Washington State Health Care Authority

Paying for successful transitions 12-months post Behavioral Health discharge for Transition Age Youth (TAY) ages 15-25

Payment practices within HCA, current options, opportunities to grow, and barriers

Project Background

Origin

HCA published a report in June 2021 outlining best practice discharges for Transition Age Youth (TAY) ages 16-25 to ensure youth are discharged into safe and supportive communities. This work came out of previous reports from the Office of Homeless Youth and Away Home WA in 2020 showing **66% of** homeless youth had discharged from a behavioral health inpatient. **20% of total TAY** exiting behavioral health inpatient experienced homelessness within 12 months of discharge.

Workgroups

HCA approved a charter in December of 2021 to implement the recommendations in the report mentioned above. This document outlines what HCA is currently doing to support successful transitions followed by expansion opportunities and barriers HCA faces. Workgroups were formed to compile these documents and further the implementation process. Division of Behavioral Health and Recovery (DBHR) co-organized this work with subject matter experts from the following internal divisions: Medicaid Programs Division, Office of Tribal Affairs and Health IT.

Background and process

HCA holds contracts with Medicaid managed care entities, Behavioral Health Administrative Services Organizations, direct providers for individuals not in managed care, Tribes and Urban Indian Health Programs FQHCs, and plans implementing Public Employee Benefits Board (PEBB) and School Employee Benefits Board (SEBB). These contractors administer health benefits so that Washingtonians enrolled in these plans receive comprehensive healthcare. During the workgroup process, members examined managed care organization, accountable communities of health, and PEBB and SEBB health plans' certificates of coverage and further clarification from those plans.

Definitions

In the following documents you may encounter new terms. While this is not a comprehensive list, you can refer to these definitions directly from current contract language and federal standards.

Contract definition: "Care Coordination" means an Individual's healthcare needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the Individual and the Individual's caregivers and works with the Individual to ensure the Individual receives the most appropriate treatment, while ensuring that care is not duplicated.

Peer Bridger- The Peer Bridgers will attempt to engage Individuals in planning their discharge. Hospital staff and the IMC/BH-ASO Hospital Liaisons will help the Peer Bridgers identify potential participants. The Peer Bridger is not a case manager, discharge planner or a crisis worker. However, the Peer Bridger can bring the Individual's perspective into the provision of those services.

"Certified Peer Counselor (CPC)" means Individuals who: have self-identified as a consumer of behavioral health services; have received specialized training provided/contracted by HCA, Division of Behavioral Health and Recovery (DBHR); have passed a written/oral test, which includes both written and oral components of the training; have passed a Washington State background check; have been certified by DBHR; and are a registered Agency Affiliated Counselor with the Department of Health (DOH).

"Rehabilitation Case Management" means a range of activities by the outpatient CMHA's liaison conducted in or with a Facility for the direct benefit of an Individual in the public mental health system.

Warm handoff- "A warm handoff is a handoff that is conducted in person, between two members of the health care team, in front of the patient (and family if present)."[1]

Important overview

Within the behavioral health world, there are two primary supports that aid successful transitions, **care coordinators** and **case managers**. These two positions facilitate **warm-hand offs, outreach,** and **in-reach** allowing the outpatient service provider to meet the client before the client leaves inpatient or before they have their outpatient visit. The **case manager** and **care coordinator** follow up with the client to ensure that the youth/young adult is linked with, and understands, what they need to do to successfully receive services. This process increases the likelihood that the TAY will engage in further clinical services and get linked with other needed supports.

Current transition support for TAY ages 15-25 phase I

Manage Care Organizations (MCO) and Behavioral Health Administrative Services Organizations (BH-ASO)

Currently, HCA contracts with MCOs for Medicaid services along with non-Medicaid covered services for Medicaid eligible individuals. BH-ASOs deliver crisis services for all residents in Washington state in addition to providing behavioral health services and supports within available resources for individuals uninsured or underinsured. BH-ASOs may contract for additional services within their regional service area. Within both contract types, care coordination and case management service provisions are included. Additionally, Washington's Medicaid benefit allows for care-coordination, outreach, and in-reach coverages through two specific mental health modalities called rehabilitative case management and crisis stabilization services (intended for short-term episodes up to weeks). However, the Medicaid state plan does cover rehabilitative case management or stabilization services for those with a single primary diagnosis of substance use disorders while, the MCO Medicaid contracts allow for case management as a specific stand-alone substance use disorder treatment modality which is not offered on the mental health side.

Through Medicaid demonstration projects (and grant funded) Foundational community supports (FCS) and peer bridgers also provide important transition supports to TAY integrating into communities and can often include care coordination, warm-hand offs, and in-reach.

As required by CMS managed care rules, the TEAMonitor program regularly monitors and supports MCOs and BH-ASOs in our common goal to utilize the above opportunities.

Block grant and state funds

Both state and federal budgets and grants also can support transitions. You can see a short, but not comprehensive list here.

[1] https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/warm-handoff-guide-for-clinicians.pdf

Some of these funds can pay for vital needs and services such as: clothing, housing deposits, and even care coordination for specific populations.

PEBB and SEBB

Public Employee Benefits Board (PEBB) and School Employee Benefits Board (SEBB) provide benefits to public and school employees of the State of Washington and cover more than 600,000 lives. PEBB and SEBB are administered by the Employee and Retiree Benefits (ERB) division at HCA. PEBB and SEBB members can chose from plans offered by the Uniform Medical Plan (UMP), Kaiser Permanente, Premera (SEBB only), and United Health Care (Medicare only). Each plan negotiates their contract with ERB and those contracts support case management for those with multiple chronic conditions. Post discharge care coordination and follow up requirements are aligned with all required regulations, but the logistics or any expansion beyond requirements are primarily left to the providers and facilities to create, execute, and monitor.

HCA expansion plans for WG2 phase II to improve TAY (ages 15-25) transitions

The workgroup will explore and if successful, monitor the progress of a new workgroup that is formed with MPD, DBHR, and the MCO and BH-ASO plans to discuss problem-solving TAY transitions and payments to ensure success. This can be used as a starting point to support future work with other contracted entities.

Further exploration, such as in Phase III, must include government to government, PEBB/SEBB, and other entity consultation and collaboration to expand transition supports outside of MCO and BH-ASO covered lives.

Some of these collaborative discussions with plans, providers, and governments, may include but not be limited to these other opportunities within our contracting to improve transitions. The following are areas of opportunity the internal HCA team will be working to prioritize and build strategy to continue this work:

Opportunity
Working with plans to encourage providers to use telehealth with Rehabilitative Case Management (RCM) and stabilization.
Problem-solve with MCOs to leverage RCM and stabilization support, as well as identify and mitigate barriers
Improve escalation pathways and quality management processes for MCO and BH-ASOs such as requiring client and provider education on escalation (targeting and reporting on key sub-populations).
Improve MCO and BH-ASO state resource directory of community resource and increase networking to support provider linkages.
Clarify the transition roles of MCOs, BH-ASOs, PEBB/SEBB, and providers.
Begin tracking the Rehab Case Management and stabilization services to increase utilization.

Barriers to dismantle and needed support to improve TAY (ages 15-25) transitions

While there are great opportunities that HCA is starting to create, there are structural barriers that need continued focus and innovation to remedy.

Barriers to dismantle
CMS federal rule prevents Medicaid supports when consumers are in state hospitals and detention centers.
Provider shortages prevent treatment centers from hiring discharge and coordination staff.
RCM and crisis stabilization services are not covered for substance use disorders under Medicaid. Case management is not covered for mental health under Medicaid.
RCM and stabilization services are underutilized, with reported low reimbursement rates.
Staffing and capacity challenges within HCA to monitor payer contracts.