2EHB 2107 - S COMM AMD
By Committee on Human Services & Corrections

Strike everything after the enacting clause and insert the following:

"**Part I**
Integrating Risk for Long-Term Civil Involuntary Treatment into Managed Care

NEW SECTION. **Sec. 101.** A new section is added to chapter 71.24 RCW to read as follows:

(1) To promote the development of effective community-based resources for treatment and prevention and align the system financial structure with the goal of reducing inpatient utilization concurrent with the integration of physical and behavioral health care, the authority shall integrate risk for long-term involuntary civil treatment provided by state hospitals into managed care contracts by July 1, 2021.

(2) To further this end, the department must collaborate with the authority and appropriate stakeholders and consultants to develop and implement a detailed transition plan taking into account recommendations from both the "Washington Mental Health System Assessment: Final Alternative Options and Recommendations Report" submitted in December 2016, and the "Inpatient Psychiatric Care Risk Model Report" submitted in December 2017. This work shall include, but not be limited by, consideration of the following issues reflected in the report recommendations:

(a) A methodology for division of the current state hospital beds between each of the behavioral health organizations and full integration regions, considering two options: (i) A method which allocates the resources supporting state hospital bed utilization solely among behavioral health organizations and full integration regions; and (ii) a method which allocates a portion of the resources supporting state hospital bed utilization among behavioral health

organizations and full integration regions, and the remainder to the state long-term care and developmental disabilities systems. The portion allocated to the state long-term care and developmental disability systems must correspond to state hospital bed utilization by patients whose primary community care needs after discharge will be funded by the state long-term care or developmental disability system, based on client history or a functional needs assessment, and include payment responsibility for the state hospital utilization by these patients;

(b) Development of payment rates for state hospital utilization that reflect financing, safety, and accreditation needs under the new system and ensure that necessary access to state hospital beds is maintained for behavioral health organizations and full integration regions;

(c) Development of acuity-based payment rates for western and eastern state hospitals that accurately reflect case complexity;

(d) Maximizing federal participation for treatment and preserving access to funds through the disproportionate share hospital program under either methodology described in (a) of this subsection;

(e) Billing and reimbursement mechanisms;

(f) Discharge planning procedures adapted to account for functional needs assessments upon admission;

(g) Identification of regional differences and challenges for implementation in different regional service areas;

(h) A means of tracking expenditures related to successful reductions of state hospital utilization by regional service areas and means to assure that the funds necessary to safely maintain gains in utilization reduction are protected;

(i) Recommendations for the timing of implementation, including exploration of options for transition to full implementation through the use of smaller-scale pilots allowing for the creation of alternative placements outside the state hospitals such as step-down or transitional placements;

(j) The potential for adverse impacts on safety and a description of available methods to mitigate any risks for patients, behavioral health organizations, full integration regions, and the community;

(k) An explanation of the benefits and disadvantages associated with the alternative methodologies described in (a) of this subsection;

(l) Updated requirements related to civil commitments that retain the integrity of the process and designated mental health professional independence while enabling behavioral health organizations and equivalent entities in full integration regions to inform the process with firsthand information about the patient and thoughtful recommendations regarding care approaches;

(m) Recommendations for contractual performance measures and withholds for behavioral health organizations and equivalent entities in full integration regions;

(n) Recommendations for ensuring that, upon admission, the entity responsible for the cost of care, including a managed care organization or administrative services organization if applicable, and the patient's outpatient community mental health provider are involved in and consulted on all treatment and discharge planning for individuals who have received services through the community mental health system and who become patients at a state psychiatric hospital;

(o) Development of a process for the entity responsible for the cost of care, including a managed care organization or administrative services organization if applicable, and the patient's outpatient community mental health provider to challenge a determination for discharge or continued inpatient care by the medical director of a state psychiatric hospital for individuals who have received services through the community mental health system and who become patients at a state psychiatric hospital;

(p) A means of tracking regional bed capacity for long-term inpatient psychiatric care in state hospital and community settings in order to determine readiness for the targeted start date in subsection (1) of this section; and

(q) Development of payment rates for community hospitals and evaluation and treatment facilities which appropriately reflect patient acuity and accurately reflect case complexity for providing ninety and one hundred eighty-day civil commitment services.

(3) Participating stakeholders under subsection (2) of this section must include, but not be limited to, interested members of the legislature, the Washington state hospital association, the association of Washington healthcare plans, each of the five contracted apple health managed care organizations or administrative services organizations, if applicable, the Washington council for behavioral health, and the Washington state association of counties.

(4) A preliminary draft of the transition plan must be submitted, in compliance with RCW 43.01.036, to the relevant committees of the legislature by November 15, 2019. The department must consider the input of the relevant committees of the legislature and external stakeholders before submitting a final transition plan by December 30, 2019.

NEW SECTION. **Sec. 102.** A new section is added to chapter 74.09 RCW to read as follows:

(1) By July 1, 2021, the authority must develop a psychiatric managed care capitation risk model that integrates long-term inpatient care as defined in RCW 71.24.025. This risk model must:

(a) Include adult inpatient civil populations, including geropsychiatric patients and patients with intellectual or developmental disabilities;

(b) Apply only to new long-term inpatient care, excluding individuals currently committed to long-term inpatient care;

(c) Exclude individuals committed under RCW 71.05.280(3) with an affirmative special finding under RCW 71.05.280(3)(b);

(d) Include all facilities licensed or otherwise authorized to provide ninety and one hundred eighty-day civil commitment services;

(e) Require behavioral health organizations and equivalent entities in full integration regions to compensate at a minimum based on the fee-for-service per diem rates to the hospital providers;

(f) Consider whether a higher, acuity-based payment rate should be recommended and required for provider reimbursement;

(g) Recognize that the community capacity building for long-term civil commitment is going to be driven by establishing higher per diem rates, expanding certification and direct capital investment in facility building by the state;

(h) Include all services currently offered to civil inpatient commitments in the state hospitals;

(i) Explore options to reduce the reliance on the institution for mental diseases disproportionate share hospital program at the state hospitals;

(j) Capitate the medicaid portion of funds but not capitate the nonmedicaid portion; and

(k) Account for the impact of the expected diversion of civil patients away from state hospitals.

(2) A final draft of the risk model must be submitted, in compliance with RCW 43.01.036, to the relevant committees of the legislature by December 1, 2020.

(3) The authority shall consider, develop, and request legislation to maximize any reductions brought on by changes in the forensic to civil patient ratio for the state hospital population, as appropriate.

Sec. 103. RCW 71.24.045 and 2016 sp.s. c 29 s 421 are each amended to read as follows:

The behavioral health organization shall:

(1) Contract as needed with licensed service providers. The behavioral health organization may, in the absence of a licensed service provider entity, become a licensed service provider entity pursuant to minimum standards required for licensing by the department for the purpose of providing services not available from licensed service providers;

(2) Operate as a licensed service provider if it deems that doing so is more efficient and cost effective than contracting for services. When doing so, the behavioral health organization shall comply with rules promulgated by the secretary that shall provide measurements to determine when a behavioral health organization provided service is more efficient and cost effective;

(3) Monitor and perform biennial fiscal audits of licensed service providers who have contracted with the behavioral health organization to provide services required by this chapter. The monitoring and audits shall be performed by means of a formal process which insures that the licensed service providers and professionals designated in this subsection meet the terms of their contracts;

(4) Establish reasonable limitations on administrative costs for agencies that contract with the behavioral health organization;

(5) Assure that the special needs of minorities, older adults, individuals with disabilities, children, and low-income persons are met within the priorities established in this chapter;

(6) Maintain patient tracking information in a central location as required for resource management services and the department's information system;

(7) Collaborate to ensure that policies do not result in an adverse shift of persons with mental illness into state and local correctional facilities;

(8) Work with the department to expedite the enrollment or reenrollment of eligible persons leaving state or local correctional facilities and institutions for mental diseases;

(9) Work closely with the designated crisis responder to maximize appropriate placement of persons into community services; and

(10) Have representation, including involvement by community mental health providers, on the hospital clinical discharge planning team to ensure coordinated services occur for individuals who have received services through the community mental health system and who become patients at a state psychiatric hospital, and to ensure they are transitioned into the community in accordance with mutually agreed upon discharge plans and upon determination by the medical director of the state psychiatric hospital that they no longer need intensive inpatient care.

Sec. 104. RCW 71.24.025 and 2016 sp.s. c 29 s 502 are each reenacted and amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Acutely mentally ill" means a condition which is limited to a short-term severe crisis episode of:

(a) A mental disorder as defined in RCW 71.05.020 or, in the case of a child, as defined in RCW 71.34.020;

(b) Being gravely disabled as defined in RCW 71.05.020 or, in the case of a child, a gravely disabled minor as defined in RCW 71.34.020; or

(c) Presenting a likelihood of serious harm as defined in RCW 71.05.020 or, in the case of a child, as defined in RCW 71.34.020.

(2) "Alcoholism" means a disease, characterized by a dependency on alcoholic beverages, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning.

(3) "Approved substance use disorder treatment program" means a program for persons with a substance use disorder provided by a treatment program certified by the department of social and health services as meeting standards adopted under this chapter.

(4) "Available resources" means funds appropriated for the purpose of providing community mental health programs, federal funds,

except those provided according to Title XIX of the Social Security Act, and state funds appropriated under this chapter or chapter 71.05 RCW by the legislature during any biennium for the purpose of providing residential services, resource management services, community support services, and other mental health services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

(5) "Behavioral health organization" means any county authority or group of county authorities or other entity recognized by the secretary in contract in a defined region, or successor entities as contracted by the authority under RCW 71.24.850(2).

(6) "Behavioral health program" means all expenditures, services, activities, or programs, including reasonable administration and overhead, designed and conducted to prevent or treat chemical dependency and mental illness.

(7) "Behavioral health services" means mental health services as described in this chapter and chapter 71.36 RCW and substance use disorder treatment services as described in this chapter.

(8) "Child" means a person under the age of eighteen years.

(9) "Chronically mentally ill adult" or "adult who is chronically mentally ill" means an adult who has a mental disorder and meets at least one of the following criteria:

(a) Has undergone two or more episodes of hospital care for a mental disorder within the preceding two years; or

(b) Has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding year; or

(c) Has been unable to engage in any substantial gainful activity by reason of any mental disorder which has lasted for a continuous period of not less than twelve months. "Substantial gainful activity" shall be defined by the department by rule consistent with Public Law 92-603, as amended.

(10) "Clubhouse" means a community-based program that provides rehabilitation services and is certified by the department of social and health services.

(11) "Community mental health service delivery system" means public, private, or tribal agencies that provide services specifically to persons with mental disorders as defined under RCW 71.05.020 and receive funding from public sources.

(12) "Community support services" means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available twenty-four hours, seven days a week, prescreening determinations for persons who are mentally ill being considered for placement in nursing homes as required by federal law, screening for patients being considered for admission to residential services, diagnosis and treatment for children who are acutely mentally ill or severely emotionally disturbed discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program, investigation, legal, and other nonresidential services under chapter 71.05 RCW, case management services, psychiatric treatment including medication supervision, counseling, psychotherapy, assuring transfer of relevant patient information between service providers, recovery services, and other services determined by behavioral health organizations.

(13) "Consensus-based" means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, and may have anecdotal or case study support, or that is agreed but not possible to perform studies with random assignment and controlled groups.

(14) "County authority" means the board of county commissioners, county council, or county executive having authority to establish a community mental health program, or two or more of the county authorities specified in this subsection which have entered into an agreement to provide a community mental health program.

(15) "Department" means the department of social and health services.

(16) "Designated crisis responder" means a mental health professional designated by the county or other authority authorized in rule to perform the duties specified in this chapter.

(17) "Drug addiction" means a disease characterized by a dependency on psychoactive chemicals, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning.

(18) "Early adopter" means a regional service area for which all of the county authorities have requested that the department and the health care authority jointly purchase medical and behavioral health

services through a managed care health system as defined under RCW 71.24.380(6).

(19) "Emerging best practice" or "promising practice" means a program or practice that, based on statistical analyses or a well established theory of change, shows potential for meeting the evidence-based or research-based criteria, which may include the use of a program that is evidence-based for outcomes other than those listed in subsection (20) of this section.

(20) "Evidence-based" means a program or practice that has been tested in heterogeneous or intended populations with multiple randomized, or statistically controlled evaluations, or both; or one large multiple site randomized, or statistically controlled evaluation, or both, where the weight of the evidence from a systemic review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial.

(21) "Licensed physician" means a person licensed to practice medicine or osteopathic medicine and surgery in the state of Washington.

(22) "Licensed service provider" means an entity licensed according to this chapter or chapter 71.05 RCW or an entity deemed to meet state minimum standards as a result of accreditation by a recognized behavioral health accrediting body recognized and having a current agreement with the department, or tribal attestation that meets state minimum standards, or persons licensed under chapter 18.57, 18.57A, 18.71, 18.71A, 18.83, or 18.79 RCW, as it applies to registered nurses and advanced registered nurse practitioners.

(23) "Long-term inpatient care" means inpatient services for persons committed for, or voluntarily receiving intensive treatment for, periods of ninety days or greater under chapter 71.05 RCW. "Long-term inpatient care" as used in this chapter does not include: (a) Services for individuals committed under chapter 71.05 RCW who are receiving services pursuant to a conditional release or a court-ordered less restrictive alternative to detention; or (b) services for individuals voluntarily receiving less restrictive alternative treatment on the grounds of the state hospital.

(24) "Mental health services" means all services provided by behavioral health organizations and other services provided by the state for persons who are mentally ill.

(25) Mental health "treatment records" include registration and all other records concerning persons who are receiving or who at any time have received services for mental illness, which are maintained by the department, by behavioral health organizations and their staffs, and by treatment facilities. Treatment records do not include notes or records maintained for personal use by a person providing treatment services for the department, behavioral health organizations, or a treatment facility if the notes or records are not available to others.

(26) "Mentally ill persons," "persons who are mentally ill," and "the mentally ill" mean persons and conditions defined in subsections (1), (9), (34), and (35) of this section.

(27) "Recovery" means the process in which people are able to live, work, learn, and participate fully in their communities.

(28) "Registration records" include all the records of the department, behavioral health organizations, treatment facilities, and other persons providing services to the department, county departments, or facilities which identify persons who are receiving or who at any time have received services for mental illness.

(29) "Research-based" means a program or practice that has been tested with a single randomized, or statistically controlled evaluation, or both, demonstrating sustained desirable outcomes; or where the weight of the evidence from a systemic review supports sustained outcomes as described in subsection (20) of this section but does not meet the full criteria for evidence-based.

(30) "Residential services" means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for persons who are acutely mentally ill, adults who are chronically mentally ill, children who are severely emotionally disturbed, or adults who are seriously disturbed and determined by the behavioral health organization to be at risk of becoming acutely or chronically mentally ill. The services shall include at least evaluation and treatment services as defined in chapter 71.05 RCW, acute crisis respite care, long-term adaptive and rehabilitative care, and supervised and supported living services, and shall also include any residential services developed to service

persons who are mentally ill in nursing homes, assisted living facilities, and adult family homes, and may include outpatient services provided as an element in a package of services in a supported housing model. Residential services for children in out-of-home placements related to their mental disorder shall not include the costs of food and shelter, except for children's long-term residential facilities existing prior to January 1, 1991.

(31) "Resilience" means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

(32) "Resource management services" mean the planning, coordination, and authorization of residential services and community support services administered pursuant to an individual service plan for: (a) Adults and children who are acutely mentally ill; (b) adults who are chronically mentally ill; (c) children who are severely emotionally disturbed; or (d) adults who are seriously disturbed and determined solely by a behavioral health organization to be at risk of becoming acutely or chronically mentally ill. Such planning, coordination, and authorization shall include mental health screening for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment program. Resource management services include seven day a week, twenty-four hour a day availability of information regarding enrollment of adults and children who are mentally ill in services and their individual service plan to designated crisis responders, evaluation and treatment facilities, and others as determined by the behavioral health organization.

(33) "Secretary" means the secretary of social and health services.

(34) "Seriously disturbed person" means a person who:

(a) Is gravely disabled or presents a likelihood of serious harm to himself or herself or others, or to the property of others, as a result of a mental disorder as defined in chapter 71.05 RCW;

(b) Has been on conditional release status, or under a less restrictive alternative order, at some time during the preceding two years from an evaluation and treatment facility or a state mental health hospital;

(c) Has a mental disorder which causes major impairment in several areas of daily living;

(d) Exhibits suicidal preoccupation or attempts; or

(e) Is a child diagnosed by a mental health professional, as defined in chapter 71.34 RCW, as experiencing a mental disorder which is clearly interfering with the child's functioning in family or school or with peers or is clearly interfering with the child's personality development and learning.

(35) "Severely emotionally disturbed child" or "child who is severely emotionally disturbed" means a child who has been determined by the behavioral health organization to be experiencing a mental disorder as defined in chapter 71.34 RCW, including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers and who meets at least one of the following criteria:

(a) Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years;

(b) Has undergone involuntary treatment under chapter 71.34 RCW within the last two years;

(c) Is currently served by at least one of the following child-serving systems: Juvenile justice, child-protection/welfare, special education, or developmental disabilities;

(d) Is at risk of escalating maladjustment due to:

(i) Chronic family dysfunction involving a caretaker who is mentally ill or inadequate;

(ii) Changes in custodial adult;

(iii) Going to, residing in, or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient, residential treatment, group or foster home, or a correctional facility;

(iv) Subject to repeated physical abuse or neglect;

(v) Drug or alcohol abuse; or

(vi) Homelessness.

(36) "State minimum standards" means minimum requirements established by rules adopted by the secretary and necessary to implement this chapter for: (a) Delivery of mental health services; (b) licensed service providers for the provision of mental health services; (c) residential services; and (d) community support services and resource management services.

(37) "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a

pathological pattern of behaviors related to the use of the substances.

(38) "Tribal authority," for the purposes of this section and RCW 71.24.300 only, means: The federally recognized Indian tribes and the major Indian organizations recognized by the secretary insofar as these organizations do not have a financial relationship with any behavioral health organization that would present a conflict of interest.

(39) "Authority" means the Washington state health care authority.

Part II
Development of Community Long-Term Involuntary Treatment Capacity

NEW SECTION. **Sec. 201.** A new section is added to chapter 71.24 RCW to read as follows:

(1) The state intends to develop new capacity for delivery of long-term treatment in the community in diverse regions of the state prior to the effective date of the integration of risk for long-term involuntary treatment into managed care, and to study the cost and outcomes associated with treatment in community facilities. In furtherance of this goal, the department shall purchase a portion of the state's long-term treatment capacity allocated to behavioral health organizations under RCW 71.24.310 in willing community facilities capable of providing alternatives to treatment in a state hospital. The state shall increase its purchasing of long-term involuntary treatment capacity in the community over time.

(2) The department shall:

(a) Work with willing community hospitals licensed under chapters 70.41 and 71.12 RCW and evaluation and treatment facilities certified under chapter 71.05 RCW to assess their capacity to become certified to provide long-term mental health placements and to meet the requirements of this chapter; and

(b) Enter into contracts and payment arrangements with such hospitals and evaluation and treatment facilities choosing to provide long-term mental health placements, to the extent that willing certified facilities are available. Nothing in this chapter requires any community hospital or evaluation and treatment facility to be certified to provide long-term mental health placements.

(3) The department must establish rules for the certification of facilities interested in providing care under this section.

(4) Contracts developed by the department to implement this section must be constructed to allow the department to obtain complete identification information and admission and discharge dates for patients served under this authority. Prior to requesting identification information and admission and discharge dates or reports from certified facilities, the department must determine that this information cannot be identified or obtained from existing data sources available to state agencies. In addition, until January 1, 2024, facilities certified by the department to provide community long-term involuntary treatment to adults on ninety or one hundred eighty-day orders shall report to the department:

(a) All instances where a patient on a ninety or one hundred eighty-day involuntary commitment order experiences an adverse event required to be reported to the department of health pursuant to chapter 70.56 RCW; and

(b) All hospital-based inpatient psychiatric service core measures reported to the joint commission or other accrediting body occurring from psychiatric departments, in the format in which the report was made to the joint commission.

(5) The information collected in subsection (4) of this section shall be used by the department for treatment comparisons between facilities certified by the department to provide treatment to adults on ninety or one hundred eighty-day inpatient involuntary commitment orders and state hospitals. In addition, the department shall provide data to compare clinical outcomes for patients in certified facilities and state hospitals, including outcomes after discharge, length of stay, and demographic information.

Sec. 202. RCW 71.24.310 and 2017 c 222 s 1 are each amended to read as follows:

The legislature finds that administration of chapter 71.05 RCW and this chapter can be most efficiently and effectively implemented as part of the behavioral health organization defined in RCW 71.24.025. For this reason, the legislature intends that the department and the behavioral health organizations shall work together to implement chapter 71.05 RCW as follows:

(1) By June 1, 2006, behavioral health organizations shall recommend to the department the number of state hospital beds that

should be allocated for use by each behavioral health organization. The statewide total allocation shall not exceed the number of state hospital beds offering long-term inpatient care, as defined in this chapter, for which funding is provided in the biennial appropriations act.

(2) If there is consensus among the behavioral health organizations regarding the number of state hospital beds that should be allocated for use by each behavioral health organization, the department shall contract with each behavioral health organization accordingly.

(3) If there is not consensus among the behavioral health organizations regarding the number of beds that should be allocated for use by each behavioral health organization, the department shall establish by emergency rule the number of state hospital beds that are available for use by each behavioral health organization. The emergency rule shall be effective September 1, 2006. The primary factor used in the allocation shall be the estimated number of adults with acute and chronic mental illness in each behavioral health organization area, based upon population-adjusted incidence and utilization.

(4) The allocation formula shall be updated at least every three years to reflect demographic changes, and new evidence regarding the incidence of acute and chronic mental illness and the need for long-term inpatient care. In the updates, the statewide total allocation shall include (a) all state hospital beds offering long-term inpatient care for which funding is provided in the biennial appropriations act; plus (b) the estimated equivalent number of beds or comparable diversion services contracted in accordance with subsection (5) of this section.

(5)(a) The department ((~~is encouraged to enter~~)) shall enter into performance-based contracts with ((~~behavioral health organizations~~)) facilities certified by the department to provide treatment to adults on a ninety or one hundred eighty-day inpatient involuntary commitment order to provide some or all of the behavioral health organization's allocated long-term inpatient treatment capacity in the community, rather than in the state hospital, to the extent that willing certified facilities and funding are available. The performance contracts shall specify the number of patient days of care available for use by the behavioral health organization in the state hospital and the number of patient days of care available for

use by the behavioral health organization or equivalent entity in a full integration region in a facility certified by the department to provide treatment to adults on a ninety or one hundred eighty-day inpatient involuntary commitment order, including hospitals licensed under chapters 70.41 and 71.12 RCW and evaluation and treatment facilities certified under chapter 71.05 RCW.

(b) A hospital licensed under chapter 70.41 or 71.12 RCW is not required to undergo certification to treat patients on ninety or one hundred eighty-day involuntary commitment orders in order to treat adults who are waiting for placement at either the state hospital or in certified facilities that voluntarily contract to provide treatment to patients on ninety or one hundred eighty-day involuntary commitment orders.

(6) If a behavioral health organization uses more state hospital patient days of care than it has been allocated under subsection (3) or (4) of this section, or than it has contracted to use under subsection (5) of this section, whichever is less, it shall reimburse the department for that care. Reimbursements must be calculated using quarterly average census data to determine an average number of days used in excess of the bed allocation for the quarter. The reimbursement rate per day shall be the hospital's total annual budget for long-term inpatient care, divided by the total patient days of care assumed in development of that budget.

(7) One-half of any reimbursements received pursuant to subsection (6) of this section shall be used to support the cost of operating the state hospital and, during the 2007-2009 fiscal biennium, implementing new services that will enable a behavioral health organization to reduce its utilization of the state hospital. The department shall distribute the remaining half of such reimbursements among behavioral health organizations that have used less than their allocated or contracted patient days of care at that hospital, proportional to the number of patient days of care not used.

NEW SECTION. **Sec. 203.** A new section is added to chapter 71.05 RCW to read as follows:

Treatment under RCW 71.05.320 may be provided at a state hospital or any willing and able facility certified to provide ninety-day or one hundred eighty-day care. The order for such treatment must remand the person to the custody of the department or designee. A prepaid

inpatient health plan, managed care organization, or the department, when responsible for the cost of care, may designate where treatment is to be provided, at a willing and able facility certified to provide ninety-day or one hundred eighty-day care or a state hospital, after consultation with the facility currently providing treatment. The prepaid inpatient health plan, managed care organization, or the department, when responsible for the cost of care, may not require prior authorization for treatment under RCW 71.05.320. The designation of a treatment facility must not result in a delay of the transfer of the person to a state hospital or facility certified to provide ninety-day or one hundred eighty-day care if there is an open bed available at either the state hospital or a certified facility.

Sec. 204. RCW 71.05.320 and 2016 sp.s. c 29 s 237 and 2016 c 45 s 4 are each reenacted and amended to read as follows:

(1)(a) Subject to (b) of this subsection, if the court or jury finds that grounds set forth in RCW 71.05.280 have been proven and that the best interests of the person or others will not be served by a less restrictive treatment which is an alternative to detention, the court shall remand him or her ((~~to the custody of the department or to a facility certified for ninety day treatment by the department~~)) for a further period of intensive treatment not to exceed ninety days from the date of judgment.

(b) If the order for inpatient treatment is based on a substance use disorder, treatment must take place at an approved substance use disorder treatment program. The court may only enter an order for commitment based on a substance use disorder if there is an available approved substance use disorder treatment program with adequate space for the person.

(c) If the grounds set forth in RCW 71.05.280(3) are the basis of commitment, then the period of treatment may be up to but not exceed one hundred eighty days from the date of judgment in a facility certified for one hundred eighty day treatment by the department.

(2) If the court or jury finds that grounds set forth in RCW 71.05.280 have been proven, but finds that treatment less restrictive than detention will be in the best interest of the person or others, then the court ((~~shall remand him or her to the custody of the department or to a facility certified for ninety day treatment by the department~~)) must commit him or her for a period of treatment of up

to ninety days or to a less restrictive alternative for a further period of less restrictive treatment not to exceed ninety days from the date of judgment. If the order for less restrictive treatment is based on a substance use disorder, treatment must be provided by an approved substance use disorder treatment program. If the grounds set forth in RCW 71.05.280(3) are the basis of commitment, then the period of treatment may be up to but not exceed one hundred eighty days from the date of judgment. If the court or jury finds that the grounds set forth in RCW 71.05.280(5) have been proven, and provide the only basis for commitment, the court must enter an order for less restrictive alternative treatment for up to ninety days from the date of judgment and may not order inpatient treatment.

(3) An order for less restrictive alternative treatment entered under subsection (2) of this section must name the mental health service provider responsible for identifying the services the person will receive in accordance with RCW 71.05.585, and must include a requirement that the person cooperate with the services planned by the mental health service provider.

(4) The person shall be released from involuntary treatment at the expiration of the period of commitment imposed under subsection (1) or (2) of this section unless the superintendent or professional person in charge of the facility in which he or she is confined, or in the event of a less restrictive alternative, the designated crisis responder, files a new petition for involuntary treatment on the grounds that the committed person:

(a) During the current period of court ordered treatment: (i) Has threatened, attempted, or inflicted physical harm upon the person of another, or substantial damage upon the property of another, and (ii) as a result of a mental disorder, substance use disorder, or developmental disability presents a likelihood of serious harm; or

(b) Was taken into custody as a result of conduct in which he or she attempted or inflicted serious physical harm upon the person of another, and continues to present, as a result of mental disorder, substance use disorder, or developmental disability a likelihood of serious harm; or

(c)(i) Is in custody pursuant to RCW 71.05.280(3) and as a result of mental disorder or developmental disability continues to present a substantial likelihood of repeating acts similar to the charged criminal behavior, when considering the person's life history, progress in treatment, and the public safety.

(ii) In cases under this subsection where the court has made an affirmative special finding under RCW 71.05.280(3)(b), the commitment shall continue for up to an additional one hundred eighty day period whenever the petition presents prima facie evidence that the person continues to suffer from a mental disorder or developmental disability that results in a substantial likelihood of committing acts similar to the charged criminal behavior, unless the person presents proof through an admissible expert opinion that the person's condition has so changed such that the mental disorder or developmental disability no longer presents a substantial likelihood of the person committing acts similar to the charged criminal behavior. The initial or additional commitment period may include transfer to a specialized program of intensive support and treatment, which may be initiated prior to or after discharge ((~~from the state hospital~~)); or

(d) Continues to be gravely disabled; or

(e) Is in need of assisted outpatient ((~~mental~~)) behavioral health treatment.

If the conduct required to be proven in (b) and (c) of this subsection was found by a judge or jury in a prior trial under this chapter, it shall not be necessary to prove such conduct again.

If less restrictive alternative treatment is sought, the petition shall set forth any recommendations for less restrictive alternative treatment services.

(5) A new petition for involuntary treatment filed under subsection (4) of this section shall be filed and heard in the superior court of the county of the facility which is filing the new petition for involuntary treatment unless good cause is shown for a change of venue. The cost of the proceedings shall be borne by the state.

(6)(a) The hearing shall be held as provided in RCW 71.05.310, and if the court or jury finds that the grounds for additional confinement as set forth in this section are present, subject to subsection (1)(b) of this section, the court may order the committed person returned for an additional period of treatment not to exceed one hundred eighty days from the date of judgment, except as provided in subsection (7) of this section. If the court's order is based solely on the grounds identified in subsection (4)(e) of this section, the court may enter an order for less restrictive alternative treatment not to exceed one hundred eighty days from the

date of judgment, and may not enter an order for inpatient treatment. An order for less restrictive alternative treatment must name the mental health service provider responsible for identifying the services the person will receive in accordance with RCW 71.05.585, and must include a requirement that the person cooperate with the services planned by the mental health service provider.

(b) At the end of the one hundred eighty day period of commitment, or one-year period of commitment if subsection (7) of this section applies, the committed person shall be released unless a petition for an additional one hundred eighty day period of continued treatment is filed and heard in the same manner as provided in this section. Successive one hundred eighty day commitments are permissible on the same grounds and pursuant to the same procedures as the original one hundred eighty day commitment.

(7) An order for less restrictive treatment entered under subsection (6) of this section may be for up to one year when the person's previous commitment term was for intensive inpatient treatment in a state hospital.

(8) No person committed as provided in this section may be detained unless a valid order of commitment is in effect. No order of commitment can exceed one hundred eighty days in length except as provided in subsection (7) of this section.

Sec. 205. RCW 71.05.320 and 2016 sp.s. c 29 s 238 are each amended to read as follows:

(1)(a) If the court or jury finds that grounds set forth in RCW 71.05.280 have been proven and that the best interests of the person or others will not be served by a less restrictive treatment which is an alternative to detention, the court shall remand him or her ((~~to the custody of the department or to a facility certified for ninety day treatment by the department~~)) for a further period of intensive treatment not to exceed ninety days from the date of judgment.

(b) If the order for inpatient treatment is based on a substance use disorder, treatment must take place at an approved substance use disorder treatment program. If the grounds set forth in RCW 71.05.280(3) are the basis of commitment, then the period of treatment may be up to but not exceed one hundred eighty days from the date of judgment in a facility certified for one hundred eighty day treatment by the department.

(2) If the court or jury finds that grounds set forth in RCW 71.05.280 have been proven, but finds that treatment less restrictive than detention will be in the best interest of the person or others, then the court ((~~shall remand him or her to the custody of the department or to a facility certified for ninety day treatment by the department~~)) must commit him or her for a period of treatment of up to ninety days or to a less restrictive alternative for a further period of less restrictive treatment not to exceed ninety days from the date of judgment. If the order for less restrictive treatment is based on a substance use disorder, treatment must be provided by an approved substance use disorder treatment program. If the grounds set forth in RCW 71.05.280(3) are the basis of commitment, then the period of treatment may be up to but not exceed one hundred eighty days from the date of judgment. If the court or jury finds that the grounds set forth in RCW 71.05.280(5) have been proven, and provide the only basis for commitment, the court must enter an order for less restrictive alternative treatment for up to ninety days from the date of judgment and may not order inpatient treatment.

(3) An order for less restrictive alternative treatment entered under subsection (2) of this section must name the mental health service provider responsible for identifying the services the person will receive in accordance with RCW 71.05.585, and must include a requirement that the person cooperate with the services planned by the mental health service provider.

(4) The person shall be released from involuntary treatment at the expiration of the period of commitment imposed under subsection (1) or (2) of this section unless the superintendent or professional person in charge of the facility in which he or she is confined, or in the event of a less restrictive alternative, the designated crisis responder, files a new petition for involuntary treatment on the grounds that the committed person:

(a) During the current period of court ordered treatment: (i) Has threatened, attempted, or inflicted physical harm upon the person of another, or substantial damage upon the property of another, and (ii) as a result of a mental disorder, substance use disorder, or developmental disability presents a likelihood of serious harm; or

(b) Was taken into custody as a result of conduct in which he or she attempted or inflicted serious physical harm upon the person of another, and continues to present, as a result of mental disorder,

substance use disorder, or developmental disability a likelihood of serious harm; or

(c)(i) Is in custody pursuant to RCW 71.05.280(3) and as a result of mental disorder or developmental disability continues to present a substantial likelihood of repeating acts similar to the charged criminal behavior, when considering the person's life history, progress in treatment, and the public safety.

(ii) In cases under this subsection where the court has made an affirmative special finding under RCW 71.05.280(3)(b), the commitment shall continue for up to an additional one hundred eighty day period whenever the petition presents prima facie evidence that the person continues to suffer from a mental disorder or developmental disability that results in a substantial likelihood of committing acts similar to the charged criminal behavior, unless the person presents proof through an admissible expert opinion that the person's condition has so changed such that the mental disorder or developmental disability no longer presents a substantial likelihood of the person committing acts similar to the charged criminal behavior. The initial or additional commitment period may include transfer to a specialized program of intensive support and treatment, which may be initiated prior to or after discharge ((~~from the state hospital~~)); or

(d) Continues to be gravely disabled; or

(e) Is in need of assisted outpatient ((~~mental~~)) <u>behavioral</u> health treatment.

If the conduct required to be proven in (b) and (c) of this subsection was found by a judge or jury in a prior trial under this chapter, it shall not be necessary to prove such conduct again.

If less restrictive alternative treatment is sought, the petition shall set forth any recommendations for less restrictive alternative treatment services.

(5) A new petition for involuntary treatment filed under subsection (4) of this section shall be filed and heard in the superior court of the county of the facility which is filing the new petition for involuntary treatment unless good cause is shown for a change of venue. The cost of the proceedings shall be borne by the state.

(6)(a) The hearing shall be held as provided in RCW 71.05.310, and if the court or jury finds that the grounds for additional confinement as set forth in this section are present, the court may

order the committed person returned for an additional period of treatment not to exceed one hundred eighty days from the date of judgment, except as provided in subsection (7) of this section. If the court's order is based solely on the grounds identified in subsection (4)(e) of this section, the court may enter an order for less restrictive alternative treatment not to exceed one hundred eighty days from the date of judgment, and may not enter an order for inpatient treatment. An order for less restrictive alternative treatment must name the mental health service provider responsible for identifying the services the person will receive in accordance with RCW 71.05.585, and must include a requirement that the person cooperate with the services planned by the mental health service provider.

(b) At the end of the one hundred eighty day period of commitment, or one-year period of commitment if subsection (7) of this section applies, the committed person shall be released unless a petition for an additional one hundred eighty day period of continued treatment is filed and heard in the same manner as provided in this section. Successive one hundred eighty day commitments are permissible on the same grounds and pursuant to the same procedures as the original one hundred eighty day commitment.

(7) An order for less restrictive treatment entered under subsection (6) of this section may be for up to one year when the person's previous commitment term was for intensive inpatient treatment in a state hospital.

(8) No person committed as provided in this section may be detained unless a valid order of commitment is in effect. No order of commitment can exceed one hundred eighty days in length except as provided in subsection (7) of this section.

NEW SECTION. **Sec. 206.** The department of social and health services shall confer with the department of health and hospitals licensed under chapters 70.41 and 71.12 RCW to review laws and regulations and identify changes that may be necessary to address care delivery and cost-effective treatment for adults on ninety or one hundred eighty day commitment orders which may be different than the requirements for short-term psychiatric hospitalization. The department of social and health services shall report its findings to the select committee on quality improvement in state hospitals by November 1, 2018.

NEW SECTION. **Sec. 207.** Section 205 of this act takes effect July 1, 2026.

NEW SECTION. **Sec. 208.** Section 204 of this act expires July 1, 2026."

2EHB 2107 - S COMM AMD
By Committee on Human Services & Corrections

On page 1, line 3 of the title, after "services;" strike the remainder of the title and insert "amending RCW 71.24.045, 71.24.310, and 71.05.320; reenacting and amending RCW 71.24.025 and 71.05.320; adding new sections to chapter 71.24 RCW; adding a new section to chapter 74.09 RCW; adding a new section to chapter 71.05 RCW; creating a new section; providing an effective date; and providing an expiration date."

EFFECT: 1. Requires the health care authority (HCA) to develop a psychiatric managed care capitation risk model, taking into account the recommendations derived from the PCG Washington Mental Health System Assessment: Final Alternative Options and Recommendations Report and the Inpatient Psychiatric Care Risk Model Report, that integrates long-term inpatient risk for long-term involuntary civil treatment provided by state hospitals, and submit a final draft to the Legislature by December 1, 2020.

2. Requires HCA to integrate long-term inpatient risk for long-term involuntary civil treatment provided by state hospitals into managed care contracts by July 1, 2021.

3. Requires HCA to request legislation, as appropriate, extending institution for mental health diseases disproportionate share hospital payments to community hospitals as an option to maximize any reductions brought on by changes in the forensic to civil ratio for the state hospital population.

4. Requires the department of social and health services (DSHS) to collaborate with HCA and invite appropriate and interested stakeholders to develop a detailed transition plan to move the cost of state hospital civil treatment into managed care, taking into account the recommendations derived from the PCG Washington Mental Health System Assessment: Final Alternative Options and Recommendations Report and the Inpatient Psychiatric Care Risk Model Report.

5. Removes the review of the DSHS draft transition plan by the select committee on quality improvement in state hospitals and clarifies that DSHS must consider the input of the relevant committees of the Legislature and external stakeholders before submitting a final transition plan. Adds that the final transition plan is due to the Legislature by December 30, 2019.

6. Clarifies that stakeholders must include, but not be limited to, interested members of the Legislature, the Washington state

hospital association, the association of Washington healthcare plans, each of the five contracted apple health managed care organizations or administrative services organizations if applicable, the Washington council for behavioral health, and the Washington state association of counties.

7. Declares the intent to purchase part of the State's capacity for 90/180-day treatment in willing community facilities that come to the table to contract with the state.

8. Specifies which data must be measured and collected pursuant to contracts in language worked out and vetted with Washington State Hospital Association, and adds January 1, 2024, for the data reporting end date.

9. Clarifies that the state contracts with facilities and allocates a mix of state hospital and community beds to the BHOs/ FIMCOs.

10. Includes that the state must develop rules to certify 90/180-day facilities, and must consult with WSHA to determine what short-term rules are inappropriate to long-term facilities.

11. Subject to funding language incorporated for 90/180-day contracts.

12. Courts must remand to the custody of department or designee, not a specific facility. The payer (BHO/FIMCO/state) must designate patient placement, provided they must place in an open bed if available. Prior authorization prohibited for ITA placement.

13. Updates language to reflect the behavioral health organizations includes successor entities as contracted by the Authority under RCW 71.24.850(2).

--- END ---