SENATE BILL REPORT
SB 5894

As of March 21, 2017

Title: An act relating to behavioral health system reform.

Brief Description: Concerning behavioral health system reform.

Sponsors: Senators O'Ban, Darneille, Braun, Becker, Rossi, Brown, Miloscia, Cleveland, Ranker, Chase, Warnick, Keiser, Hunt, Hasegawa, Wellman and Zeiger.

Brief History:
Committee Activity: Ways & Means: 3/20/17.

Brief Summary of Bill

- Requires risk for long-term involuntary treatment services to be integrated with managed care by January 1, 2020.
- Requires the Department of Social and Health Services (DSHS) to purchase a portion of the long-term involuntary treatment services provided in state hospital bed allocations in community facilities.
- Amends requirements for assisted outpatient mental health treatment.
- Amends availability of forensic inpatient commitment services.

SENATE COMMITTEE ON WAYS & MEANS

Staff: Kevin Black (786-7747) and Travis Sugarman (786-7446)

Background: Behavioral Health System. The public behavioral health system in Washington is administered through managed care entities, which contract with the state to provide Medicaid and non-Medicaid services to eligible clients. The Health Care Authority (HCA) contracts with managed care organizations that provide physical and low-acuity mental health services, and, in one region located in Southwest Washington, HCA contracts with fully-integrated managed care organizations (FIMCOs) that provide a full range of physical and behavioral health services. DSHS contracts with behavioral health organizations (BHOs) which provide high-acuity mental health services, substance use disorder treatment services, and crisis services in every region except Southwest Washington.

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.

State law requires HCA to contract with FIMCOs in all regions of the state by January 1, 2020.

Long-Term Involuntary Treatment Services. Long-term involuntary treatment services are mental health services provided under the Involuntary Treatment Act to patients subject to 90-day or 180-day involuntary commitment orders. Inpatient long-term involuntary treatment services are provided at one of two state hospitals, Western State Hospital and Eastern State Hospital, and to a limited extent in private health care facilities to patients who are on a waiting list for admission to a state hospital or who are placed in a community facility pursuant to a single-bed certification.

Long-term involuntary commitment beds are provided for the use of BHOs and FIMCOs through state hospital bed allocations, which provide a certain number of state hospital beds to each region. BHOs and FIMCOs are required to reimburse DSHS if their clients use more state hospital beds than provided in their state hospital bed allocation.

Assisted Outpatient Mental Health Treatment. Assisted outpatient mental health treatment (AOT) is a process by which a court order may be sought requiring a person to participate in outpatient mental health treatment through a less restrictive alternative order (LRA). If a designated mental health professional (DMHP) determines through investigation that a person is in need of AOT, a petition for AOT may be filed by two health professionals, including at least one physician, advanced registered nurse practitioner, or physician assistant, which must include involvement or consultation with the facility or agency that will provide LRA treatment. This petition must be reviewed in superior court at a probable cause hearing within 72 hours following the DMHP investigation, excluding weekends and holidays. A person subject to AOT may not be detained for inpatient treatment pursuant to the AOT order, including for the purpose of revocation if the person does not comply with the order or experiences substantial deterioration in functioning.

LRA Revocation to Inpatient Detention. A person on an LRA may be revoked by a DMHP or the Secretary of DSHS to inpatient detention. A court hearing must be held within five days of the revocation to determine whether the person should be released. The court must determine:

- whether the person adhered to the terms of the LRA;
- whether substantial deterioration in functioning has occurred;
- whether there is evidence of substantial decompensation with a reasonable probability that it can be reversed by inpatient treatment; or
- there is a likelihood of serious harm;

and, if one of the above findings is applicable, whether the court should reinstate or modify the LRA or order further detention for inpatient treatment.

Forensic Mental Health Services. The state provides competency evaluation and competency restoration treatment services to criminal defendants. Most competency evaluations are provided on an outpatient basis in jails or community settings. A defendant may be admitted to an inpatient facility for up to 15 days for a competency evaluation if the evaluator determines that inpatient admission is needed to complete an accurate evaluation. The court may order an inpatient competency evaluation directly if:

- the defendant is charged with murder in the first or second degree;

- the court finds that an evaluation in jail will be inadequate to complete an accurate evaluation; or
- the court finds that an inpatient evaluation is necessary for the health, safety, or welfare of the defendant.

A defendant determined to be incompetent to stand trial (IST) after an evaluation who is charged with a serious nonfelony or felony crime may be committed for competency restoration treatment. The period for nonfelony competency restoration is 14 days plus any unused time from the evaluation period. Most felony defendants are eligible for three periods of competency restoration. The first period is for up to 45 days for defendants charged with a Class C or nonviolent Class B felony, and up to 90 days for other felony defendants. The second competency restoration period is for up to 90 days, and the third period is for up to 180 days. If a defendant remains IST at the end of all allowable competency restoration periods, the charges must be dismissed without prejudice and the defendant must be referred for civil commitment. Nonfelony defendants are referred for civil commitment to an evaluation and treatment facility, while felony defendants are referred for civil commitment to a state hospital.

Summary of Bill: The bill as referred to committee not considered.

Summary of Bill (Proposed Substitute): The path of reform for the behavioral health system over upcoming biennia for long-term psychiatric care must include transitioning state purchasing of long-term involuntary treatment services to a regionally-based system under a managed care framework. State hospital practices must be modernized, and state hospital resources must be focused on service to forensic and higher-acuity civil patients.

Risk for Long-Term Involuntary Civil Commitment. HCA must integrate risk for long-term involuntary treatment provided by state hospitals into managed care contracts by January 1, 2020. The Office of Financial Management must engage a consultant to create a state psychiatric hospital managed care risk model by December 31, 2017. The risk model must include analysis and recommendations related to the transition, including performance metrics to hold managed care entities and treatment providers accountable for legal requirements and public policy goals related to civil commitment.

Purchasing Long-Term Involuntary Treatment in Community Facilities. DSHS must purchase a portion of the long-term involuntary treatment capacity allocated to BHOs and FIMCOs in willing community facilities. The state must increase its purchasing of community long-term involuntary treatment capacity over time. DSHS must establish rules for facility certification which include reporting requirements that allow measurement of performance, the acuity of patients accepted into care, and comparison of results achieved with state hospitals in a consistent format. DSHS must develop a standardized behavioral health assessment tool to measure acuity among patients admitted to long-term involuntary treatment.

A managed care entity may designate a willing certified facility or state hospital to provide long-term involuntary treatment after consultation with the facility providing current treatment. Administrative approval must not be required for such treatment.

Procurement of Expanded Community Resources. Intent is stated to purchase increased community placement options for complex patients in settings such as nursing homes, assisted living facilities, adult family homes, enhanced service facilities, state-operated living alternatives, and supported housing. These resources must decrease utilization of the state hospital for patients with needs related to developmental disabilities or long-term care. Intent is stated to procure crisis walk-in centers in high-need urban areas geographically distributed around the state, and to procure clubhouses that demonstrate fidelity to an evidence-based model and are credentialed through Clubhouse International.

Discharge Planning in State Hospitals and Long-Term Involuntary Treatment Facilities. Discharge planning for long-term involuntary treatment must start at admission. The Aging and Long-Term Support Administration (ALTSA) and Developmental Disabilities Administration (DDA) must assume expanded responsibility for facilitating transitions for their clients. Facilities providing long-term involuntary treatment must allow access to staff from ALTSA, DDA, and managed care entities for the purpose of functional assessments and care coordination, and must allow these entities to provide input into treatment and discharge planning processes.

State hospitals must screen patients upon admission for medical necessity for substance use disorder treatment, and provide coordinated substance use disorder treatment services to patients with an identified need.

Within 14 days of a state hospital's designation of a patient as ready for discharge, a BHO or FIMCO must establish an individualized discharge plan arranging for transition of the patient to an identified community placement. If this does not occur, the BHO or FIMCO must reimburse DSHS for the cost of the patient's state hospital care until a discharge plan is established. DSHS must establish an appeal process to the Secretary of DSHS or the Secretary's designee if, after 14 days, the patient's readiness for discharge is disputed. The managed care entity may use this appeal procedure to request relief from the reimbursement obligation based on an obstacle to discharge created by a third party outside of the managed care entity's contracting authority or control. This reimbursement requirement is suspended when risk for state hospital treatment is integrated into managed care contracts.

State Hospital Use of Physician Extenders. The role of directing psychiatric treatment in state hospitals is expanded to include participation of qualified psychiatric advanced registered nurse practitioners and physician assistants supervised by a psychiatrist. The role of state hospital psychiatrists is expanded to include providing supervision necessary for these professionals to practice at the top of their scope of license. DSHS must work with the University of Washington to create a residency program for psychiatric advanced registered nurse practitioners at Western State Hospital and Eastern State Hospital, and report its recommendations to the Governor and Legislature by December 15, 2017.

Assisted Outpatient Mental Health Treatment. Eligibility requirements for AOT are reduced by eliminating a requirement that the person must have been detained for involuntary treatment twice in the preceding 36 months, and for the DMHP to find that the person is unlikely to survive safely in the community without supervision. The person must have a history of nonadherence with treatment recommendations, or current behavior which

indicates they are unlikely to voluntarily participate in outpatient treatment without an LRA. LRA revocation to inpatient detention is available for persons on an AOT order.

The initial petition process for AOT is simplified to allow up to 48 hours to complete the DMHP investigation. The probable cause hearing must be held within five judicial days of filing an AOT petition. An AOT petition may be filed by the DMHP and must include a statement of the DMHP's observations and evidence supporting AOT, declarations of additional witnesses if any, and the name of the agency or facility which has agreed to assume responsibility for providing LRA treatment. The DMHP must provide the person with a summons to the court hearing and a designation of appointed counsel if applicable. The DMHP must file proof of service of the AOT petition.

If a person subject to an AOT petition is in the custody of a jail or prison at the time of the DMHP investigation, the probable cause hearing may be scheduled within five judicial days of the anticipated release date. The hearing on the petition may be held while the person is still in custody, provided that the filing of the petition does not extend the person's time in custody, the time for the probable cause hearing is reduced to three judicial days, the charges against the person are not a pretext for the purposes of an involuntary commitment hearing, and the person's release from custody is expected to swiftly follow the adjudication of the petition.

Medication management is eliminated as a mandatory service under an LRA, but is added as an optional LRA requirement.

Forensic Inpatient Commitments. Eligibility for competency restoration treatment is eliminated for defendants whose highest charge is a nonfelony. A defendant whose highest charge is a Class C or nonviolent Class B felony is limited to one period of competency restoration treatment. The duration of an inpatient competency evaluation is shortened from up to fifteen days inpatient to up to eight days inpatient.

Planning for Fully Integrated Managed Care. HCA must establish a workgroup to examine options for structuring full integration of physical and behavioral health by January 1, 2020. The workgroup must consider models including:

- a model where a county authority or group of county authorities manage crisis and non-Medicaid services; and
- a model where a county authority or group of county authorities contract with and coordinate a network of behavioral health providers.

The workgroup must consist of no more than fifteen members, including one Legislative member from each caucus of the House of Representatives and the Senate, and submit a report by December 1, 2017.

HCA and DSHS must form a small work group to develop performance expectations to align purchasing expectations for fully integrated physical and behavioral health care. The performance expectations must be vetted with a larger group of stakeholders before being used to develop procurement and contract terms for managed care entities.

Data Measurement. The Washington Institute for Public Policy must evaluate changes to the behavioral health system and the effectiveness of specific investments in order to provide policymakers with information to aid decision-making on an ongoing basis.

Appropriation: None.

Fiscal Note: Requested on March 16, 2017.

Creates Committee/Commission/Task Force that includes Legislative members: Yes.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Proposed Substitute: PRO: The bill does something completely different with how we treat high acuity patients. There is bipartisan recognition that there should be civil beds moved into the community. There needs to be time to create the capacity and create the risk model on how the BHOs or MCOs are going to be at risk for long-term beds that traditionally they have not been. We want the BHOs to be thinking about how much it will cost to send this person to Western State and look at other options to keep them from going to Western State. The bill attempts to streamline the Assisted Outpatient Treatment to increase utilization. This tries to reduce the number of individuals that we are going to try to restore because after the 45 day period if you haven't restored the individual, you only get a 6 percent return on investment in a subsequent restoration period. Given the money spent and the fines, it makes sense to take a look at who we are spending the money on and maybe the patients should be flipped sooner and get them the medical care they need. Congratulations for the approach. Timing is important and needs to be dove-tailed with integrated care. You must be prepared to fund the system and need to get the risk assessment right. As far as the study of the county role, this could delay integration. Psychiatric ARNPs do not need to be supervised by psychiatrists and this should be changed with regard to the residency programs for ARNPs to allow the ARNPs to practice at the top of their scope of license. We also request that ARNPs are involved in the development of the residency program. We greatly support the basic thrust to try to reserve the state hospital for high acuity and forensic patients. We support the move to more community hospital beds and the support for clubhouses. There are likely some rough edges but overall positive legislation. We like section 6 because it allows us to make sure we are doing what is right for our communities. The only integrated system in the state started in April. We shouldn't assume that a model that has been in operation since April. Risk sharing and shifts of risk are important as to are the right entities holding the risk. The counties hold quite a bit of the risk. Hoping for a hybrid solution. BHOs need to be part of the fully integrated model beyond 2020 to ensure that people are receiving the services they need. Our mobile outreach team is loved by law enforcement and emergency rooms and is option for them. The focus on community investments is good. We support long-term beds in the community and the AOT changes. Many of the recommendations in this bill came from the SQUISH committee. How does this affect the rates? What about right of refusal from the new hospitals?

CON: The intersection of forensic evaluations and law enforcement in Sections 504 to 508. The label felony, misdemeanor, or gross misdemeanor when you are dealing with mentally ill and criminal actions is less predictive of risk than other populations. Your competency to

stand trial standards and the standards for involuntary commitment are different. Pretty scary situations may get walked away from. We are also opposed to sections 504 to 508 as the removing of competency restoration for misdemeanors will bring people back to their communities and have the charges dismissed. I think the gap between those that are incompetent to stand trial and those that would meet the involuntary treatment act commitments is of concern.

OTHER: Please include physician assistants (PAs) as part of the residency program for the state hospitals in the bill language. PAs must have an agreement delegating authority from the Psychiatrist to provide services. This will help King County meet its goal of moving people into the community but the details matter a lot. We really like the discharge planning provisions at the state hospital in the bill. We find it difficult to review this bill without the budget. The changes to the assisted outpatient treatment are welcomed, but goes too far by taking out the requirement that the person has been committed to state hospital in the last 3 years. Counties are generally in favor of a regionally based involuntary treatment system, so long as it is responsive and properly funded. Community capacity needs to be funded to include supported housing, low-no barrier housing, and respite care. We need to be thoughtful as to how risk is shifted. If the managed care entity is going to be responsible for individuals in the state hospital, they should have input into the individual's treatment and when the person is ready for discharge. We hope the counties will be able to appoint CDPs and DMHPs as they will work with the county programs. This bill gets at moving treatment upstream. We have problems with revoking AOT, the standard for depriving someone of their liberty is higher than providing someone treatment in the community. We are in opposition to the taskforce in section 6 as a distraction, as we are on the front lines trying to figure this out and should not be delayed on the way to 2020. Why are we studying this again, to keep the status quo? We really need to build up the community system before diverting risk and changing our finance model. We also cannot change the state hospital structure while we continue the work of stabilizing it and to fully understand what is needed in a fully integrated system. We need to make sure there are places for individuals to discharge to. There are three key concepts: (1) mental health SOLAs, (2) placement for hard to serve clients which is similar to the former PALS program, and (3) the development of the state behavioral health hospitals. I testified on this issue in 1979 and the issue is still the same, which was can we have a system that stops criminally penalizing people for their mental illness. 30 percent with major mental illness get better, 30 percent become functional with their illness, and 30 percent remain severely mentally ill. I support this bill because it acknowledges the needs for hospitals. Are the primary beneficiaries of this bill the patients? Dismissing charges for misdemeanor charges when there is no competency restoration is concerning for some of these crimes. We request maybe looking at a little more specificity in this section. We prefer adding capacity to the hospital system through the communities and not replacing capacity. We are concerned about the managed care entity being the designating party for commitment. Currently we have up to 60 patients every day staying in beds that are waiting for 90- and 180-day commitments at a state hospital and sometimes we rehabilitate them before they ever need to go there. We need to ensure the ability to discharge folks. We would like capital advancements that could be built into the rates.

Persons Testifying: PRO: Senator Steve O'Ban, Prime Sponsor; Leslie Emerick, ARNPs United of WA; Seth Dawson, National Alliance on Mental Illness, NAMI Washington; Brad Banks, Behavioral Health Organizations; Bud Blake, Thurston County Commissione; Abby

Moore, Washington Council for Behavioral Health.

CON: Tom McBride, Washington Association of Prosecuting Attorneys; James McMahan, WA Assoc Sheriffs & Police Chiefs.

OTHER: Len McComb, Community Health Plan of Washington; Kate White Tudor, Washington Academy of Physician Assistants; Kim Putney, King County; Juliana Roe, WA State Association of Counties; Bill Stauffacher, Coordinated Care; Bob Cooper, WA Defender Association & WA Association of Criminal Defense Lawyers; Patricia Seib, Molina Healthcare of Washington; Lindsey Grad, SEIU Healthcare 1199NW; Matt Zuvich, Washington Federation of State Employees; Melissa Johnson, Association of Advanced Practice Psychiatric Nurses; Eleanor Owen, citizen; Jason McGill, Governor's office; Candice Bock, Association of Washington Cities; Chelene Whiteaker, Washington State Hospital Assn; Ian Goodhew, UW Medicine-Harborview Medical Center; Nick Federici, Fairfax Hospital.

Persons Signed In To Testify But Not Testifying: No one.