Anne Deacon

From: Anne Deacon
Sent: Wednesday, March 13, 2019 10:58 AM
To: Gupta, Rashi (GOV); Juliana Roe
Cc: Washburn, Doug (ESD Partner); Tcardwell-burns@co.douglas.wa.us; julied@co.skagit.wa.us; Joe Valentine
Subject: Stabilization and Detox Facilities

Importance: High

Rashi,

Thank you for your response. Sorry for the tome below, but I don't want to consume your time with back and forth phone calls, so I've tried to include everything in this email to help articulate the continued concern about the inadequate funding mechanism for these facilities as we head into the FIMC world. I've copied others who may be able to provide further clarification if necessary.

ACHS meets next Wednesday, March 20th in Olympia at the WSAC building. This is short notice, but if you can make yourself available either in person or by phone, we would love to have you join us briefly for this discussion. We meet from 1PM – 4PM, with 2:30 slated for this discussion. If you are able to join us at any point, we will try to adjust our schedule to meet yours.

I have identified a few points below that don't appear to be understood by HCA, or perhaps are not a priority concern. Until we achieve a clear mutual understanding of the current funding challenges as well as the state's priorities for services/funding, it is certain that stabilization facilities across the state will be standing empty. As I previously noted, stabilization facilities (Triage and Detox) historically demonstrate that 30% of the utilization is by non-Medicaid individuals – much different than E&T statistics.

1. The contract with BH ASOs currently mandates the following crisis services: Crisis Line, DCRs, ITA Court Hearings, and IMD costs for non-Medicaid
2. The contract with BH ASOs does NOT mandate Triage/Stabilization services and does not mandate (or identify) Substance Withdrawal Management services
    a. Stabilization services are allowed to be funded only within available resources
3. The GFS dollars provided to the BH ASOs will rarely be sufficient to cover costs beyond the mandated services noted in #1 above
    a. BH ASOs cannot control the costs of ITAs or Court Hearings, and in those regions where large private psych hospitals exist, these costs have escalated far beyond the state's actuarial estimates, and therefore, the BHOs and BH ASOs exceed budgeted expenses now
4. The funding proviso information you state below does not mirror the BH ASO contracts. Crisis Triage/Stabilization does not have a designated funding allotment. Where did you get your information? How do we clarify this information gap?
5. I understand that the proviso items you list below are funded by HCA line by line as opposed to a "lump sum". This challenges flexibility to respond to regional needs, and eliminates the ability for the state and partners to view the big picture of the needs as well as the ability to create system solutions – not to ignore the fact that the total proviso dollars available are still insufficient to meet current needs or current service delivery
    a. Unless sufficient GFS dollars are designated for existing services, the behavioral health system will experience harm

6. Substance Withdrawal Management services are not listed in the proviso language – there does not appear to be any dedicated funding mechanism for these services. I assume they aren't mandated services in the MCO contracts either?
    a. Withdrawal Mgmt services act as the front door to treatment, thereby reducing excessive emergency medical costs
7. Based on historical information, a 16-bed stabilization or detox facility costs approximately $1.8 million/year to operate. If MCOs are inclined to fully cover the costs of the Medicaid utilization (70%), each facility still requires $600K/year to cover the costs of services to non-Medicaid individuals (30%). These funds do not exist anywhere within the BH ASO contract, except for a few dollars here and there if lucky
    a. I understand that a Tri-cities stabilization facility has already closed its doors, and in talking with counties and treatment providers across the state, they express significant concern about their ability to continue operations of these facilities in the new IMC world.
    b. One treatment provider in SW Washington stated that they felt pressure to sign an undesirable contract with the MCOs for fear that they wouldn't get a contract at all. They fear their costs won't be fully covered under the current agreements.
    c. Counties' local behavioral health sales tax (those that have it) will never be sufficient to cover these costs, and certainly would never be extended to individuals who are not residents of their county; therefore, if county dollars were used to some extent, the facilities will no longer be regionally accessible
8. The Department of Commerce has awarded many grants to counties and treatment providers to build more of these community-based facilities. Although a major focus is on building facilities that will reduce the immediate burden on Western State Hospital, stabilization facilities will reduce the burden on the front end by preventing more acute symptoms of mental illness that then require the services of the state hospitals.
    a. Treatment providers are expressing reticence to sign facility leases. Commerce requires a facility to operate for at least ten years as intended/funded, yet no long-term funding strategy has been established by the state that will ensure a provider can meet this requirement. Counties who have built, or are building these facilities have an obligation to their taxpayers that the promise they made with these facilities/services will be fulfilled.
    b. Some counties have placed construction plans on hold until a long-term funding strategy is established. Promised community-based behavioral health facilities will not be built even though state capital dollars are available and awarded.

In short, adequate funding is not available in current contracts for Triage or Substance Withdrawal Management facilities. I assume that HCA either hasn't fully researched this fact, or just doesn't value the services as priorities. As a result, it has become very difficult to trust the communications and information coming from the HCA. These services/facilities are absolutely a priority for the counties and communities throughout the state who see them as critical components to the continuum of behavioral health care. The services divert individuals from the hospital emergency departments, excessive EMS responses, and from the entire criminal justice system.

Thank you for getting to the end of this soliloquy ☺ As always, I truly appreciate your contribution to the behavioral health issues of our state and hope we can find a resolution to this impending crisis.

Whatcom County HEALTH Department

Anne Deacon, LICSW | Human Services Manager
509 Girard Street, Bellingham, WA 98225
Direct: 360 778-6054 | Office: 360 778-6002
Website | Facebook | Twitter

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