SENATE BILL REPORT
2EHB 2107

As Reported by Senate Committee On:
Human Services & Corrections, February 23, 2018

Title: An act relating to the addition of services for long-term placement of mental health patients in community settings that voluntarily contract to provide the services.

Brief Description: Concerning the addition of services for long-term placement of mental health patients in community settings that voluntarily contract to provide the services.

Sponsors: Representatives Schmick, Cody and Ormsby.

Brief History: Passed House: 3/01/17, 98-0; 5/25/17, 94-0; 1/22/18, 95-0.
Committee Activity: Human Services & Corrections: 2/20/18, 2/23/18 [DPA].

Brief Summary of Amended Bill

- Requires the Health Care Authority (HCA) to integrate risk for long-term involuntary civil treatment into managed care contracts by July 1, 2021.
- Requires the Department of Social and Health Services (DSHS) to collaborate with HCA and appropriate stakeholders to develop a detailed transition plan, with a final report due to the Legislature by December 30, 2019.
- Requires HCA to develop a psychiatric managed care capitation risk model and submit a final draft by December 1, 2020.
- Requires DSHS to purchase a portion of the state's long-term treatment capacity allocated to Behavioral Health Organizations (BHOs) from willing and able community hospitals.
- Requires DSHS to enter into performance based contracts with willing and able facilities certified to provide 90 and 180-day involuntary treatment.
- Clarifies that 90 and 180-day treatment under the Involuntary Treatment Act (ITA) may be provided at a state hospital or any willing and able community facility certified to provide such care.

SENATE COMMITTEE ON HUMAN SERVICES & CORRECTIONS

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: Do pass as amended.

Signed by Senators Darneille, Chair; Dhingra, Vice Chair; O'Ban, Ranking Member; Carlyle, Frockt and Miloscia.

Staff: Keri Waterland (786-7490)

Background: The Office of Financial Management (OFM) contracted with Public Consulting Group (PCG) to examine the structure and financing of the adult mental health system, as provided for in the 2016 supplemental Operating Budget and directed in the Governor's veto message for ESSB 6656 (2016). The study identified key challenges in the state's existing mental health system and recommended solutions to address critical challenges related to the state's 2020 transition to full integration of physical and behavioral health. The findings and recommendations are provided in the *Washington Mental Health System Assessment: Final Alternative Options and Recommendations Report* submitted in November 2016. One of the report's recommendations was for HCA to develop a risk model to support placing Medicaid managed care organizations, including BHOs and their successor fully-integrated managed care entities, at risk for state psychiatric hospital services.

The 2017-2019 Operating Budget provided funding for HCA to continue its work with PCG to develop the risk model, requesting analysis on how to:

- integrate civil inpatient psychiatric hospital services, including 90 and 180-day commitments provided in state hospitals or community settings, into Medicaid managed care capitation rates and non-Medicaid contracts;
- phase in the financial risk such that managed care entities bear full financial risk for long-term civil inpatient psychiatric hospital commitments beginning January 2020; and
- address strategies to ensure that Washington is able to maximize the state's allotment of federal disproportionate share funding.

This resulted in the production of an *Inpatient Psychiatric Care Risk Model Report* submitted to the Legislature in December 2017, which contains 18 recommendations designed to address policy questions integral to supporting the aim of enabling fully-integrated managed care organizations to manage care for patients with complex behavioral health needs and reduce the need for institutional care at state hospitals for these patients.

The Involuntary Treatment Act (ITA) allows for the civil commitment of a person for involuntary inpatient mental health treatment if:

- the person is found to have a mental disorder;
- the person is found as a result of the mental disorder, to present a likelihood of serious harm or to be gravely disabled;
- the person is found to be unwilling to accept voluntary treatment; and
- there is no less restrictive alternative that will adequately meet the person's needs of health and safety.

DSHS contracts with BHOs to oversee the delivery of behavioral health services for persons with mental illness or substance use disorder in seven of the nine regional service areas (RSAs) established to provide coordinated regional systems of care. A BHO may be a county, group of counties, or a nonprofit or for-profit entity. Currently, five of the six BHOs

are county-based, except for Pierce, which is operated by a private entity. Two RSAs, the Southwest Washington RSA and North Central RSA, are served by fully-integrated managed care organizations contracted through the Health Care Authority (HCA). A provision of law enacted in 2006 allows DSHS to enter into performance-based contracts with BHOs to provide some or all of the BHOs allocation for long-term treatment under the ITA in the community instead of in a state hospital. Inpatient commitments for 90 or 180-day involuntary commitment orders occur at one of two state hospitals, Eastern State Hospital (ESH) or Western State Hospital (WSH), operated by DSHS. Long-term inpatient care beds at ESH and WSH are divided among the BHOs and managed care entities within the two fully-integrated RSAs with a specific allocation to each entity. If a BHO exceeds its allocation of patient days of care at a state hospital, it must reimburse DSHS for the excess days.

Summary of Amended Bill: Integrating Risk for State Hospital Treatment Into Managed Care. HCA must develop a psychiatric managed care capitation risk model and submit a final draft to the Legislature by December 1, 2020. HCA must integrate the risk for long-term involuntary civil treatment into managed care contracts by July 1, 2021.

DSHS must collaborate with HCA and the named stakeholders to develop a detailed transition plan to move the cost of state hospital civil treatment into managed care, taking into account the recommendations derived from the PCG *Washington Mental Health System Assessment: Final Alternative Options and Recommendations Report* and the *Inpatient Psychiatric Care Risk Model Report*, including:

- a methodology for division of the current state hospital beds between each of the BHOs and full integration regions;
- development of acuity-based payment rates for western and eastern state hospitals that accurately reflect case complexity;
- discharge planning procedures adapted to account for functional needs assessments upon admission;
- a means of tracking expenditures related to successful reductions of state hospital utilization by regional service areas;
- updated requirements related to civil commitments that retain the integrity of the process; and
- recommendations for contractual performance measures and withhold for BHOs and full integration regions.

A preliminary draft of this transition plan is due to the Legislature by November 15, 2019, with a final report due December 30, 2019.

BHOs must have representation, including involvement by community mental health providers, on the hospital clinical discharge planning team. The BHO definition includes successor entities as contracted by HCA.

Developing Capacity for Long-Term Involuntary Treatment in the Community. DSHS must use performance-based contracts to purchase a portion of the state's long-term treatment capacity allocated to BHOs and fully-integrated managed care entities from willing community hospitals certified to provide 90 and 180-day involuntary treatment. The contracts must specify the number of patient days of care to be provided in community hospitals and evaluation and treatment facilities. Data reporting requirements are established

for facilities which contract with DSHS to provide these services, including admission and discharge data and a requirement to report to DSHS all instances where a patient on a 90 or 180-day involuntary commitment order experiences an adverse event required to be reported to the Department of Health (DOH), and all hospital-based inpatient psychiatric service core measures reported to the joint commission or other accrediting body occurring from psychiatric departments.

DSHS must confer with DOH and community hospitals to review laws and regulations and identify changes that may be necessary to address care delivery and cost-effective treatment for adults involuntarily civilly committed for 90 or 180-days, which may be different than the requirements for short-term psychiatric hospitalization, and must report its findings to the select committee on quality improvement in state hospitals by November 1, 2018.

Court orders for 90-day treatment under the ITA must remand the person to the custody of DSHS or a designee, instead of to a specific facility. The entity responsible for the cost of care, whether a prepaid inpatient health plan, managed care organization, or DSHS, may designate a willing and able certified facility to provide care. The designation of a treatment facility must not result in a delay of the transfer of the person to a state hospital or certified treatment facility, if there is an available bed at either a state hospital or certified facility.

EFFECT OF HUMAN SERVICES & CORRECTIONS COMMITTEE AMENDMENT (S):

- Replaces language from 2EHB 2107 with language from SSB 6573, and adding further clarifying language.
- Requires the health care authority (HCA) to develop a psychiatric managed care capitation risk model, taking into account the recommendations derived from the PCG Washington *Mental Health System Assessment: Final Alternative Options and Recommendations Report* and the *Inpatient Psychiatric Care Risk Model Report*, that integrates long-term inpatient risk for long-term involuntary civil treatment provided by state hospitals, and submit a final draft to the Legislature by December 1, 2020.
- Requires HCA to integrate long-term inpatient risk for long-term involuntary civil treatment provided by state hospitals into managed care contracts by July 1, 2021.
- Requires DSHS to collaborate with HCA and invite appropriate and interested stakeholders to develop a detailed transition plan to move the cost of state hospital civil treatment into managed care, taking into account the recommendations derived from the PCG *Washington Mental Health System Assessment: Final Alternative Options and Recommendations Report* and the *Inpatient Psychiatric Care Risk Model Report*. The transition plan is due to the Legislature by December 30, 2019.
- Clarifies that stakeholders must include, but not be limited to, interested members of the Legislature, the Washington State Hospital Association (WSHA), the Association of Washington Healthcare Plans, each of the five contracted Apple Health managed care organizations or administrative services organizations if applicable, the Washington Council for Behavioral Health, and the Washington State Association of Counties.
- Updates language to reflect the BHOs include successor entities as contracted by the Authority under RCW 71.24.850(2).

- Declares the intent to purchase part of the State's capacity for 90/180-day treatment in willing community facilities that come to the table to contract with the state.
- Specifies which data must be measured and collected pursuant to contracts in language worked out and vetted with WSHA, and adds January 1, 2024, for the data reporting end date.
- Clarifies the state contracts with facilities and allocates a mix of state hospital and community beds to the BHOs/FIMCOs.
- Includes that the state must develop rules to certify 90/180-day facilities, and must consult with WSHA to determine what short-term rules are inappropriate to long-term facilities.
- Subject to funding language incorporated for 90/180-day contracts.
- Courts must remand to the custody of department or designee, not a specific facility. The payer—BHO/FIMCO/state—must designate patient placement, provided they must place in an open bed if available. Prior authorization prohibited for ITA placement.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: Supportive of this bill because it keeps people close to families and jobs. It evaluates community capacity and requires contracts if available. Appreciate working on SB 6573 and working on a required integration to managed care and believe some pieces from that bill would be good here too. Higher per diem rates to work on acuity payments and appropriate reimbursement are needed. Need a language change to address the reporting provisions of this bill and measuring outcomes in certified facilities vs. a state hospital.

Persons Testifying: PRO: Representative Joe Schmick, Prime Sponsor; Lisa Thatcher, Washington State Hospital Association; Michael Hatchett, Washington Council for Behavioral Health.

Persons Signed In To Testify But Not Testifying: No one.