HOUSE BILL REPORT
2SSB 6312

As Reported by House Committee On:
Health Care & Wellness
Appropriations

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].

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

- Changes 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 contract requirements for the purchase of behavioral health services for Medicaid and non-Medicaid clients and factors to consider in the purchasing process.
- Establishes a process for awarding managed care contracts for mental health and chemical dependency services to behavioral health and recovery organizations, effective April 1, 2016.
- 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 must 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).

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.
The Task Force must review additional topics. 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 October 1, 2014, regarding:

- the creation of common regional service areas for purchasing behavioral health and medical care services by the Department and the Health Care Authority (Authority);
- the design and requirements of future Medicaid behavioral health and health care delivery systems and purchasing; and

- state interactions with the Centers for Medicare and Medicaid Services related to the purchasing of Medicaid mental health services if guidance is received detailing recommendations for changing state purchasing.

In addition, the Task Force must provide recommendations by January 1, 2015, regarding the creation of a statewide behavioral health ombuds office.

The membership of the Task Force is expanded to include three members appointed by the Washington State Association of Counties. The Task Force begins on April 1, 2014, rather than May 1, 2014.

Regional Service Areas.
If the Task Force recommends the creation of regional service areas, the Department and the Authority may jointly establish regional service areas by March 1, 2015. By September 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 services, and behavioral health crisis response resources.

When counties form a regional support network, it must be consistent with the boundaries of a regional service area.

Contracting for Behavioral Health Services.
The term "behavioral health services" is defined to include both community mental health services and chemical dependency services. The Department and Authority contracts 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;
- 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 to and experience in serving low-income populations;
- commitment to and experience in 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 regional support networks, 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 regional support networks 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 regional support networks 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 regional support networks, 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 regional support network programs, including peer support counseling, community support services, resource management services, and supported housing and supported employment services.

Contracting for Chemical Dependency Services.
Any regional support network contract for behavioral health services or program 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.

Appropriation: None.

Fiscal Note: Available.

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 takes effect immediately; and sections 4 through 17, relating to standards for mental health and chemical dependency programs, which take effect April 1, 2016.

Staff Summary of Public Testimony:

(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.

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

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).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

Adult Behavioral Health System Task Force.
Four additional legislators are added to the Task Force and participants are added from the Department of Commerce, chemical dependency advocates, chemical dependency experts from drug courts, and associated delivery systems.

The Task Force is no longer required to make recommendations on the design of the future Medicaid behavioral health and health care delivery and purchasing system; interactions with the federal government; the availability of means to promote recovery and prevent harm from mental illness; or public safety practices involving persons with mental illness with forensic involvement.

The Task Force is required to provide recommendations as needed to facilitate the full integration of medical and behavioral health purchasing by January 1, 2020, with attention to workforce and provider issues, performance measures, incentives to reduce criminal justice system utilization, obstacles to sharing health care information, and other key issues. The Task Force must review and make recommendations on detailed plan criteria to be used for awarding contracts to behavioral health and recovery organizations and on the appropriate use of Criminal Justice Treatment Account funding in a fully integrated behavioral health and physical health care system. The Task Force must review variations in commitment rates in different jurisdictions across the state.

Regional Service Areas.
The creation of regional service areas is no longer contingent upon recommendations from the Task Force, and the Department and the Authority must create up to nine regional service areas by October 1, 2014. Recommendations from the counties to the Task Force related to the creation of regional service areas must be submitted by August 1, 2014, rather than September 1, 2014. Recommendations from the Task Force to the Governor on the creation of regional service areas must be submitted by September 1, 2014, rather than by October 1, 2014. Managed care contracts for behavioral health services and for health system contracts under chapter 74.09 RCW must use the same geographic regions effective April 1, 2016.

Contracting for Behavioral Health Services.
The term "regional support network" is changed to "behavioral health and recovery organization."

Contracts for behavioral health and recovery organizations must require a continuum of chemical dependency services, make available medically necessary mental health and chemical dependency treatment, include injunctive remedies for failure to comply with contract requirements, and maintain the independence of designated chemical dependency specialists.

The Department must purchase mental health and chemical dependency services primarily through managed care contracting but may continue to purchase services from tribal clinics and tribal providers. Services and funding provided through the Criminal Justice Treatment Account are exempt from the managed care contracting requirement.

The Department must request a detailed plan from counties, groups of counties, or private entities currently serving as a regional support network as to how they are able to provide behavioral health services within a regional service area that meet federal and state requirements including but not limited to: (1) having a sufficient network of mental health and chemical dependency providers; (2) the ability to maintain and manage adequate reserves; and (3) maintenance of quality assurance processes. The Department must award a contract that will be effective April 1, 2016, to responding entities that submit a detailed plan demonstrating they can meet these requirements. Prior to January 1, 2020, the Department and the Authority may jointly purchase behavioral health services through an integrated medical and behavioral health services contract upon the request of one or more county authorities.

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 purchasing system. The Department and the Authority must use a fully integrated managed care health care purchasing system for mental health, chemical dependency, and physical health care by January 1, 2020.

A requirement under current statute for the Department to assure the availability of an appropriate amount of community-based, geographically distributed residential services as determined by the operating budget is removed.

Contracts for behavioral health services must require behavioral health organizations to offer contracts to managed health care systems or primary care settings to integrate chemical dependency and mental health services in primary care settings and ensure medically necessary chemical dependency treatment services are available to clients.

The Department and the Authority are prohibited from releasing any public reports of client outcomes unless the data have been de-identified and aggregated so that client identities cannot be determined.

Physical Healthcare Services for Medicaid Clients.
The managed health care system contractor for physical healthcare services (e.g. Healthy Options) must offer contracts to behavioral health and recovery organizations, mental health providers, or chemical dependency treatment providers to provide access to primary care services integrated into behavioral health clinical settings for individuals with behavioral health and medical comorbidities. These contracts must use the regional service areas established under the bill, effective April 1, 2016.

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.

Certification Requirements for Chemical Dependency Professionals and Trainees.
Individuals who are credentialed as CDPs or CDPTs and are also licensed in any of the following professions may treat patients in settings other than those approved by the Department:

- 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.

Contracting for Chemical Dependency Services.
Current services under statutes for the state chemical dependency program are provided with additional clarification including: (1) detoxification services must be available 24 hours a day; and (2) outpatient treatment must include medication-assisted treatment. The program must include contracts with at least one provider for case management and residential treatment services for pregnant and parenting women and may include peer support, supported housing, supported employment, crisis diversion, or recovery support services. The Criminal Justice Treatment Account funds are exempted from being used for managed care purchasing.

Makes technical and terminology corrections.

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 System Task Force, which takes effect immediately; sections 6, 7, 9 through 71, and 73 through 93 relating to standards for mental health and chemical dependency programs, which take effect April 1, 2016; and section 72 relating to transitions from state hospitals which takes effect on July 1, 2018.

Staff Summary of Public Testimony:

(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: (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: None.