HOUSE BILL REPORT
2SSB 6312

As Passed House - Amended:
March 12, 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: 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).

Brief History:

Committee Activity:

Health Care & Wellness: 2/19/14, 2/20/14 [DP];

Appropriations: 2/27/14, 3/1/14 [DPA].

Floor Activity:

Passed House - Amended: 3/12/14, 75-22.

Brief Summary of Second Substitute Bill
(As Amended by House)

- Expands the scope of the work and membership of the Adult Behavioral Health System Task Force.
- Directs the Department of Social and Health Services and the Health Care Authority to establish 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.

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.

- Directs that mental health, chemical dependency, and medical care services for Medicaid clients be fully integrated by January 1, 2020.
- Allows certified chemical dependency professionals and certified chemical dependency professional trainees who also hold a license to practice another specified health care profession to treat patients in settings other than programs approved by the Department of Social and Health Services.
- Exempts hospitals from certificate of need requirements during fiscal year 2015 if they are changing the use of licensed beds to increase the number of beds to provide psychiatric services, including involuntary treatment services.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 16 members: Representatives Cody, Chair; Riccelli, Vice Chair; Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; Clibborn, DeBolt, G. Hunt, Jinkins, Manweller, Moeller, Morrell, Rodne, Ross, Short, Tharinger and Van De Wege.

Staff: Chris Blake (786-7392).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended. Signed by 28 members: Representatives Hunter, Chair; Ormsby, Vice Chair; Ross, Assistant Ranking Minority Member; Wilcox, Assistant Ranking Minority Member; Buys, Carlyle, Christian, Cody, Dahlquist, 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 Chandler, Ranking Minority Member; 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.

Approximately 40 percent of the state's resources for community mental health services are supported by federal Medicaid funding. Receipt of these funds is conditioned upon compliance with federal requirements.

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.

Physical Healthcare Services for Medicaid Clients.
Medical assistance is available to eligible low-income state residents and their families from the Health Care Authority (Authority), primarily through the Medicaid program. Coverage for physical healthcare services is provided through fee-for-service and managed care systems. Managed care is a prepaid, comprehensive system of medical and health care delivery. Healthy Options is the Authority Medicaid managed care program for low-income people in Washington. Healthy Options offers eligible families, children under age 19, low-income adults, certain disabled individuals, and pregnant women a complete medical benefits package.

Certificate of Need.
Under state law, the Department of Health (DOH) is authorized and directed to implement a program which requires health care facilities to obtain a certificate of need in a number of circumstances. In order to add specialized services such as psychiatric inpatient evaluation and treatment beds, a hospital licensed under chapter 70.41 RCW must have a certificate of

need specific to these specialized services. When determining whether to issue a certificate of need, the Department of Health must consider a variety of criteria including:
- the population's need for the service;
- the availability of less costly or more effective methods of providing the service;
- the financial feasibility and probable impact of the proposal on the cost of health care in the community;
- the need and availability of services and facilities for physicians and patients in the community;
- the efficiency and appropriateness of the use of existing similar services and facilities;
- improvements in the financing and delivery of health services that contain costs and promote quality assurance; and
- the quality of care provided by such services or facilities in the past.

Certification Requirements for Chemical Dependency Professionals and Trainees.
The Department certifies chemical dependency treatment programs that meet established standards. The DOH certifies chemical dependency professionals (CDPs) and chemical dependency professional trainees (CDPTs) who meet educational, experience, and examination requirements established by the DOH. Use of the title "certified chemical dependency professional" or "certified chemical dependency professional trainee" for individuals treating patients in settings other than programs approved by the Department is prohibited.

Individuals who are licensed, certified, or registered under the laws of the state are not prohibited from performing services within the authorized scope of practice. Under rules adopted by the Department and in the Medicaid state plan, chemical dependency counseling for patients admitted to Department-approved programs must be performed by DOH certified CDPs or CDPTs.

Washington State Health Care Innovation Plan.
The Affordable Care Act established the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services to test innovative payment and service delivery models without reducing the quality of care. As part of the State Innovation Models Initiative, Washington received approximately $1 million from the CMMI to work on the State Health Care Innovation Plan (Innovation Plan). The Innovation Plan includes three strategies:
- encourage value-based purchasing, beginning with state-purchased health care;
- build healthy communities through prevention and early mitigation of disease; and
- improve chronic illness care through better integration of care and social supports, in particular for people with both physical and behavioral health issues.

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.

Summary of Bill:

Adult Behavioral Health System Task Force.
In addition to its other study items, the Adult Behavioral Health System Task Force (Task Force) must make recommendations as to how mental health and chemical dependency services are purchased and delivered by the Department of Social and Health Services (Department) and Health Care Authority (Authority) for adults with mental illness and chemical dependency. Specifically, the Task Force must provide recommendations related to:

- the creation of common regional service areas for purchasing behavioral health and medical care services by the Department and the Authority;
- key issues for accomplishing integration of chemical dependency into managed care contracts by April 1, 2016;
- strategies to move toward full integration of medical and behavioral health services by January 1, 2020;
- the review of Department and Authority performance measures and outcomes;
- the review of the detailed plan criteria for awarding behavioral health and recovery organization contracts and requests to adopt fully integrated purchasing;
- whether or not a statewide behavioral health ombuds office should be created;
- the services offered by the state chemical dependency program;
- obstacles to sharing health care information; and
- the extent to which there are variations in commitment rates in different jurisdictions.

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 to serve as alternates. The Department of Commerce, Department of Corrections, the Office of Financial Management, 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. A preliminary report of the Task Force is due December 15, 2014 and a final report is due December 15, 2015.

Regional Service Areas and Behavioral Health and Recovery Organizations.
Upon receipt of guidance from the Task Force, the Department and the Authority must jointly establish regional service areas. By August 1, 2014, the Washington State Association of Counties may propose the composition of 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 term "regional support network" is changed to "behavioral health organization."

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. Contracts for behavioral health 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 Medicaid managed care organization. Counties which adopt full integration by January 1, 2016 may receive an incentive payment equal to 10 percent of savings realized by the state within the regional service area.

Behavioral health organizations must offer contracts to Medicaid managed health care systems or primary care practice settings to promote access to the services of chemical dependency professionals and mental health professionals that are integrated into primary care settings for patients with behavioral health and medical comorbidities.

The Department and the Authority must report to the Legislature and the Governor by December 1, 2018 as to the preparedness of each regional service area to provide mental health, chemical dependency, and physical health services to Medicaid clients under a fully integrated managed health care system. The community behavioral health program must be fully integrated in a managed care health care system for mental health, chemical dependency, and physical health care by January 1, 2020.

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;
- 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;
- performance and compliance monitoring mechanisms;
- 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 and recovery 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.

Allows a regional support network or behavioral health organization to establish reasonable limitations on the administrative costs charged by agencies that contract with the regional support network or behavioral health organization.

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 and recovery 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 services, community support services, resource management services, and supported housing and supported employment services.

Contracting for Chemical Dependency Services.
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. The program may include peer support, supported housing, supported employment, crisis diversion, or recovery support services. Criminal Justice Treatment Account funds may not be used for purchasing managed care services for Medicaid enrollees.

Medicaid Managed Care Contracts.
By April 1, 2016, Medicaid managed health care systems must offer contracts to behavioral health and recovery 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.

Plan for Integrated Care for Foster Children.
The Department and the Authority must develop a plan to provide integrated managed health and mental health care for foster children enrolled in Medicaid. The plan must address the necessary steps to implement and operate an integrated program for foster children. The plan must meet the requirements for providing mental health services to children under the *T.R. v. Dreyfus and Porter* settlement. The plan must be submitted to the Legislature by December 1, 2014.

Information Disclosure Practices.
Records of persons confined in jail may be released to the Washington State Institute for Public Policy, the Department, the Authority, higher education institutions of Washington state, State Auditor's Office, Caseload Forecast Council, or Office of Financial Management for the purpose of research in the public interest.

The Department and the Authority are prohibited from releasing any public reports of client outcomes unless the data have been deidentified and aggregated so that client identities cannot be determined. The Department, the Authority, and service contracting entities must establish record retention schedules for maintaining performance measure and outcome data reported by service contracting entities.

Certificate of Need.
Hospitals changing the use of licensed beds to increase the number of beds to provide psychiatric services, including involuntary treatment services, are exempt from certificate of

need requirements during fiscal year 2015. The certificate of need exemption shall be valid for two years.

Chemical Dependency Professionals.
Individuals who are credentialed as chemical dependency professionals or chemical dependency professional trainees and are also licensed in certain professions may treat patients in settings other than those approved by the Department. The specific professions are advanced registered nurse practitioner, marriage and family therapist, mental health counselor, advanced social worker, independent clinical social health worker, psychologist, osteopathic physician, osteopathic physician assistant, physician, or physician assistant.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: 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 Health System Task Force, which contains an emergency clause and takes effect immediately; and sections 7, 10, 13 through 54, and 56 through 84, and 86 through 104 of this act, relating to standards for mental health and chemical dependency programs, which take effect April 1, 2016, and section 85, relating to discharge planning for persons involuntarily committed, which takes effect July 1, 2018.

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

(In support) Integrating mental health services, chemical dependency services, and primary medical care makes sense to improve care, improve outcomes, have accountability, promote recovery, and achieve fiscal savings. This legislation is the next logical step in the Legislature's direction toward having accountability for outcomes and improved performance for mental health and chemical dependency services and increased use of effective practices. The system needs to be able to adapt and serve people's needs in a setting that works for them. There needs to be a full array of services for people, whether they are only chemically dependent, only mentally ill, or are experiencing both. Moving chemical dependency into managed care has several benefits, including actuarial soundness requirements and flexibility that does not exist in a fee-for-service system.

There is support for the bi-directional integration of behavioral health and primary care, the early convening of the Adult Behavioral Health System Task Force (Task Force), the move away from fee-for-service chemical dependency funding, the protection of essential behavioral health system infrastructure and capacity. Counties support substance abuse integration with mental health and primary health care because it acknowledges that individuals in behavioral health care programs have disproportionately poor health outcomes. Moving to full integration requires attention to the safety net that is currently in place and that it not be undermined. There is support for moving the substance abuse system from a fee-for-service system to a capitated system, the studying of provider rates, and having three county members.

The Task Force should be an open table concept and provide an environment for people to be involved. Chemical dependency providers would like to ensure that their concerns are addressed by the Task Force and that there is a continuum of programs and recovery supports specific to people with chemical dependency issues.

Several components from the House bill should be incorporated into this bill: moving chemical dependency services into managed care, having a process for entering into managed care contracts for chemical dependency services, having consistency between mental health and chemical dependency recovery support services, allowing counties to become early adopters of full integration, renaming regional support networks as "behavioral health organizations," and allowing behavioral health organizations and medical managed care plan contracts to integrate into each other's services.

(In support with amendment(s)) The bill should specify that Criminal Justice Training Act funding is not affected. The direction of the Senate bill is good because of the Task Force involvement with chemical dependency. There are several amendments that should be considered. It is important to acknowledge that there is a continuum of care.

(Opposed) None.

Staff Summary of Public Testimony (Appropriations):

(In support) The purchasing of mental health and chemical dependency services needs to be integrated and it is good to have a specified date of April 2016 for doing this. Language should be added to require the Department to have a plan to assure the state is able to meet requirements for federal Medicaid contracting. The proposed House of Representatives budget included funding for actuarial work and other infrastructure required to move chemical dependency into managed care in a way that will ensure improved system performance.

The language which allows contracts for fully integrated services in counties which agree to this should be included in the final bill. The Task Force should be required to identify key issues for getting to full integration with physical healthcare by 2019 or 2020.

The integration of mental health and chemical dependency funding will lead to efficiencies at the state, regional, and provider level. There may be a need for future policy changes that would require private health plans to pay for services that are currently excluded such as crisis intervention and evaluation and treatment services.

There is a good representation of counties on the Task Force included in the bill and the counties have already identified members and work groups to support this effort. The task force provides a forum to identify system outcomes that will lead to efficiencies that can be reinvested in the system.

There are disproportionate poor health outcomes for individuals with behavioral health disorders. On average, these individuals die 25 years younger than the general population, mostly from treatable and preventable chronic illnesses. Integrated care provides the best outcomes for this population.

Integration of mental health and chemical dependency services at the county level has already resulted in an increase in coordinated care for those with co-occurring disorders. There is work being done at the provider level to integrate mental health and primary care treatment through federal grants. Resources and time are required to make sure the services are designed to meet the specialized needs of different populations as one size does not fit all.

(Other) The Senate version of the bill is preferable because it gives the Task Force the time needed to look at the issues related to integrating mental health and chemical dependency into primary care. Chemical dependency services should be moved from fee-for-service to managed care.

(Opposed) None.

Persons Testifying (Health Care & Wellness): (In support) Senator Darneille, prime sponsor; Andi Smith, Office of the Governor; Jane Beyer, Department of Social and Health Services; Gregory Robinson, Washington Community Mental Health Council; and Abby Murphy and Jim Vollendroff, Washington State Association of Counties.

(In support with amendment(s)) Melanie Stewart, Pierce County Alliance; Michael Transue, Seattle Drug and Narcotics Treatment Center; and Melissa Johnson, Association of Alcoholism and Addiction Programs.

Persons Testifying (Appropriations): (In support) Andi Smith, Office of the Governor; Jane Beyer, Department of Social and Health Services; Gregory Robinson, Washington Community Mental Health Council; Abby Murphy, Washington State Association of Counties; and Jean Robertson, King County Regional Support Network.

(Other) 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.