GAA	334,400			
ENDING BASE FUND BALANCE	**14,900,574**	**6,160,770**	**12,334,913**	
Less Reserves & Designations:	(2,130,913)	(2,926,981)	(2,242,718)	
Carryover	90,289			
ENDING PROPOSED UNDESIGNATED FUND BALANCE	12,859,950	3,233,789	10,092,194	
Target Fund Balance 3	738,187	821,354	803,067	

Financial Plan Notes:

[1] *Beginning Fund Balance is from 1998 CAFR.*

[2] *Inpatient full risk contract with State Mental Health will start July 2000.*

[3] *Fund Balance Policy is 1% of expenditures set by Motion 7516 passed on May 1, 1989;*
PHP expenditures has 5% insurance risk reserve set by Motion 9399 passed on October 10, 1994.
Proposed insurance risk reserve level of 1% is set aside starting 2H2000 with the Phase III PHP model.

[4] *PHP policy set county administration to be limited to 5% of revenues. By July 2000, administration will be limted to 3.33%.*

[5] *1999 Projections is based on financial model dated May 6, 1999.*

[6] *1% to 3% growth assumptions for revenues; Entity management concept will start on July 2000; King County will continue to manage Crisis & Commitment Services; Federal Child Grant; ORT & Ombuds; Muckleshoot and DVR. While the Entity will manage integrated serv including MIO initiatives & pilot programs*

ATTACHMENT E

Currently Contracted Carveout Programs

Crisis and Engagement Services

Emergency Telephone Services

Outreach and Engagement

Crisis Triage Unit

Older Adult Crisis Outreach

Children's Crisis Outreach

Crisis Support Services

Crisis Aftercare Services—Children and Adults

Children's Crisis Foster Care

Language Interpretation

Hospitals and Hospital Diversion

Evaluation and Treatment Facilities

Hospital Diversion Beds—Children and Adults

Hospital Liaisons

Other Programs

Residential Services

Interagency Staffing Teams

Blended Funding

First Time Youth Offender

Intensive Case Management for Juvenile Offenders

10749

Department of Vocational Rehabilitation (DVR)

Ombuds Service

Mentally Ill Offender—Community Transition Program

Information and Referral/Self-Help

Children's Flex Funds

Functional Family Therapy

Muckleshoot Tribe

Parent Advocacy

Consumer Projects

Consumer Conferences

Provider Training

Mental Health Court

ATTACHMENT F

Inpatient/Integrated System Planning Timeline

Date	Integrated System Task	Inpatient Task
4/9/99		Identify alternatives to inpatient treatment
4/12-4/16/99	Receive public comment on the proposed Integrated System models	
4/23/99		Develop specifications for initial inpatient management indicator reports
by 4/30/99	Financial projections for inpatient and outpatient dollars	
week of 5/3/99	Consultant selected for second planning phase	
by 5/7/99		Letter to the state outlining KCMHCADSD intent for inpatient management, including risk sharing, PAS requirements, and inpatient alternatives
week of 5/10/99	Review Requests for Proposals (RFPs)/contracts from other states for language on performance measures, incentives and sanctions Brief Department of Community and Human Services Director and King County Executive	Gather sample public and private contracts for language on inpatient performance measures, incentives, and sanctions Evaluate current Policy and Procedure Manual for possible revisions to Section VI. Management of Inpatient Services
week of 5/17/99	Brief Metropolitan King County Council Staff	

Date	Integrated System Task	Inpatient Task
week of 5/17/99 (continued)	Brief the Law, Justice and Human Services Subcommittee of the King County Council on the Integrated System recommendations	
5/17-6/11/99	Metropolitan King County Council briefing and review	
5/17 – 8/31/99	Develop and write the Integrated System RFP	
by 5/17/99	Negotiate the terms for the state biennial integrated contract	
5/17-6/1/99		Evaluate the current inpatient authorization tool
5/17-6/9/99		Review current United Behavioral Health (UBH) inpatient contract requirements and inpatient initial authorization, length of stay extension, and concurrent review practices. Develop recommendations to tighten, as necessary. Develop performance measures for the UBH contract amendment to manage inpatient services
by 5/21/99		Inpatient quality management addendum to the MAA inpatient contract developed
5/21-6/11/99		Develop monitoring plan for inpatient quality management addendum; develop staffing needs and monitoring tools for the new system, and begin recruitment Develop and staff a reconciliation function responsible for reconciling

Date	Integrated System Task	Inpatient Task
		MAA and KCMHCADSD inpatient data and disputed billings
5/21-6/18/99		UBH inpatient contract language amended
6/1-12/31/99		Develop financial and information systems to manage inpatient risk and quality management
week of 6/21/99	Sign state biennial contract	
by 6/30/99		UBH contract amendment signed
7/1-7/31/99		Develop inpatient alternatives specifications. Develop RFPs if indicated.
7/1-8/31/99.		Work with inpatient units to begin implementing the quality management policies
7/1-7/15/99		Inpatient profile survey developed and released to King County psychiatric inpatient units
8/1-9/30/99		Brief inpatient facilities on the inpatient pilot project and timelines
8/2/99		Release inpatient alternative RFPs, if indicated
8/9/99-10/8/99		Inpatient alternatives RFP and contract negotiations, if inpatient alternatives RFPs released
9/1-9/30/99	Legal and management review of the Integrated System RFP	

Date	Integrated System Task	Inpatient Task
10/1/99	Integrated System RFP released	
week of 10/11/99	Integrated System RFP bidders' conference	
10/18/99		Inpatient alternatives implemented
11/1/99	Integrated System RFP addendum published	
01/01-6/30/00		Monitor inpatient quality performance Begin to work with the Medical Assistance Administration to remove from the general inpatient contracts language specific to psychiatric services
01/14/00	Integrated System RFP responses due	
01/24-2/25/00	System Change RFP raters' conference and bidder interviews	
02/28/00	Successful Integrated System bidder announced	
02/28-5/31/00	Integrated System contract negotiations and contract signed	
07/1/00	Integrated system begins	Assume full risk for inpatient services
12/31/00	ASO contract ends	

ATTACHMENT G

Populations and Service Needs[18]

Continuum of Chemical Use

Continuum of Mental Illness	Chemical Dependence	Chemical Abuse	Chemical Use	Abstinent
	Serious and Persistent Mental Disorders	Without fully integrated services, individuals in this group consume large amounts of public funds in multiple systems without positive results.	Integrated mental health and alcohol/drug abuse services promote improved client outcomes for individuals in this group.	Individuals in this group need and benefit from traditional mental health services, but may require alcohol/drug prevention and education.	Individuals in this group need and benefit from traditional mental health services.
	Serious Mental disorders	Integrated mental health and alcohol/drug services promote improved client outcomes.	Integrated mental health and alcohol/drug services promote improved client outcomes.	Benefits from mental health services and alcohol/drug education and prevention.	If eligible, individuals in this group need and benefit from traditional mental health services.
	Situational Mental Disorder	This group may not be eligible for or prioritized for publicly funded mental health services. Alcohol/drug treatment needs may vary for those who are eligible.	This group may not be eligible for or prioritized for publicly funded mental health services. Alcohol/drug treatment needs may vary for those who are eligible.	This group may not be eligible for or prioritized for publicly funded mental health or alcohol/drug services.	Crisis intervention and stabilization services are available for individuals in this category.
	Healthy	Individuals in this group need and benefit from traditional alcohol/drug services.	Individuals in this group need and benefit from traditional alcohol/drug services.	Individuals in this group may benefit from chemical use prevention and education interventions.	Services for this group are limited to prevention and education services.

Dark shaded areas indicate primary adult populations that benefit from service and systems integration. The **four highlighted boxes** in the center indicate primary children and youth populations that benefit from service and systems integration. **Light shaded areas** indicate services that will not need to change as a result of reorganization.

[18] This matrix was adapted from materials provided by Jim Bixler, President and CEO of JBX & Associates.