HOUSE BILL REPORT
E2SHB 2639

As Passed House:
February 17, 2014

Title: An act relating to state purchasing of mental health and chemical dependency treatment services.

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

Sponsors: House Committee on Appropriations (originally sponsored by Representatives Moeller, Harris, Green, Cody, Morrell, Clibborn, Riccelli, Van De Wege, Bergquist and Freeman; by request of Governor Inslee).

Brief History:

Committee Activity:

Health Care & Wellness: 1/27/14, 2/3/14, 2/5/14 [DPS];
Appropriations: 2/10/14 [DP2S(w/o sub HCW)].

Floor Activity:

Passed House: 2/17/14, 66-31.

Brief Summary of Engrossed Second Substitute Bill

- Expands the scope of the work and membership for the Adult Behavioral Health System Task Force.
- Directs the Department of Social and Health Services and the Health Care Authority to establish up to nine regional service areas.
- Establishes a process for awarding contracts for behavioral health organizations in regional service areas.
- Establishes contract requirements for the purchase of behavioral health services for Medicaid and non-Medicaid clients and factors to consider in the purchasing process.
- Establishes requirements for contracts to assure that primary care services are available in behavioral health settings and behavioral health services are available in primary care settings.
- Directs that mental health, chemical dependency, and medical care services for Medicaid clients must be fully integrated by January 1, 2019.

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.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 9 members: Representatives Cody, Chair; Riccelli, Vice Chair; Clibborn, Green, Jinkins, Moeller, Morrell, Tharinger and Van De Wege.

Minority Report: Do not pass. Signed by 8 members: Representatives Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; DeBolt, G. Hunt, Manweller, Rodne, Ross and Short.

Staff: Chris Blake (786-7392).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care & Wellness. Signed by 27 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Chandler, Ranking Minority Member; Ross, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Buys, Carlyle, Cody, Dunshee, Fagan, Green, Haigh, Haler, Harris, Hudgins, S. Hunt, Jinkins, Kagi, Lytton, Morrell, Parker, Pettigrew, Schmick, Seaquist, Springer, Sullivan and Tharinger.

Minority Report: Do not pass. Signed by 3 members: Representatives Christian, G. Hunt and Taylor.

Staff: Andy Toulon (786-7178).

Background:

Community Mental Health System.
The Department of Social and Health Services (Department) contracts with regional support networks to oversee the delivery of mental health services for adults and children who suffer from mental illness or severe emotional disturbance. A regional support network may be a county, group of counties, or a nonprofit or for-profit entity. Currently, 10 of the 11 regional support networks are county-based, except for one which is operated by a private entity.

Regional support networks are paid by the state on a capitation basis and funding is adjusted based on caseload. The regional support networks contract with local providers to provide an array of mental health services, monitor the activities of local providers, and oversee the distribution of funds under the state managed care plan.

Chemical Dependency Services.
The Department contracts with counties to provide outpatient chemical dependency prevention, treatment, and support services, either directly or by subcontracting with certified providers. The Department determines chemical dependency service priorities for those activities funded by the Department.

Adult Behavioral Health System Task Force.
In 2013 the Legislature established the Adult Behavioral Health System Task Force (Task Force) to examine the reform of the adult behavioral health system. Specifically, the Task Force must review the adult behavioral health system and make recommendations for reform related to:

- the delivery of services to adults with mental illness and chemical dependency disorders;
- the availability of effective means to promote recovery and prevent harm associated with mental illness;
- crisis services;
- 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.

The Task Force is comprised of two members of the House of Representatives, two members of the Senate, five members appointed by the Governor from various agencies, and a tribal representative. The Task Force begins on May 1, 2014, and must report its findings by January 1, 2015.

Summary of Engrossed Second Substitute Bill:

Adult Behavioral Health System Task Force.
Topics are added to the review that the Adult Behavioral Health System Task Force (Task Force) must conduct. Recommendations of the Task Force must include: (1) means to promote recovery and prevent harm associated with chemical dependency; and (2) public safety practices involving chemical dependency with forensic involvement. In addition to making recommendations for the way that services are delivered to adults with mental illness and chemical dependency disorders, the Task Force must consider the way that the services are purchased. Specifically, the Task Force must provide recommendations:

- by August 1, 2014, regarding the creation of common regional service areas for purchasing behavioral health and medical care services by the Department of Social and Health Services (Department) and the Health Care Authority (Authority); or
- by September 1, 2014, regarding the design and requirements of future Medicaid behavioral health and health care delivery systems and purchasing.

The membership of the Task Force is expanded to include three members appointed by the Washington State Association of Counties and two additional members from each chamber of the Legislature. The Department of Commerce, chemical dependency advocates, and chemical dependency experts working with drug courts are added to the list of stakeholders with whom the Task Force must consult. The date that the Task Force begins is advanced from May 1, 2014, to April 1, 2014.

Regional Service Areas and Behavioral Health Organizations.
The term "regional support network" is changed to "behavioral health organization."

The Department and the Authority must jointly establish regional service areas by September 1, 2014. By July 1, 2014, the Washington State Association of Counties may propose the composition of up to nine regional service areas to the Department, the Authority, and the Task Force. The regional service areas must:

- include enough Medicaid lives to support full financial risk managed care contracting for services;
- include full counties that are contiguous with each other; and
- reflect medical and behavioral health services referral patterns and shared health care services, behavioral health service, and behavioral health crisis response resources.

When counties form a behavioral health organization, it must be consistent with the boundaries of a regional service area. After April 1, 2016, Medicaid managed care contracts must serve geographic areas that correspond to the borders of regional service areas.

Contracting for Behavioral Health Services.
The Department must purchase mental health and chemical dependency treatment services primarily through managed care contracting. The Department must request a detailed plan from each county or group of counties within a regional service area, or private entity that operates as a regional support network for a county. The detailed plan must demonstrate compliance by the responding entity with federal regulations regarding managed care contracting, including provider network adequacy, management of adequate reserves, and maintenance of quality assurance processes. The Department shall award the contract to serve as the behavioral health organization for a regional service area to any responding entity that meets the requirements of the request for a detailed plan. The Department must use a procurement process if a responding entity does not meet the requirements of the request for a detailed plan, does not submit a detailed plan, or more than one entity meets the requirements of the request for a detailed plan. Contracts for behavioral health service organizations begin on April 1, 2016.

The Department and the Authority may authorize one or more county authorities to jointly purchase behavioral health services through an integrated medical and behavioral health services contract with a behavioral health organization or a Medical managed care organization.

The term "behavioral health services" is defined to include both community mental health services and chemical dependency services. The Department and the Authority contract to provide behavioral health services, whether for persons eligible for Medicaid or not, must include specific provisions related to:

- adherence to intent statements for programs providing community mental health services, children's mental health services, and chemical dependency;
- standards for quality of services, including the increased use of services that are evidence-based, research-based, or promising practices;
- accountability for client outcomes and performance measures;
- the maintenance of appropriate provider networks to provide adequate access to contract services and to protect the behavioral health system infrastructure and capacity;
- behavioral health organizations offering contracts to managed health care systems or primary care practice settings to provide chemical dependency professional services

and mental health services that are integrated into primary care settings for patients with behavioral health and medical comorbidities;
- requirements that medically necessary chemical dependency treatment services are available to clients;
- reimbursement methods to incentivize improved performance regarding client outcomes, integration of behavioral health and primary care services, and improved care coordination for persons with complex needs;
- financial integrity standards;
- the maintenance of decision-making independence of designated mental health professionals; and
- prohibiting the use of public funds to discourage employees from asserting collective bargaining rights.

The process for purchasing behavioral health services must give significant weight to several factors, including:
- commitment and experience serving low-income populations;
- commitment and experience serving persons with severe mental illness or chemical dependency;
- commitment to and experience in partnering with local criminal justice systems, housing services, and other critical support services necessary to meet outcome measures;
- recognition that meeting both physical and behavioral health needs is a shared responsibility of contracted behavioral health organizations, managed health care systems, service providers, the state, and communities;
- consideration of past and current performance and participation in other public behavioral health programs; and
- the ability to meet Department requirements.

When purchasing behavioral health services and medical care services, the Department and the Authority must use common regional service areas.

Specific requirements that regional mental health programs prioritize certain populations and provide enumerated services are replaced with a general requirement that behavioral health organizations provide medically necessary services to Medicaid enrollees according to state and federal requirements and to non-Medicaid enrollees according to state priorities.

The Department's auditing procedures for behavioral health organizations must be designed in such a way that they assure compliance with contractual agreements. The Department's duty to certify regional support networks is eliminated.

In addition to using resources for behavioral health organizations, the Department may use resources to incentivize improved performance regarding client outcomes, integration of behavioral health and primary care services, and improvement of care coordination for persons with complex needs.

Elements are added to the list of services covered by behavioral health organization programs, including peer support counseling, community support services, resource management services, and supported housing and supported employment services.

Contracting for Chemical Dependency Services.
Any behavioral health organization contract for behavioral health services or programs to treat persons with alcohol or drug use disorders must provide medically necessary services to Medicaid enrollees according to state and federal requirements and to non-Medicaid enrollees according to state priorities.

The Department must require behavioral health organization contracts and Medicaid managed care contracts to include a continuum of chemical dependency and mental health services. The Department's and Authority's chemical dependency program must include detoxification services that are available 24 hours per day, outpatient treatment that includes medication assisted treatment, and contracts with at least one provider for case management and residential treatment services for pregnant and parenting women. The program may include peer support, supported housing, supported employment, crisis diversion, or recovery support services.

Medicaid Managed Care Contracts.
By April 1, 2016, Medicaid managed health care systems must offer contracts to behavioral health organizations, mental health providers, or chemical dependency treatment providers to provide access to primary care services that are integrated into behavioral health clinical settings for clients with behavioral health and medical comorbidities. Medicaid managed health care system contracts must include incentives to integrate behavioral health services in the primary care setting to promote care that is integrated, collaborative, co-located, and preventive.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 13, 2014.

Effective Date: The bill takes effect 90 days after the adjournment of the session in which the bill is passed, except for section 1, relating to the Adult Behavioral System Task Force, which contains an emergency clause and takes effect immediately; and sections 6, 7, and 9 through 41, relating to standards for mental health and chemical dependency programs, which take effect April 1, 2016.

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) One in four adults experience mental illness in a given year, and one in 17 suffer from serious mental illness such as bipolar disorder or schizophrenia. Almost half of homeless adults suffer from both mental illness and substance abuse issues. In the chemical dependency system, 43 percent have had a felony or gross misdemeanor in the last year, 60 percent are unemployed, 28 percent are homeless, and 50 percent have a co-occurring mental health disorder.

This bill changes the way that services are provided in order to get better outcomes. This bill addresses meaningful outcomes for clients; evidence-based practices; provider incentives to coordinate and integrate care at the clinical level; and the critical relationship between the

mental health system, chemical dependency system, housing, the social service system, and the social service system.

Services need to be provided more efficiently, and that can be done by moving to an integrated managed care model. There need to be enough resources to plan together across systems and consolidate resources to assure continuity of care. Research and data shows that the integration of health services improves patient care, moves people into recovery more quickly, and saves money in the health care system and other systems like jails and juvenile justice. Recent correspondence from the federal government has prompted conversations about integration and aligning the procurement and planning of services. Washington must design a system that can serve those with very complex needs and provide linkages to other services necessary to succeed. It makes sense that the regional service areas for medical and behavioral health be aligned and it will help with efforts toward integration. This will bring a consistent, statewide benefits package supported by an actuarially established rate. This bill supports the careful integration of mental health, chemical dependency, and physical health because clients in these systems often present with very complex needs, such as co-occurring disorders. This bill supports collaboration with citizen stakeholders.

Counties support integrating mental health and chemical dependency services. It is helpful to have county membership on the task force to identify ways to improve the delivery of services and addressing the critical support services, such as housing. Counties have large portions of their budgets going toward the criminal justice system, and they have a vested interest in treating these people rather than incarcerating them.

There should be some flexibility in the consolidation of regional support networks. There needs to be a good look at the Medicaid chemical dependency rates to make sure that they are supportive of the needed workforce and the appropriate service delivery. The floor level list of services in current law should be maintained and not deleted.

(With concerns) Maintaining separate mental health and chemical dependency systems and collaboration is a balancing act. The mental health and chemical dependency disciplines each have unique aspects and education requirements. The Legislature needs to recognize that mental health and chemical dependency are unique and that the funding should be used as intended. The chemical dependency system has good outcomes that are very cost-effective. Chemical dependency clients who get treatment become functional. Appropriate services help people become employable, active in the community, and successful parents.

There need to be assurances in the bill that the chemical dependency system will be protected because it addresses chemical dependency as a primary disease. Funding needs to be applied for chemical dependency. There should be language in the bill to better protect access to appropriate care for patients and the survival of the chemical dependency treatment system.

(In support with concerns) When people do not get the medical care, mental health care, and chemical dependency care that they need, they shift costs to local fire departments, emergency medical services, law enforcement, jails, and hospital emergency rooms. The Task Force should be amended to look at both mental health and chemical dependency. The Task Force should look at whether or not to fully integrate physical and behavioral health or split up chemical dependency funding for the non-persistent, severely mentally ill between

the regional support networks and the Apple Health plans. There should be a review of the perverse incentives that divert persons with mental illness to hospital emergency departments instead of a detoxification facility or a triage facility or crisis stabilization unit.

(Opposed) None.

Staff Summary of Public Testimony (Appropriations):

(In support) This bill mandates integration of chemical dependency and mental health services and moves away from fee for service purchasing of chemical dependency services, which has been underfunded. It requires that the systems for mental health, physical health, and chemical dependency are planning together in the same regions and along the same timelines. The addition of three county representatives to the task force helps to preserve local decision making and input on the new regional service areas.

Bringing chemical dependency into managed care is a major change and brings into consideration a set of requirements for managed care contracting under federal law. There are areas where the mental health and chemical dependency programs operate in silos and work needs to be done to bring these together and reduce the administrative burden on providers. There are efficiencies that will occur from significantly reducing the number of contracts. However, there will also be work related to monitoring access and quality of care, fiscal integrity, program integrity, and network adequacy to ensure the outcomes of the program meet the expectations of the Legislature.

There have been positive meetings to work on some of the issues. These meetings need to continue as the bill still needs some work. The Request for Qualifications process for the counties will be costly at the local level and there are alternative ways to assure progress is being made on integration of services. Moving to a managed care system for chemical dependency services will be beneficial to clients. Eighty percent of county budgets go to criminal justice so it is important the treatments being provided are effective and efficient.

(In support with concerns) Chemical dependency should be integrated and the best way to do that is to integrate the services with the physical managed care health plans. Chemical dependency agencies successfully work with health plans now and that is the best approach to having a client-centered health care system.

(Opposed) None.

Persons Testifying (Health Care & Wellness): (In support) Representative Moeller, prime sponsor; Andi Smith, Office of the Governor; Jane Beyer, Department of Social and Health Services; Ann Christian, Washington Community Mental Health Council; Seth Dawson, National Alliance on Mental Illness; Lindsey Grad, Services Employees International Union #1199 of Washington; and Abby Murphy, Washington State Association of Counties.

(With concerns) Marcia Roi, Clark College Addiction Counseling, Education Department; Linda Grant, Washington Association of Alcoholism and Addiction Programs; and Irene Slagle.

(In support with concerns) Ken Stark, Snohomish County.

Persons Testifying (Appropriations): (In support) Andi Smith, Office of the Governor; Jane Beyer, Department of Social and Health Services; and Abby Murphy, Washington State Association of Counties.

(In support with concerns) Melissa Johnson, Association of Alcoholism and Addictions Programs.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.