

FINAL BILL REPORT

2SSB 6312

C 225 L 14
Synopsis as Enacted

Brief Description: Concerning state purchasing of mental health and chemical dependency treatment services.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Darneille, Hargrove, Rolfes, McAuliffe, Ranker, Conway, Cleveland, Fraser, McCoy, Keiser and Kohl-Welles; by request of Governor Inslee).

Senate Committee on Human Services & Corrections

Senate Committee on Ways & Means

House Committee on Health Care & Wellness

House Committee on Appropriations

Background: The state of Washington purchases mental health and chemical dependency services through a number of different agencies and entities. Among these are the Health Care Authority (HCA), Department of Social and Health Services (DSHS), county-administered regional support networks (RSNs), and tribal authorities.

In 2013 the Legislature adopted two bills, Second Substitute Senate Bill 5732 and Engrossed Substitute House Bill 1519, which require the state to establish outcome expectations and performance measures in its purchasing of medical, behavioral, long-term care, and social support services. HCA and DSHS must establish a steering committee to guide this change process. Reports describing this process are due to the Governor and Legislature in 2014 and 2016.

The Adult Behavioral Health Task Force (taskforce) is a Legislature-led taskforce, consisting of ten voting members, which is charged with examining reform of the adult behavioral health system. The taskforce must begin its work on May 1, 2014, and report its findings by January 1, 2015. The taskforce must make recommendations for reform concerning, but not limited to, the following subjects:

- the means by which services are delivered for adults with mental illness and chemical dependency disorders;
- availability of effective means to promote recovery and prevent harm associated with mental illness;
- crisis services, including boarding of mental health patients outside of regularly certified treatment beds;

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- best practices for cross-system collaboration between behavioral health treatment providers, medical care providers, long-term care service providers, entities providing health home services to high-risk Medicaid clients, law enforcement, and criminal justice agencies; and
- public safety practices involving persons with mental illness with forensic involvement.

Also in 2013, with the support of a \$1 million federal grant from the Center for Medicaid and Medicare Innovation, Washington created a document called the Washington State Health Care Innovation Plan (Innovation Plan). The Innovation Plan sets forth a framework for health system transformation, consisting of three strategies for achieving better health, better care, and lower costs, and seven foundational building blocks of reform. Some key recommendations relevant to the purchasing of behavioral health services include achieving greater integration of mental health, substance abuse, and primary care services by phased reductions in administrative and funding silos; restructuring Medicaid procurement into regional service areas; and requiring all health providers to collect and report common performance measures. The Innovation Plan forms the basis of an application for further awards of federal funding in the form of testing grants, to be awarded in 2014.

In July 2013, the Center for Medicare and Medicare Services (CMS), which is the federal agency that oversees state Medicaid contracts, sent a letter to the state of Washington asserting that Washington's means of procuring behavioral health services through RSN contracts is not valid under federal law. Over the course of a series of correspondence, Washington has raised legal questions with respect to this guidance, and is currently waiting for a further response from CMS.

Summary: Upon the receipt of guidance from the taskforce, DSHS and HCA must jointly establish common regional service areas for behavioral health and medical care purchasing. The Washington Association of Counties (WSAC) must be given the opportunity to propose composition of regional service areas by August 1, 2014. The taskforce must provide its guidance by September 1, 2014. Each regional service area must contain a sufficient number of Medicaid lives to support full financial risk managed care contracting, include full counties which are contiguous with each other, and reflect natural referral patterns and shared service resources.

DSHS must integrate chemical dependency purchasing primarily with managed care contracts administered by RSNs, exempting the Criminal Justice Treatment Account, by April 1, 2016. On that date, RSNs are renamed behavioral health organizations (BHOs). Counties corresponding to regional service areas, or the RSN if the county has made a decision not to contract as an RSN prior to January 1, 2014, must submit a detailed plan demonstrating capacity to serve as BHOs; if an adequate plan is submitted, the counties or RSN must be awarded the contract in that region. BHOs must offer contracts to managed health care systems for co-location of behavioral health professionals in primary care settings, and managed health care systems must offer contracts to BHOs for co-location of primary care services in behavioral health clinical settings.

By January 1, 2020, the community behavioral health program must be fully integrated into a managed health care system that provides mental health services, chemical dependency

services, and medical care services to Medicaid clients. By December 1, 2018, DSHS and HCA must report on preparedness for integration in each regional service area. A group of county authorities corresponding with a regional service area may request earlier integration of medical and behavioral health service purchasing in the regional service area. County authorities which elect to move to full integration by January 1, 2016, may receive an incentive payment of up to 10 percent of state savings within their regional service areas related to statutory outcome and performance measures for up to a six-year period, according to rules to be developed by DSHS and HCA.

DSHS may hold back a portion of the resources appropriated for the use of RSNs in order to incentivize outcome-based performance, the integration of behavioral health and primary care services, and improved care coordination for individuals with complex care needs. DSHS may establish priorities for expenditures of appropriations for non-Medicaid services.

The start date of the taskforce is accelerated to April 1, 2014. Voting membership of the taskforce is altered by adding three members appointed by WSAC and removing two executive members. The mission of the taskforce is expanded to include making recommendations for reform related to the following: purchasing behavioral health services; guidance concerning the creation of common regional service areas for purchasing behavioral health and medical care services; performance measures and outcomes related to managed care contracts; obstacles to sharing of health care information across practice settings; identification of key issues for integration of physical and behavioral health by 2020; whether to create a statewide behavioral health ombuds office; whether requirements for the state chemical dependency program should be amended to mandate specific services, and a review of involuntary commitment disparities across jurisdictions. The expiration date for the taskforce is extended by one year, and a final report is added on December 15, 2015.

DSHS and HCA must ensure that their behavioral health purchasing contracts are consistent with existing legal provisions requiring establishment of quality standards, accountability for outcomes, and adequate provider networks. These contracts must require the implementation of provider reimbursement methods which incentivize improved performance, integration of behavioral health and primary care services, and improved care coordination for individuals with complex care needs.

DSHS must adopt financial solvency requirements for RSNs which allow DSHS to initiate contract action if it finds that an RSN's finances are inadequate. DSHS must establish mechanisms for monitoring RSN performance, including remedies for poor performance such as financial penalties or contract termination procedures.

In the event of a reprocurement for behavioral health services, DSHS must give significant weight to several enumerated factors, including demonstrated commitment and experience serving persons who have serious mental illness or chemical dependency disorders; and demonstrated commitment to and experience with partnerships with criminal justice systems, housing systems, and other critical support services.

Certificate of need requirements are suspended in fiscal year 2015 for hospitals that change the use of licensed beds to increase the number of beds used to provide psychiatric services. A person licensed as a chemical dependency professional or chemical dependency

professional trainee may treat patients in settings other than programs approved under chapter 70.96A RCW if the person is licensed in another specified health care profession.

DSHS and HCA must develop a plan to provide integrated medical and behavioral health care to foster children by December 1, 2014. Jails may share booking data with specified entities for the purpose of research in the public interest. DSHS and HCA must establish record retention schedules for maintaining data related to contract performance measures. Terminology is updated relating to chemical dependency services, including changing references to "alcoholics" and "drug addicts" to "persons with a substance use disorder."

Votes on Final Passage:

Senate	49	0
House	69	29 (House amended)
House	75	22 (House amended)
Senate	48	1

Effective: April 4, 2014 (Section 1)

June 12, 2014

April 1, 2016 (Sections 7, 10, 13-54, 56-84, and 86-104)

July 1, 2018 (Section 85)