SENATE BILL REPORT
SB 5432

As Reported by Senate Committee On:
Behavioral Health Subcommittee to Health & Long Term Care, February 14, 2019
Ways & Means, February 28, 2019

Title: An act relating to fully implementing behavioral health integration for January 1, 2020, by removing behavioral health organizations from law.

Brief Description: Concerning fully implementing behavioral health integration for January 1, 2020, by removing behavioral health organizations from law; clarifying the roles and responsibilities among the health care authority, department of social and health services, and department of health, and the roles and responsibilities of behavioral health administrative services organizations and medicaid managed care organizations; and making technical corrections related to the behavioral health system.

Sponsors: Senators Dhingra, Rivers, Cleveland, Darneille, O'Ban, Keiser, Conway, Das and Kuderer; by request of Office of the Governor.

Brief History:
Committee Activity: Behavioral Health Subcommittee to Health & Long Term Care: 1/25/19, 2/14/19 [DPS-WM].
Ways & Means: 2/26/19, 2/28/19 [DP2S, w/oRec].

Brief Summary of Second Substitute Bill

- Removes behavioral health organizations from law.
- Establishes managed care organizations and behavioral health administrative services organizations (BH-ASOs) to manage the community behavioral health system.
- Establishes a work group led by the Health Care Authority to determine how to manage access to long-term, involuntary commitment resources in the community and state hospitals until such a time as the risk may be fully integrated into managed care and how to expand the availability and utilization of co-occurring disorder services and provide a report by December 15, 2019.
- Allows counties that operate BH-ASOs to also form provider organizations only if they have clear separation of powers, duties, and finances from the BH-ASO.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

SENATE COMMITTEE ON BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5432 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Dhingra, Chair; Wagoner, Ranking Member; Darneille, Frockt and O'Ban.

Staff: Kevin Black (786-7747)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5432 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Operating, Capital Lead; Mullet, Capital Budget Cabinet; Bailey, Billig, Carlyle, Conway, Darneille, Keiser, Liias, Palumbo, Pedersen, Van De Wege and Wagoner.

Minority Report: That it be referred without recommendation.

Signed by Senators Braun, Ranking Member; Brown, Assistant Ranking Member, Operating; Honeyford, Assistant Ranking Member, Capital; Becker, Hasegawa, Hunt, Rivers, Schoesler and Wilson, L..

Staff: Travis Sugarman (786-7446)

Background: Behavioral Health Organizations. The County-Based Mental Health Services Act of 1989 established county-based regional support networks (RSNs) to locally administer state and federally-funded mental health services for persons with serious mental illness. By 2016, RSNs evolved into behavioral health organizations (BHOs) which receive a capitated payment to cover the mental health needs for those Medicaid clients in their regional service area who have a level of impairment that meets access-to-care standards, and to cover the substance use disorder treatment needs of all Medicaid clients. BHOs also serve the behavioral health needs of patients who do not qualify for Medicaid and provide services which are not within the Medicaid state plan, such as residential treatment, to the extent that limited, but flexible, state-appropriated funding allows. The most prominent non-Medicaid service provided by BHOs is crisis services, which include a crisis line and team of designated crisis responders to respond to emergencies and administer involuntary commitments. BHOs pay for the court costs of involuntary treatment and manage a range of state-mandated programs from mobile crisis and assertive community treatment teams to Ombuds services to behavioral health advisory boards that include input from persons and families with lived experience of behavioral health disorders.

Movement to Integrated Health Care. In 2014, the Legislature enacted 2SSB 6312 which declared state policy to fully integrate behavioral health services with physical health for Medicaid clients in a single managed care plan by January 1, 2020. These managed care plans must be offered in nine purchasing regions consisting of a single county or group of counties that combine to form a regional service area. Regional service areas were given the option to provide integrated managed care prior to 2020. Six regions have either

accomplished this or declared an intention to do so later in 2019. Three final regions plan to complete health integration on time in 2020. The model of full integration chosen by the Health Care Authority (HCA) depends on the procurement of Medicaid services through a risk-bearing prepaid contract in each region from three to five managed care organizations (MCOs) operated by private insurance carriers. Additional non-Medicaid services, including crisis services, are procured in each region from a behavioral health administrative services organization (BH-ASO), which may be a private insurance carrier or a county or group of counties that elects to provide non-Medicaid services within the region.

State Hospital Bed Allocations. The state provides state hospital beds to meet the adult long-term involuntary commitment (long-term ITA) needs of state residents. These beds are allocated without charge to BHOs based on a formula that considers population and the incidence of mental illness. If a BHO exceeds its state hospital bed allocation, it is required to reimburse HCA for its excess bed use. One half of the reimbursements are retained by the state and one half are distributed to BHOs that are below their bed allocations. In regions that are early adopters of full integration, HCA has split the former BHO's bed allocation among the MCOs and BH-ASO.

Summary of Bill (Second Substitute): References to BHOs and their supporting structure are removed from the code effective January 1, 2020. The duties of HCA as the state behavioral health authority are consolidated and defined, including the duty to contract with MCOs and BH-ASOs. MCOs and BH-ASOs are established and defined as the entities delivering community behavioral health services and crisis services. Duties and powers for MCOs and BH-ASOs are established by allocating them from the former BHOs. A partial list of reallocated duties are as follows:

Duties of Former BHO	Allocated to MCO	Allocated to BH-ASO
Administer crisis services		X
Provide adequate access to behavioral health services	X	
Provide adequate network of crisis services providers		X
Coordinate state hospital discharges		X
Collaborate to ensure no adverse shift of persons with mental illness into jails and prisons		X
Accept enrollment of eligible persons leaving jail or prison	X	X
Maintain a behavioral health advisory board to provide local oversight		X
Provide for a behavioral health Ombuds office in each regional service area		X

Contract with courts to provide drug court services	X	X
Reimburse counties for costs related to involuntary commitment		X

The state's method for allocating state hospital beds is repealed effective January 1, 2020. HCA must establish a work group with stakeholders including BH-ASOs, MCOs, the Washington State Association of Counties, community behavioral health providers, and the Washington State Hospital Association to provide recommendations:

- how to manage access to adult long-term ITA in the community and state hospitals until such a time as the risk may be fully integrated in MCO contracts;
- how to guide the risk integration process; and
- how to expand bidirectional services through increased support of co-occurring disorder services, including recommendations related to purchasing and rates.

The work group must provide recommendations to the Office of Financial Management and the Legislature by December 15, 2019.

Rules are provided for counties within a regional service area to collaborate, based on mutual agreement, to provide BH-ASO services. A BH-ASO which consists of a county or group of counties may obtain services from a county-administered service provider only if the service provider has a clear separation of powers and duties separate from the BH-ASO and follows suitable accounting procedures to ensure the funding is traceable and accounted for separately from other funds. Administrative costs for BH-ASOs are limited to 10 percent of available funds. Counties within a regional service area are permitted to create a licensed provider organization to meet BH-ASO contract requirements, as long as the provider operation has a clear separation of powers, duties, and fiscal responsibilities from the BH-ASO.

HCA must require MCOs to include in their networks sufficient access to co-occurring treatment from providers that offer fully-integrated co-occurring treatment services.

HCA must allow tribes to participate in an interlocal leadership structure, upon request. HCA must establish a committee consisting of executive agencies, the Office of the Governor, and representatives of the BH-ASO and county government from each regional service area to meet quarterly to address systemic issues and to coordinate the behavioral health system.

HCA must report to the Governor's Office and the Legislature by December 1st of every even-numbered year concerning community behavioral health system expenditures against appropriation levels.

Neither HCA nor the Department of Health may provide initial documentation requirements for patients receiving care in a behavioral health agency which are substantially more time-consuming to complete than initial documentation requirements in primary care settings.

References to mental health services are changed to behavioral health services, and new references to the obligation providing substance use disorder services are incorporated

throughout the code. An expanded role is created for tribes in the administration of behavioral health services. References to chemical dependency are changed to substance use disorder. Outdated references are removed, and technical corrections are made to reflect modern practices.

EFFECT OF CHANGES MADE BY WAYS & MEANS COMMITTEE (Second Substitute):

- Removes requirement for the HCA to create a separate reimbursement rate for providing dual diagnosis enhanced co-occurring disorder treatment services that is higher than the rate for providing mental health services alone.
- Expands work group by adding community behavioral health providers, including providers with experience providing co-occurring disorder services, and requires the work group to study how to expand bidirectional integration through increased support for co-occurring disorder services, including recommendations related to purchasing and rates.
- Narrows prohibition for HCA or the Department of Health to provide initial documentation requirements for behavioral health patients that are more administratively burdensome than requirements for primary care patients by adding "unless such documentation is required by federal law or to receive federal funds."

EFFECT OF CHANGES MADE BY BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Adds specified stakeholders to the work group to determine how to manage access to long-term inpatient care and specifies that the access management is until such time as the risk may be fully integrated into MCO contracts, and that the work group must provide advice to guide the integration process.
- Prohibits HCA and the Department of Health from creating initial documentation requirements for patients receiving care in a behavioral health agency which are substantially more time-consuming to complete than initial documentation requirements in primary care settings.
- Requires a county-run provider in a county operated BH-ASO to have a clear separation of powers and duties from the BH-ASO and suitable accounting procedures to ensure funding is traceable and accounted for separately from other funds.
- Requires HCA to establish a separate rate for dual diagnosis enhanced co-occurring treatment services that is greater than the rate for mental health services alone and require MCOs to provide sufficient access to fully integrated co-occurring treatment services.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: January 1, 2020, except for section 1003 which is subject to an emergency clause and effective immediately.

Staff Summary of Public Testimony on Original Bill (Behavioral Health Subcommittee to Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: This bill is an important step in the right direction. Having one system to address physical and behavioral health needs will be good for our communities and help countless people get the help they need and stay healthy. This bill implements a legislative mandate to complete integration by 2020. As we removed the words BHO, we had to make policy decisions as to where responsibilities would lie. The bed allocation methodology is something we still need to look at in an in-depth conversation that pulls together stakeholders with data and history. The interlocal leadership structure falls under BH-ASOs; we did not eliminate this function. We recognize counties want to continue talking about what happens when they want to be providers. Counties are partners in this effort; we recognize they have to stay involved. We need to do a better job of using clear terms to define our health care systems; we will provide written suggestions. Accountability and transparency of appropriated resources will continue to be important. Integration of physical and behavioral health benefits the entire person. We look forward to continued partnership with the state. Please add MCOs to the workgroup in the bill. The MCOs see themselves as a partner to assist bridging the schism between policy and implementation. We need to to build a bridge between physical and behavioral health which is seamless for the client. MCOs have strict guidelines limiting profit to 3 percent. There are caps on the medical loss ratio and administrative spend. We want to tweak the language around how county-run systems can directly provide behavioral health services. Counties want to stay engaged because they bear risk through their justice system and other services. County operated behavioral health providers are a critical part of the system. We need an oversight and compliance system that's uniform. Funding for ITA court costs remains important. When we introduce metrics we need to make sure they apply equally to all. Guidelines relating to administrative costs and profits must be appropriate and uniform for all actors.

OTHER: Behavioral health must be integrated at the service level, not just the funding level. Clients with co-occurring disorders need to be able to get the care they need from the same providers in the same location in a fully integrated way. This is a national best practice. Please increase incentives and requirements to integrate mental health and substance use services through co-location or full integration, including dual diagnosis enhanced treatment. We need to focus on outcomes and pay for clients to get better, not just for services provided.

Persons Testifying (Behavioral Health Subcommittee to Health & Long Term Care): PRO: Senator Manka Dhingra, Prime Sponsor; Rashi Gupta, policy advisor to Governor Inslee; Meg Jones, Association of Washington Healthcare Plans; Juliana Roe, Washington State Association of Counties; Brad Banks, Behavioral Health Organizations; Brian Enslow, Amerigroup; Andrea Davis, Coordinated Care; Joan Miller, Washington Council for Behavioral Health; Lindsey Grad, SEIU Healthcare 1199NW.

OTHER: Alicia Ferris, Community Youth Services.

Persons Signed In To Testify But Not Testifying (Behavioral Health Subcommittee to Health & Long Term Care): No one.

Staff Summary of Public Testimony on First Substitute (Ways & Means): *The committee recommended a different version of the bill than what was heard.* PRO: This bill implements the legislative mandate to fully integrate physical and behavioral health purchasing by 2020. As staff pointed out there are a lot of changes, many of them are technical changes as we move to full integration. I do think the timing of the workgroup makes it so we will have to figure out a different allocation method and risk around allocation of beds. We are going to need different timing. This is a good bill that is absolutely necessary for integration.

OTHER: King County continues to have some concerns with section 10 which deals with delivery of integrated services. King County has a strong network of community behavioral health providers who have chose to partner with King County to deliver an innovative public private partnership and we would like to make sure this can continue to work.

Persons Testifying (Ways & Means): PRO: Rashi Gupta, Governor's Policy Office.

OTHER: Mac Nicholson, King County.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.