HOUSE BILL REPORT
2ESHB 1388

As Passed Legislature

Title: An act relating to changing the designation of the state behavioral health authority from the department of social and health services to the health care authority and transferring the related powers, functions, and duties to the health care authority and the department of health.

Brief Description: Changing the designation of the state behavioral health authority from the department of social and health services to the health care authority and transferring the related powers, functions, and duties to the health care authority and the department of health.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Cody, Rodne, Harris, Macri and Frame; by request of Governor Inslee).

Brief History:

Committee Activity:

Health Care & Wellness: 1/31/17, 2/17/17 [DPS];
Appropriations: 2/24/17 [DPS(HCW)].

Floor Activity:

Passed House: 3/2/17, 73-25.
Passed House: 5/25/17, 68-26.
Passed House: 2/7/18, 98-0.
Passed Senate: 2/28/18, 44-2.
Passed Legislature.

Brief Summary of Second Engrossed Substitute Bill

- Transfers responsibilities for the oversight and purchasing of behavioral health services from the Department of Social and Health Services (DSHS) to the Health Care Authority, except for the operation of the state hospitals.
- Transfers responsibilities for the certification of behavioral health providers from the DSHS to the Department of Health.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

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.

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 14 members: Representatives Cody, Chair; Macri, Vice Chair; Graves, Assistant Ranking Minority Member; Clibborn, DeBolt, Harris, Jinkins, MacEwen, Riccelli, Robinson, Rodne, Slatter, Stonier and Tharinger.

Minority Report: Do not pass. Signed by 3 members: Representatives Schmick, Ranking Minority Member; Caldier and Maycumber.

Staff: Chris Blake (786-7392).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill by Committee on Health Care & Wellness be substituted therefor and the substitute bill do pass. Signed by 26 members: Representatives Ormsby, Chair; Robinson, Vice Chair; MacEwen, Assistant Ranking Minority Member; Stokesbary, Assistant Ranking Minority Member; Bergquist, Buys, Cody, Fitzgibbon, Haler, Hansen, Harris, Hudgins, Jinkins, Kagi, Lytton, Nealey, Pettigrew, Pollet, Sawyer, Senn, Springer, Stanford, Sullivan, Tharinger, Vick and Wilcox.

Minority Report: Do not pass. Signed by 6 members: Representatives Chandler, Ranking Minority Member; Caldier, Condotta, Schmick, Taylor and Volz.

Minority Report: Without recommendation. Signed by 1 member: Representative Manweller.

Staff: Catrina Lucero (786-7192).

Background:

Administration of Medical Assistance.

The Health Care Authority (Authority) administers the Medicaid program which is a state-federal program that pays for health care for low-income state residents who meet certain eligibility criteria. Federal law requires each state that participates in Medicaid to designate a single state agency responsible for administration and supervision of the state's Medicaid program. Since 2011, in Washington, that agency has been the Authority.

The Authority primarily administers the Medicaid program through contracts with managed care organizations under the name "Washington Apple Health." The managed care organizations provide a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services. There are currently six managed care organizations participating in Washington Apple Health.

Administration of Community Behavioral Health Services.

Since April 1, 2016, the Department of Social and Health Services (DSHS) has contracted with behavioral health organizations to oversee the delivery of mental health and substance use disorder services for adults and children. A behavioral health organization may be a

county, group of counties, or a nonprofit entity. Behavioral health organizations are paid by the state on a capitation basis and funding is adjusted based on caseload. Behavioral health organizations 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.

In 2014 legislation was passed to direct all behavioral health services to be integrated into Medicaid managed organizations by April 2020. In one regional service area in Southwest Washington, behavioral health services have already been integrated into the contracts of Medicaid managed care organizations.

Behavioral health organizations are also responsible for the administration of community-based commitments and services under the Involuntary Treatment Act, which is the statutory scheme that governs the civil commitment of persons who, due to a mental disorder, pose a likelihood of serious harm or are gravely disabled. Inpatient commitments for 90 or 180 days of treatment take place at one of two state hospitals operated by the DSHS. Under the involuntary substance use disorder treatment system, an adult or minor may be committed upon a finding by clear, cogent, and convincing evidence that the person, due to substance use disorder, poses a likelihood of serious harm or is gravely disabled. In 2016 the Legislature enacted Engrossed Third Substitute House Bill 1713 which integrates the involuntary treatment systems for substance use disorders and mental health, effective April 1, 2018.

Behavioral Health Licensing Activities.

The DSHS certifies behavioral health programs that meet established standards, including evaluation and treatment facilities, substance use disorder treatment providers, crisis stabilization units, and triage facilities. The Department of Health (DOH) licenses and certifies several behavioral health professionals, including social workers, mental health counselors, marriage and family therapists, psychologists, and chemical dependency professionals who meet educational, experience, and examination requirements established by the DOH.

Summary of Second Engrossed Substitute Bill:

Responsibilities of the Health Care Authority.

The Health Care Authority (Authority) is designated as the state behavioral health authority, rather than the Department of Social and Health Services (DSHS), and is recognized as the single state authority for substance use disorders and mental health. Responsibilities for the community mental health system are transferred from the DSHS to the Authority, including developing the state behavioral health program, developing contracts with behavioral health organizations, and any Medicaid waiver requests to the federal government. The Authority assumes the responsibility for establishing behavioral health organization and regional service area boundaries. In the event that a behavioral health organization fails to meet state minimum standards, the Authority may be designated as the new behavioral health organization.

The responsibility for substance use disorder programs is shifted from the DSHS to the Authority. These responsibilities include developing statewide and local programs for the prevention of drug addiction, assuring that contracts for substance use disorder services provide medically necessary services, coordinating substance use disorder activities with other agencies, and developing and implementing educational programs for persons with substance use disorders.

The responsibility for administering the Involuntary Treatment Act is changed from the DSHS and the behavioral health organizations to the Authority and the behavioral health organizations. If the behavioral health organizations are not able to agree upon an allocation of state hospital beds for each behavioral health organization, the Authority must make the determination. The Authority assumes the responsibility for making single-bed certification decisions, adopting standard reporting forms and receiving reports from designated mental health professionals and designated crisis responders, and sharing reports with behavioral health organizations. The Authority must combine the functions of designated mental health providers and designated chemical dependency specialists into the single role of a designated crisis responder.

Responsibilities are shifted from the DSHS to the Authority to evaluate the quality, effectiveness, efficiency, and use of services and standards for commitment, and establish criteria and procedures for the placement and transfer of committed minors. The Authority assumes oversight duties for psychiatric or substance use disorder evaluations of minors. The Authority assumes responsibilities for minors placed on 180-day inpatient commitments. The Authority and the DSHS share authority over minors who fail to comply with less restrictive alternative treatment conditions.

Notifications related to the restoration of a person's right to possess a firearm are sent to the Authority, rather than the DSHS. The DSHS's electronic database that must be consulted when determining eligibility to possess a firearm is changed to the Authority's electronic database.

Psychiatric nurse practitioners are added to the definition of "mental health professionals" in the children's mental health laws and integrated crisis response laws. The requirement that psychiatric nurses have either two or three years of experience treating persons with mental health conditions is removed.

The Authority must collaborate with the county authorities within a regional service area, upon the counties' request, to establish an interlocal leadership structure. The interlocal leadership structure must include participation from counties and managed health care systems and representation from physical and behavioral health providers, tribes, and other entities in the regional service area. The purpose of the interlocal leadership structure is to design and implement a fully integrated managed care model for the regional service area that places clients at the center of care delivery and supports the integrated delivery of physical and behavioral health care. The interlocal leadership structure may address:

- aligning contracting and administrative functions;
- monitoring implementation of fully integrated managed care in the regional service area;

- developing a regional service area process for coordinating capital infrastructure requests, local capacity building, and other community investments;
- identifying and using measures and data to track and maintain regional service area accountability for delivery system performance; and
- discussing the possibility of managed health care systems subcontracting with county or local administrative service organizations to provide services to support a bi-directional system of care.

For regional service areas that adopt fully integrated managed care after 2016 and prior to 2020, the interlocal leadership structure must be allowed one year to develop and implement a local plan to transition to fully integrated managed care. The local plan may include provisions for county organizations to maintain existing contracts until 2019. Interlocal leadership structures expire on December 1, 2021, unless continued by the local leadership group.

Responsibilities of the Department of Health.

The responsibility for certifying and licensing behavioral health service providers is transferred from the DSHS to the DOH. The DOH assumes the responsibility for establishing minimum standards for service providers and community support services and for disciplining those entities that do not meet the standards. The licensing and certification functions apply to evaluation and treatment facilities, crisis stabilization units, clubhouses, triage facilities, substance use disorder programs, and secured detoxification facilities. The DOH must develop notifications for evaluation and treatment facilities, emergency departments, and inpatient facilities to give to parents regarding all treatment options available for a minor.

Persons who are licensed as mental health counselors, mental health counselor associates, marriage family therapists, or marriage family therapist associates are added to the list of professions who may become designated crisis responders.

Responsibilities of the Department of Social and Health Services.

The DSHS retains authority over the operation and maintenance of the state hospitals and the Child Study and Treatment Center.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect July 1, 2018, except for sections 3010, 3013, 3027, 5018, and 5021, relating to the integration of the mental health commitment and substance use disorder commitment systems, which take effect July 1, 2026.

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

(In support) Legislation in 2014 set out a bipartisan vision and a mandate to integrate care for substance use disorders, mental health conditions, and physical health. With the goal to treat

the whole person, the delivery system, as well as the state's agencies, must integrate to operate most efficiently. The Legislature has established policy guidance that behavioral health would be purchased and provided within a fully-integrated managed care system, so it makes sense to move the behavioral health program to the Health Care Authority (Authority) because of the depth of the staff's programmatic and clinical knowledge about the population and the availability of community services. The bill aligns with the work that Medicaid managed care organizations want to see from full integration. This bill will help a complex population not get lost in the health system.

The time is right to align the state's limited resources to best support integration of behavioral and physical health. This is good and efficient government. As the state moves toward integration, it makes sense to consolidate all funding at the Authority. If the change is not made now, then more time is lost in advance of full integration in 2020. This bill will provide a single point of accountability.

There should be a timeline for state hospital integration to occur since they are a part of the continuum of care and this could lead to fragmentation and perverse incentives. There is support for moving licensing and certification functions, including substance use disorder programs, to the Department of Health; however, an advisory committee should be established for oversight of the community mental health and substance use disorder providers to promote direct communication and streamline administrative burdens.

(Opposed) None.

(Other) Behavioral health organizations support the goal to integrate behavioral health and physical health care, but this may not be a prudent time to make such sweeping changes while federal Medicaid policy is unsettled. If there will be fewer Medicaid dollars in the future, it does not make sense to dismantle the existing county-administered behavioral health system which also benefits from the contribution of local dollars. It makes more sense to build on the existing system and find more ways to integrate the financing and treatment that use the strengths of both the behavioral health organizations and the managed care organizations. The behavioral health organizations and counties have recently made investments in strengthening and expanding the substance use disorder treatment system and integrating it with mental health treatment.

The merger makes sense, but this is a good chance to split off the Criminal Justice Account and give it to the court system because this is not really a health program. This is money that is saved by not sending people to prison. This account belongs at the Administrative Office of the Courts. There are references to psychiatrists that do not reference osteopathic physicians.

Staff Summary of Public Testimony (Appropriations):

(In support) None.

(Opposed) None.

Persons Testifying (Health Care & Wellness): (In support) Jason McGill, Office of the Governor; Patty Seib, Molina Health Care; Ann Christian, Washington Council for Behavioral Health; Seth Dawson, National Alliance on Mental Illness; and Scott Munson, Association of Alcohol Abuse Prevention.

(Other) Joe Valentine, North Sound Behavioral Health Organization; Bob Cooper, Washington State Association of Drug Court Professionals; and David Knutson, Washington Osteopathic Medical Association.

Persons Testifying (Appropriations): None.

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

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