Washington State Department of Social & Health Services

Transforming lives

DSHS Response to ACHS Questions- Released 6/09/14

Questions received from the Washington Association of County Human Services and response provided on June 6, 2014.

1. Medical and Behavioral Health referral patterns are complicated for Klickitat Co. and other rural counties. Depending on where residents live within the county, some travel to Oregon, some to Vancouver, and some go east for treatment. There are many concerns about how inter-local agreements would play into this, and if residents would still have flexibility based on where they live.

   Current regulations (RCW, WAC and Mental Health 1915 (B) Waiver) require that federal funds used to provide mental health and substance abuse services are contracted to DBHR licensed and certified providers. At this time this is limited to providers within Washington State. We are looking into what kinds of flexibility can be allowed under these regulations. Recently passed legislation SB 6419 contains language that directs

   > *"The authority and department must collaborate and seek opportunities to expand access to care for enrollees in the Medicaid programs who live in border communities"*

   Both the Healthcare Authority and DSHS are currently reviewing the opportunities to provide this access and strategies identified will be included in contracts for the BHOs.

2. Commissioners who are in counties that have applied to be in an ACH are still concerned about joining a Regional Service Area with other counties that were not involved with the ACH application. The same issue applies to counties that are in a RHA and want to keep those relationships, but may want to join other counties in a Regional Service Area and/or BHO that are not part of that RHA. Any chance we can get written clarification that this will not be an issue in the future?

   Washington health system transformation depends upon coordinating and integrating the delivery system with community services, social services and public health. This strategy would be greatly enhanced by the development of a single Accountable Community of Health within each regional service area. Though not legally required, it is desirable from an administrative, business, and community linkages perspective to align Medicaid purchasing regions and Accountable Communities of Health to the greatest degree possible.

3. I continue to have commissioners who are concerned that we do not have the data to show what the health plan encounter rates are...major concern being that risk for counties increase if the mild MH cases are not addressed. Data on performance with this population would be very helpful.

   Attached to this email you will find a high-level overview of specialty mental health utilization by children and adults enrolled in managed care plans for calendar year 2013. (See attachment named: MCO-MHUtilizationv4_Final.pdf) There are several important considerations for this particular report: This utilization information does not reflect behavioral health services in primary care settings and does not include pharmacy utilization. It also reflects CY 2013 services prior to the application of MH parity under the ACA. In addition to this initial overview, we will be providing more detailed information in weeks to come.

4. There is continued concern regarding cuts to state dollars in CD, specifically money to pay for residential CD treatment as many facilities are considered IMD. There is considerable concern that there will not be state funding to cover this additional risk.

   In the current mental health system the RSNs are at risk to pay for these services when they are medically necessary even when provided in an IMD and this will be true as well for the CD programs. DSHS is provided funding by the legislature and will contract for services based on the funding provided.