# SENATE BILL REPORT
# 2SSB 6312

As Amended by House, 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**: Human Services & Corrections: 1/28/14, 2/05/14 [DPS-WM].
Ways & Means: 2/10/14, 2/11/14 [DP2S].
Passed Senate: 2/14/14, 49-0.
Passed House: 3/05/14, 69-29; 3/12/14, 75-22.

## SENATE COMMITTEE ON HUMAN SERVICES & CORRECTIONS

**Majority Report**: That Substitute Senate Bill No. 6312 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators O'Ban, Chair; Pearson, Vice Chair; Darneille, Ranking Member; Hargrove and Padden.

**Staff**: Kevin Black (786-7747)

## SENATE COMMITTEE ON WAYS & MEANS

**Majority Report**: That Second Substitute Senate Bill No. 6312 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Hill, Chair; Baumgartner, Vice Chair; Honeyford, Capital Budget Chair; Hargrove, Ranking Member; Keiser, Assistant Ranking Member on the Capital Budget; Ranker, Assistant Ranking Member on the Operating Budget; Bailey, Becker, Billig, Braun, Conway, Dammeier, Fraser, Frockt, Hasegawa, Hatfield, Hewitt, Kohl-Welles, Padden, Parlette, Rivers, Schoesler and Tom.

**Staff**: Carma Matti-Jackson (786-7454)

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*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.*

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

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

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

- the means by which services are delivered for adults with mental illness and chemical dependency disorders;
- availability of effective means to promote recovery and prevent harm associated with mental illness;
- crisis services, including boarding of mental health patients outside of regularly certified treatment beds;
- best practices for cross-system collaboration between behavioral health treatment providers, medical care providers, long-term care service providers, entities providing health home services to high-risk Medicaid clients, law enforcement, and criminal justice agencies; and
- public safety practices involving persons with mental illness with forensic involvement.

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

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

**Summary of Second Substitute Bill**: The start date of the Behavioral Health Task Force is accelerated to April 1, 2014. Three voting members appointed by the Washington Association of Counties (WSAC) are added to the taskforce. The mission of the taskforce is expanded to include making recommendations related to the following: purchasing behavioral health services; the creation of common regional service areas for purchasing behavioral health and medical care services; the design of future behavioral health purchasing contracts; advice regarding future state interactions with CMS concerning behavioral health purchasing provided that CMS provides written guidance concerning its rationale for changing state purchasing; and whether a statewide behavioral health ombuds office should be created. Additional reports from the taskforce are required in October of 2014.

If the establishment of regional services areas is recommended by the Adult Behavioral System Task Force, DSHS and HCA may establish common regional service areas for behavioral health and medical care purchasing by March 1, 2015. WSAC must be permitted to propose composition of regional service areas by September 1, 2014. Each regional service area must contain a sufficient number of Medicaid lives to support full financial risk managed care contracting, include full counties which are contiguous with each other, and reflect natural referral patterns and shared service resources.

DSHS is given explicit authority to coordinate with HCA in order to contract for chemical dependency services through contracts for integrated behavioral health services or managed care.

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

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

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

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

**Appropriation**: None.

**Fiscal Note**: Available.

**Committee/Commission/Task Force Created**: No.

**Effective Date**: The bill contains several effective dates. Please refer to the bill.

**Staff Summary of Public Testimony on Original Bill (Human Services & Corrections)**: PRO: Research and data tell us that integration of health services improves patient care, promotes recovery, and saves taxpayer dollars. The impetus for these changes comes from a mandate from CMS. This bill takes a first step toward the integration of mental health and chemical dependency, moving from a fee-for-service system into managed care. We should design a system that provides continuity of care for the health needs of the whole population. This bill retains the RSN's right of first refusal. The way we purchase behavioral health services needs to reflect meaningful outcomes and increase opportunities for integration of behavioral health and medical care. We must incentivize co-location of behavioral health and medical providers. The RSNs would change under this bill. The Legislature should consider whether to rename RSNs as behavioral health organizations. The existing chemical dependency system works well, and creates significant savings in health and criminal justice systems. We support integration of chemical dependency treatment with primary care, but do not see the utility in integrating with behavioral health organizations. We must maintain the integrity of the chemical dependency system that has developed over the past 40 years. Persons with complex needs are best served by a coordinated, integrated approach. Please do not remove from statute the list of services that RSNs are required to cover. Medicaid expansion will bring increases in demand for services and increases in federal resources. Parity rules apply to chemical dependency treatment as well as mental health. We need existing chemical dependency providers, mental health providers, and co-occurring disorder providers. System change has real impacts on vulnerable persons and can bring unintended consequences. Please do not underestimate the disruption that could occur if the state moves too far and too fast. We believe that consolidation of service regions is a local issue. The money that was proposed for reprocurement in the Governor's budget should be redirected to an actuarial study of Medicaid rates for chemical dependency services.

OTHER: There is great angst in the provider community about behavioral health organizations taking over provider contracts. This bill should be amended to ensure that the investments that existing chemical dependency providers have made to the community and state are recognized and preserved. We could be put out of business by this decision. Existing chemical dependency providers should be added to the taskforce. Please give the providers a voice. We should amplify the services we already provide, and find ways to pay for expansion of these services.

**Persons Testifying (Human Services & Corrections)**: PRO: Andi Smith, Office of the Governor; Jane Beyer, DSHS; Scott Munson, Sundown M Ranch; Seth Dawson, National Alliance on Mental Illness WA; Ann Christian, WA Community Mental Health Council; Abby Murphy, WA State Assn. of Counties.

OTHER: David Laws, Prosperity Wellness Center; Beth Dannhardt, Triumph Treatment Services.

**Staff Summary of Public Testimony on Recommended First Substitute (Ways & Means)**: PRO: We support the goal of this bill to integrate chemical dependency mental health with primary care physical health. Local decision making is preserved. The bill does not remove the counties' first right of refusal. The approach of having the taskforce weigh in and make recommendations on the boundaries of these regions is acceptable.

OTHER: This mandates that we integrate how we fund chemical dependency and mental health services. Often times function follows funding and if we want to get to integration at the clinical level, it makes sense to integrate the way we do our finances. It aligns our various health systems, whether they are mental health, physical health, or chemical dependency, to be thinking and planning in the same regional areas. Even if a full procurement is not required, bringing chemical dependency into the mental health system takes a whole set of work that would still require developing an actuarial sound rate, bringing information systems together to promote integrated services, and a more active role from DSHS with respect to the providers we contract with for fiscal integrity, quality services, and access to clients. We believe the actuarial development of new rates is needed. The preference would be for integration of chemical dependency into the physical health managed care plans now. There is already experience with integrating chemical dependency with managed care plans on the private insurer side and chemical dependency agencies already contract with managed care organizations. The taskforce is where a lot of this work should be done. There is a little too much prescription in the bill and more should be left to the taskforce.

**Persons Testifying (Ways & Means)**: PRO: Abby Murphy, WA State Assn. of Counties.

OTHER: Melissa Johnson, Assn. of Alcoholism & Addictions Programs; Andi Smith, Governor's Office; Jane Beyer, DSHS.

**House Amendment(s)**: DSHS and HCA may designate regional service areas after receiving guidance from the taskforce.

DSHS must integrate chemical dependency purchasing primarily with managed care contracts administered by RSNs, exempting the Criminal Justice Treatment Account, by April 1, 2016. On that date, RSNs are renamed behavioral health and recovery organizations (BHOs). Counties or RSNs corresponding to regional service areas must submit a detailed plan demonstrating capacity to serve as BHOs; if an adequate plan is submitted, the counties or RSN must be awarded the contract in that region. BHOs must offer contracts to managed health care systems for co-location of behavioral health professionals in primary care settings, and vice versa.

DSHS and HCA integrate the community behavioral health program into a managed health care system that provides fully integrated mental health services, chemical dependency services, and medical services to Medicaid clients by January 1, 2020. A report on readiness for full system integration must be submitted by December 1, 2018. A group of county authorities corresponding with a regional service area may request earlier integration of medical and behavioral health service purchasing in the regional service area. Counties which do so by January 1, 2016, may receive incentives of up to 10 percent of state savings in their regions related to outcome and performance measures.

The voting membership of the taskforce is altered. The taskforce obligations are expanded to include making recommendations related to performance measures and outcomes related to managed care contracts; obstacles to sharing of health care information across practice settings; identification of key issues for integration of physical and behavioral health by 2020; whether to create of a statewide behavioral health ombuds office; whether the requirements for the state chemical dependency program should be amended to mandate specific services, and a review of involuntary commitment disparities across jurisdictions.

Certificate of need requirements are suspended in fiscal year 2015 for hospitals that change the use of licensed beds to increase the number of beds used to provide psychiatric services. A person licensed as a chemical dependency professional or chemical dependency professional trainee may treat patients in settings other than programs approved under chapter 70.96A RCW if the person is licensed in another specified health care profession. DSHS and HCA must develop a plan to provide integrated medical and behavioral health care to foster children by December 1, 2014. Jails may share booking data with specified entities for the purpose of research in the public interest. Terminology is updated relating to chemical dependency, including changing references to "alcoholics" and "drug addicts" to "persons with a substance use disorder."