

Washington State Health Care Authority

Report to the Legislature

MEDICAL CARE ACCESS – BORDER COMMUNITIES

As Required by SB 6419, Chapter 39, Laws of 2014

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EXECUTIVE SUMMARY

Chapter 39, Laws of 2014 (SB 6419) expands access to care for Medicaid managed care enrollees and clients receiving services through the fee-for-service delivery system living in border communities. The Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) must collaborate and seek opportunities to expand access to care for enrollees receiving medical care services through the Apple Health Managed Care program, mental health services through the Regional Support Networks, chemical dependency, and long-term care services.

For many years, HCA has relied on providers in bordering communities to serve Washington Medicaid enrollees in the areas closest to where they live. The agency requires any Managed Care Organization (MCO) wishing to serve enrollees in a given service area to provide proof that its provider network is adequate to serve at least eighty percent of all eligible individuals who reside in the service area, including those living in border communities.

When accessing out-of-state care, enrollees in southwest Washington typically access medical services across the Columbia River in Oregon; those in eastern Washington may receive services from providers in nearby larger communities in Idaho. HCA is able to approve these arrangements because these cross-border providers are located within federally established distance standards related to Medicaid.

Since the Governor signed the bill into law in March 2014, HCA has executed its 2015 Apple Health Managed Care Contract. Across the state, six Managed Care Organizations (MCOs) provide the full scope of medical care services to one in six Washington State residents.¹ For 2015, HCA revised its managed care contract, strengthening and enhancing provisions clearly directing the MCOs to offer contracts to providers in bordering communities and requiring the MCOs to include information about their contracting activities in reports required quarterly. HCA uses these reports to monitor the MCOs' provider networks on an ongoing basis, and requires the MCOs to notify HCA whenever there is a loss of a material provider.

Chapter 225, Laws of 2014 (2SSB 6312) provides the framework toward integration of medical and behavioral health care services in Washington, with full integration accomplished by 2020. As with the 2015 Apple Health Managed Care contract, the upcoming Fully Integrated Managed Care (FIMC or "Early Adopter") contract will also include provisions consistent with the legislation. As part of this transformation, the Regional Support Networks (RSNs) will no longer exist and will be replaced with Behavioral Health Organizations (BHOs). The BHOs will administer the delivery of behavioral health services through managed care arrangements. The July 1, 2015, RSN RSN contracts and the future BHO contracts will include provisions for border RSNs to

¹ For 2014, HCA was contracted with five MCOs: Amerigroup, Washington; Community Health Plan of Washington; Coordinated Care Corporation; Molina Healthcare of Washington; and United Healthcare Community Plan. For 2015, all five MCOs signed new contracts and were joined by Columbia United Providers, serving Clark County.

develop Memoranda of Agreement (MOA) with cross-border community mental health centers and psychiatric inpatient facilities to facilitate cross-border services for ease of access and timeliness of care. MOAs will include terms for purchasing out of network services when it is necessary to ensure access and timeliness, including agreements with out of state providers for those RSNs that share borders with other states. In addition, language comporting with SB 6419 will be incorporated into the new BHO contracts.

HCA submits this report on behalf of both agencies to provide an update on the contractual opportunities and anticipated impacts on patient access to timely care, the impact on the availability of inpatient and outpatient services, and the fiscal implications for the Medicaid programs.

1. Background/Existing System and Access

Senate Bill 6419, Chapter 39, Laws of 2014, signed by the Governor on March 17, 2014, directed the Department of Social and Health Services (DSHS), in collaboration with the Health Care Authority (HCA), to seek opportunities to expand access to care for enrollees in identified Medicaid programs, living in border communities. These opportunities could require contractual agreements with providers across state borders when care is appropriate, available, and cost-effective.

This report provides an update on the contractual opportunities and the anticipated impacts on patient access to timely care, the impact on the availability of inpatient and outpatient services, the fiscal implications for the Medicaid programs, and identified challenges to implementation.

A. Mental Health Services

Washington's current Medicaid mental health service system is administered by two different state agencies—DSHS and HCA.

DSHS

DSHS has managed care contracts with eleven Regional Support Networks (RSNs). The RSNs assume the responsibility and financial risk for providing mental health services to all Medicaid eligible individuals who are experiencing serious and persistent mental illness. RSNs are required to develop provider networks comprised of licensed Community Mental Health Agencies (CMHAs) and psychiatric inpatient facilities to serve the RSN enrollees within their catchment area.

RSN Medicaid clients have access to 19 different treatment or service modalities, including crisis services. Many of these services are provided out-of-facility, in community locations convenient to the individual. Examples of these locations include an individual's home, local community centers, or any safe location identified by the individual.

RSN services do not have specific limits on the number of visits; service frequency and intensity are determined by the individual's level of need and the presence of medical necessity. Crisis services are provided on demand; there is no requirement for determining medical necessity for these services, as long as the individual is experiencing a mental health crisis.

Outpatient services may be provided as long as the individual presents with medical necessity for care. The medical necessity determination is based on the enrollee presenting with a covered diagnoses and a functional impairment as defined in the CMS-approved *Access to Care Standards*².

² Access to Care Standards can be found at this website: <http://www.dshs.wa.gov/dbhr/mhdefinitions.shtml>.

HCA

Most individuals entitled to Medicaid must be enrolled in and receive their medical care through contracted managed care organizations (MCOs). This program is known as Apple Health Managed Care. These MCOs are also responsible for providing outpatient mental health services to enrollees who do not meet the *Access to Care Standards*. Typically these services are provided within a clinic setting and are primarily comprised of psychotherapy and psychotropic medication management and monitoring. Individuals requiring more frequent contact, or who are not able to participate in clinic-based outpatient therapy as a result of their mental illness, are referred to their RSN to determine whether they meet *Access to Care Standards* for RSN-level care. If the enrollee lives in a border community, he or she may receive services from a contracted provider(s) in the bordering community.

B. Substance Use Disorder Treatment Services

DSHS

DSHS contracts with counties to provide outpatient substance use disorder treatment services to youth and adults. The counties, in turn, contract with state-certified facilities for Medicaid, state funded and Substance Abuse Treatment and Prevention (SAPT) block grant funded services.

DSHS contracts directly with Tribal Governments to provide substance use disorder treatment.

Services provided include group and individual treatment, drug screens, acute/sub-acute detoxification, sobering services, outreach, brief intervention, case management, opiate substitution treatment, and education.

Currently, all outpatient substance use disorder treatment services are based on a fee-for-service payment model. Counties may also utilize 1/10th of 1% local tax dollars and other local dollars to cover the cost of providing these services. As described in Section 3. A. of this report, publicly funded substance use disorder treatment services will move to a managed care model with the implementation of Behavioral Health Organizations (BHOs) on April 1, 2016.

DSHS directly contracts with residential facilities for residential substance use disorder treatment for youth and adults and provides access to involuntary treatment services for adults. DSHS will also transition residential treatment services and contracting to the BHOs April 1, 2016, as part of the BHO implementation.

HCA

Apple Health contracted MCOs do not provide substance use disorder treatment services. However, the MCO is responsible to ensure enrollees who have been identified as needing substance use disorder treatment receive care from the appropriate provider(s).

2. Current Practices that Address Access to Services

A. RSN Mental Health Services

As per federal regulations (42 CFR Section 438.206 and 438.207)), all RSNs must meet network adequacy requirements and distance standards. Network adequacy requires that there be sufficient depth of services to meet the medically necessary treatment needs of its service population. If an individual presents with medical necessity for a treatment service that the RSN does not have the capacity to meet, the RSN is required to contract out of network for that service.³

Access standards require that an RSN consumer receive an intake assessment within ten business days of their initial request for services. As managed care entities, RSNs cannot have waiting lists for services. All individuals requesting intakes must be seen within the ten business day timeframe. If the intake assessment determines that the individual meets the *Access to Care Standards*, the RSN must ensure that routine treatment services begin within 28 calendar days of the initial service request.

Current practice for border RSNs is that when no local psychiatric inpatient beds are available, the RSN pays for authorized voluntary psychiatric inpatient treatment in bordering hospitals. An example of this would be Southwest RSN authorizing an inpatient stay at one of the psychiatric hospitals in Portland, Oregon. During the 2014 fiscal year, RSNs authorized 167 voluntary inpatient stays in Oregon and Idaho hospitals treating psychiatric disorders. The total amount paid for these hospitalizations was \$1.2 million. Of these hospitalizations, 111 were in Idaho and 56 were in Oregon. Most often, these authorizations were issued because the individual consumers presented themselves for care at the out-of-state facilities.

While an RSN can authorize an out-of-state hospitalization, an involuntary treatment hold is only valid within Washington. The Involuntary Treatment Act (ITA) applies only within Washington's borders; states do not recognize involuntary holds from other states as each state has its own standards and laws governing involuntary treatment and hospitalization. Given this limitation, it is possible that a person detained in Clark County could be sent across the state to Seattle, or even to Yakima,

³ An example of this could be a person who presents with a serious and life-threatening eating disorder who is in need of eating disorder treatment. If the RSN does not have a specialized practitioner within its network, the RSN would be required to contract outside of the RSN for the service. If clinically indicated, this could include placement in an out-of-state, Medicaid approved, inpatient treatment facility.

for ITA treatment services if no bed were available within the local RSN, even if there were available beds in nearby Portland.

B. Substance Use Disorder Treatment Services

While the current funding structure of substance use disorder treatment discourages out-of-state treatment placement, when substance use disorder treatment transitions into managed care via the BHOs, the Medicaid-funded substance use disorder treatment system will be required to meet the same requirements for access and network adequacy as the current RSN system. This will include distance standards, admission time frames, and the provisions for going out of network to meet an individual's medically necessary treatment needs.

C. Medical Services

Apple Health Managed Care

HCA has long recognized the need to ensure access to care for residents of border communities. As of October 2014 all of the MCOs have contracts with providers in Oregon and Idaho, with the majority of those located in Hood River, The Dalles, Astoria, and Portland, Oregon and Sandpoint/Priest River, Moscow, Coeur d'Alene, and Lewiston, Idaho.⁴ To further emphasize and clarify this expectation, beginning January 1, 2015, HCA's Apple Health Managed Care contracts include specific direction to MCOs to offer subcontracts to providers in bordering states.

To contract for services in a given service area, an MCO first must provide evidence to HCA that its provider network is adequate to meet the needs of the population to be served, specifically in six critical provider types.⁵ The provider network must also meet the minimum distance and appointment standards. For example, at least 2 primary care providers (PCPs) must be available within 10 miles in urban zip codes and at least one PCP within twenty-five miles in non-urban. Wait times for appointments must also be within contractually established standards.

If an enrollee needs a medically necessary covered service that is not available within the MCO's contracted provider network, the MCO must provide the service through a "nonparticipating" provider at no cost to the enrollee. Consistent with [RCW 74.09.522](#), HCA requires the MCOs to report to HCA on the proportion of services provided by participating and nonparticipating providers to ensure network adequacy. HCA reports its findings to the Legislature annually by January 1.

HCA monitors the MCOs' ongoing network adequacy through the use of quarterly network submissions, a quality assurance review, and a biannual report. The first of these quarterly reports is due to HCA April 30, 2015.

⁴ The two largest contractors report 60 contracted hospitals in Oregon and 29 in Idaho; 224 contracted primary care providers in Oregon and 62 in Idaho; and 639 specialists in both states.

⁵ The critical provider types are: Primary care, mental health professional, hospital, pharmacy, obstetrician/gynecologist, and pediatrician. Effective January 1, 2015, this will also include mental health providers.

Fee-For-Service Medical Care Services

A Washington resident may receive medical services from a provider located in a bordering city under [WAC 182-501-0175](#)⁶. This rule allows for providers to be enrolled and treated the same as an “in-state” provider in certain border cities. There are approximately 7,100 active providers labeled with the necessary indicator in the ProviderOne system.

[WAC 182-501-0180](#) generally requires services received outside of Washington to be authorized, although the rule specifically exempts services received under the Involuntary Treatment Act, even in bordering cities.

3. Contract Opportunities: Purchasing Behavioral Health Services

A. Behavioral Health Organizations

There have been no new RSN contracts since March 17, 2014 (the date SB 6419 was enacted.) DSHS will issue new contracts to the RSNs on July 1, 2015. These contracts will be in place through March 31, 2016. Beginning April 1, 2016, the BHO contracts will be issued. The July 1, 2015 RSN contracts and the future BHO contracts will include provisions for border RSNs to develop Memoranda of Agreement (MOA) with cross-border community mental health centers and psychiatric inpatient facilities to facilitate cross-border services for ease of access and timeliness of care. MOAs will include terms for purchasing out of network services when it is necessary to ensure access and timeliness, including agreements with out of state providers for those RSNs that share borders with other states.

There have been no new substance use disorder contracts since SB 6419 was enacted. However, as with the DBHR RSN contracts, future county contracts for substance use disorder treatment will include reciprocity provisions to comport with SB 6419. New substance use disorder contracts will be issued July 1, 2015.

Chapter 225, Laws of 2014 (2SSB 6312) requires that DSHS, in conjunction with HCA, integrate behavioral health care services purchasing by 2016, and by 2020 integrate behavioral health and medical care services. Mental health and substance use disorder treatment will be combined into a single managed care benefit package administered through the BHOs April 1, 2016.

DSHS will issue a request for a “detailed plan” to the potential BHOs. The detailed plan and the subsequent new contracts will provide an opportunity for DSHS to ask those BHOs bordering Oregon and Idaho to submit a document describing their plan to ensure reciprocity and ease of access for border communities. The potential BHOs will submit a response to the plan request, and if they qualify, be awarded the

⁶ The only recognized bordering cities are Coeur d’Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho and in Oregon, Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria.

BHO contract for their region. The BHO detailed plans are due to the state October 31, 2015.

Language comports with SB 6419 will be incorporated into the new BHO contracts.

B. Purchasing of Medical Services

HCA has incorporated the necessary revisions into its 2015 Apple Health Managed Care contract, including required reports to ensure ongoing efforts to build and maintain robust provider networks that include providers in border communities.

4. Anticipated Impacts on Patient Access to Timely Care, Inpatient and Outpatient Services

DSHS

The greatest anticipated positive impact on patient access to timely care will occur when substance use disorder treatment falls under managed care. When this occurs, the above mentioned access and distance standards will apply to the BHOs managing Medicaid outpatient substance use disorder treatment.

As for inpatient mental health services, RSNs currently authorize voluntary inpatient care at out of state hospitals.

HCA

Because the MCO provider networks and the Fee-For-Service delivery systems already allow for or provide access to care in bordering cities, HCA believes this legislation will have minimal effect. However, if full reciprocity with the neighboring states is achieved, this could possibly reduce barriers to care for residents of the participating states.

5. Fiscal implications

Given that DSHS and HCA do not know how many individuals on either side of the border would avail themselves of cross-border Medicaid services, the fiscal impact of reciprocity cannot be predicted.

6. Obstacles to Implementation

A. Mental Health Services

For outpatient services, statute requires RSNs to contract with DSHS licensed Community Mental Health Agencies (CMHAs). For RSNs to contract with mental health centers out-of-state, a change in statute would be required. Please note that this does not apply to hospitals with core provider agreements with HCA and do not directly contract with RSNs.

B. Substance Use Disorder Treatment

Substance use disorder services are less likely to be out of state because the facility either must be a Medicare facility or agree to unbundle the rate. In the past, most out of state facilities have not been willing to unbundle their rate for Washington patients.

Licensing requirements for facilities, programs and professional staff also may impact reciprocal agreements between Washington, Idaho, and Oregon.

A substantial portion of substance use disorder outpatient treatment is driven by the criminal justice system through deferred prosecutions and Driving under the Influence (DUI) arrests. Washington's court system and the Department of Licensing would have to recognize out-of-state outpatient treatment as meeting the requirements for satisfying the terms of a deferred prosecution before there could be significant reciprocity for court-ordered patients.

C. Full Reciprocity

Applicability: The bill does not define "border communities", but HCA assumes [WAC 182-501-0175](#) applies, limiting out-of-state coverage to the specific cities mentioned. HCA has received comment from providers and clients that this is unnecessarily restrictive as many practices are located in suburbs, not just in the cities identified in the rule. To address applicability, the Legislature may consider tying the border areas to providers located in specifically identified counties rather than limiting it to the cities mentioned in rule; this would address concerns over access to providers in suburbs or neighboring cities.

Authority: Subsection (3) of the bill reads as follows, (emphasis added):

*"(3) All authority and department contracts for medicaid services issued or renewed after July 1, 2014, must include provisions that allow for care to be accessed cross-border ensuring timely access to necessary care, including inpatient and outpatient services. **The contracts must include reciprocal arrangements that allow Washington, Oregon, and Idaho border residents to access care when care is appropriate, available, and cost-effective.**"*

HCA assumes the 'reciprocal arrangements' would be between the state governments of Oregon and Idaho and Washington so that each state's residents may receive Medicaid services in the neighboring states. HCA believes this type of reciprocal arrangement would not be accomplished through its managed care contracts, but that this may be realized through negotiation with officials of the Oregon Health Plan and Idaho Health Plan and the federal Centers for Medicare and Medicaid Services (CMS). HCA has consulted with the bill's Sponsor, the Governor's Office, and DSHS to explore this approach and will continue to seek ways to ensure all enrollees have access to care when they need it.