From:	Julia O"Connor
To:	OIC Rules Coordinator
Subject:	BBPA Prepublication Language Feedback
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Attachments:	image001.png

External Email

Please see the below comments submitted by members of the Washington Council for Behavioral Health regarding proposed language for WAC 284-170-205. Note that comments are the views of the individual member organizations and do not reflect the views of the Council as a collective organization.

Thank you,
Julia

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Comment 1:

The new section pasted below is specific to Insurance Payers and putting specificity into requirements they will be held to regarding their plan and payment to non-contracted providers for services considered to be emergent and/or when they do not have providers or specialty types within defined network adequacy standards. It also requires Health Plans to attempt to contract with all ASOs and when the ASOs are unwilling to contract, to then engage in good faith efforts to directly contract with a sufficient number of licensed BH agencies providing crisis/emergent services directly in an attempt to meet network adequacy standards. This requires Health Plans to accept crisis and emergent BH service codes outlined in the SERI which will make it easier for providers in not having to change the service code based on the payer type (commercial, Medicare, Medicaid, etc.).

Health Plans contracting directly with ASOs will be required to accept delegation of credentialing from the ASO in an effort to create administration simplification. If contracting with the provider directly, the Health Plan would credential meeting basic outlined requirements which would show the provider is licensed and in good standing. Obviously it would be much less administrative burden if they required the ASOs to contract directly and not the providers. While Carelon has indicated they

will contract directly, GCASO has indicated they will not as they do not have the capacity or resources to take on this work. This will make a lot of additional work for BH providers in areas with smaller ASOs, which does create inconsistency and unfairness as it relates to dollars and where they are spent. Those who will have to contract directly with all of these Health Plans will be taking on a lot of additional work in contracting, billing setup, claim processing, working denials, configuration, etc.

- *I would like to see them add some language that indicates they will be required to pay claims outside of the credentialed date given they were provided as crisis and/or emergent, etc.*
- *It would be ideal to require the ASOs to contract directly and not put the administrative Burden on providers in areas where the ASOs are smaller, creating more of a negative financial impact .*

There is additional new language in the bill, not pasted below, around Ambulance and specifically Air Ambulance transport. This new language requires Health Plans to reimburse as if contracted (within parameters) as well as requires these providers to accept "reasonable" reimbursement. There is clearly defined methods of acceptable reimbursement calculation along with language that allows the parties to agree to an alternative payment arrangement. While this doesn't directly impact us, it does impact our use of AMR for secure transport services. The impact is for the betterment and to the positive for our clients and their families, etc.

While this can seem like it is a good thing on the outside, it is not necessarily. It sets parameters for allowing the OIC to define "reasonable" payment for specific services.

Comment 2:
The language looks ok, except that I am worried about ASOs having the ability to choose ***not*** *to contract with commercial insurance, leaving providers to carry that load. As the language notes, if we must contract directly, it creates a substantial burden for CBHAs in contract negotiations, billing, etc. What is also concerning is that they can then add our organizations to an audit schedule. That of course is a headache, mainly because we end up having to schedule CQI staff to meet their needs (downloading into their portal, typically), and to spend substantial energy in educating commercial plan auditors about community behavioral health, our less traditional approaches, service intensity needs, etc. And there are so many plans....*

I cannot imagine how this would work, unless the ASOs come up with a standard contract that they can use, and ASOs then contract with all plans. I would imagine there are hundreds of plans out there.

Also - If CBHAs do have to take care of the contracting directly, can the OIC say anything about the number of commercial plans that would be sufficient?

It was very challenging in the early days of IMC to help the commercial plans understand what they could and could not require in Medicaid contracting. Their contracts contained multiple sections that were not consistent with the state Medicaid Plan, and we had to push to have each of those removed

- one by one. Adam Falcone was a huge help - pouring over contracts that were often long with extensive legal jargon. He red-lined entire pages that were not consistent with Apple Health in WA.

The individuals negotiating from each MCO typically came from the commercial side of things (with the happy exception of Molina). They had no idea what IMC entailed or how to serve a population insured by Medicaid. What was frightening was that Steve and I knew more than they did, lol.

And honestly, one ASO that we work with in two regions is more challenging than all MCOs put together. The other ASO is great to work with. Trying to do this with the challenging ASO determining the rules (e.g. numbers of plans...) would be extremely difficult.