HOUSE BILL REPORT
E2SSB 5432

As Passed House - Amended:
April 12, 2019

Title: An act relating to fully implementing behavioral health integration for January 1, 2020, by removing behavioral health organizations from law.

Brief Description: Concerning fully implementing behavioral health integration for January 1, 2020, by removing behavioral health organizations from law; clarifying the roles and responsibilities among the health care authority, department of social and health services, and department of health, and the roles and responsibilities of behavioral health administrative services organizations and medicaid managed care organizations; and making technical corrections related to the behavioral health system.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators Dhingra, Rivers, Cleveland, Darneille, O'Ban, Keiser, Conway, Das and Kuderer; by request of Office of the Governor).

Brief History:
Committee Activity:
Health Care & Wellness: 3/19/19, 3/27/19 [DPA];
Appropriations: 4/6/19, 4/8/19 [DPA(HCW)].
Floor Activity:
Passed House - Amended: 4/12/19, 95-0.

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

- Eliminates behavioral health organizations and divides their responsibilities between behavioral health administrative service organizations to administer crisis services and non-Medicaid services, and managed care organizations to provide behavioral health services to Medicaid enrollees.
- Establishes a work group to determine how to manage access to adult long-term inpatient involuntary care and the Children's Long-Term Inpatient Program in the community and in state hospitals.

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: Do pass as amended. Signed by 13 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Chambers, Davis, Harris, Jinkins, Riccelli, Robinson, Stonier, Thai and Tharinger.

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

Staff: Chris Blake (786-7392).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Health Care & Wellness. Signed by 32 members: Representatives Ormsby, Chair; Bergquist, 2nd Vice Chair; Robinson, 1st Vice Chair; Stokesbary, Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Rude, Assistant Ranking Minority Member; Caldier, Chandler, Cody, Dolan, Dye, Fitzgibbon, Hansen, Hoff, Hudgins, Jinkins, Kraft, Macri, Mosbrucker, Pettigrew, Pollet, Ryu, Schmick, Senn, Springer, Stanford, Steele, Sullivan, Sutherland, Tarleton, Tharinger and Ybarra.

Staff: Andy Toulon (786-7178).

Background:

Except in regional service areas with fully integrated medical care, the Health Care Authority (Authority) contracts with behavioral health organizations (BHOs) to oversee the delivery of services related to mental health and substance use disorders, collectively known as behavioral health, for adults and children. The BHOs provide services to Medicaid enrollees and limited services to non-Medicaid enrollees. The BHOs also administer the Involuntary Treatment Act and associated crisis services. A BHO may be a county, group of counties, or a nonprofit or for-profit entity. Each BHO provides services for counties within the boundaries of the regional service area in which it operates. Regional services areas are 10 geographic areas used by the Authority for purchasing health care services across the state.

The Authority also provides medical care services to eligible low-income state residents and their families, primarily through the Medicaid program. Coverage for medical services is provided through fee-for-service and managed care systems. Managed care is a prepaid, comprehensive system for delivering a complete medical benefits package that is available for eligible families, children under age 19, low-income adults, certain disabled individuals, and pregnant women.

In 2014 legislation was enacted that requires that all behavioral health services and medical care services be fully integrated in a managed care health system for Medicaid clients. Statewide full integration is required to occur by January 1, 2020, however, counties were authorized to shift services to a fully integrated system beginning January 1, 2016. As of January 2019, six of the 10 regional service areas had adopted a fully integrated medical care model.

Summary of Amended Bill:

The responsibilities of behavioral health organizations (BHOs) to oversee the delivery of services for mental health and substance use disorders, collectively known as behavioral health, is divided between either behavioral health administrative services organizations (BHASOs) or managed care organizations (MCOs). After January 1, 2020, the BHOs will no longer exist.

Functions and Responsibilities Specific to a Behavioral Health Administrative Service Organizations.
A "BHASO" is defined as an entity contracted with the Health Care Authority (Authority) to administer behavioral health services and programs for all individuals within a regional service area, including crisis services and the administration of the Involuntary Treatment Act.

A BHASO may be established by a county or group of counties submitting a request to contract with the Authority to operate a BHASO for the entire regional service area. All counties within the regional service area must mutually agree to enter into the contract with the Authority to become a BHASO. In the event of termination of the contract with the Authority, all counties within the regional service area must mutually agree to terminate it. If a BHASO for a regional service area fails to meet the Authority's contracting requirements, the Authority shall act as the BHASO for the regional service area until another BHASO is designated.

A BHASO may not contract with itself as a behavioral health agency or contract with a behavioral health agency that has administrative relationships with the BHASO in a way that would give the agency a competitive advantage in obtaining or competing for contracts. A BHASO may provide designated crisis responder services, initial crisis services, criminal diversion services, hospital reentry services, and criminal reentry services if the county-administered service has a clear separation of powers and duties separate from a county-operated BHASO and accounting procedures to ensure that funding is traceable and accounted for apart from other funds.

The BHASOs must:
- administer crisis services within the regional service area, including a behavioral health crisis hotline; continuously available crisis response services; services related to involuntary commitments for adults and minors; noncrisis behavioral health services for persons meeting contract criteria; care coordination, diversion services, and discharge planning for persons who are not enrolled in Medicaid and are transitioning from state hospitals or inpatient settings; and regional, cross-system, and cross-jurisdictional coordination with tribal governments;
- administer and provide for the availability of an adequate network of evaluation and treatment services to ensure access to treatment, investigation, transportation, court-related services, and other services;
- coordinate planning services for individuals for discharge from long-term involuntary commitment;
- administer and provide for the availability of resource management services, residential services, and community support services;
- contract with a sufficient number of licensed or certified providers for crisis services and other behavioral health services;

- maintain adequate reserves;
- establish and maintain quality assurance processes;
- meet limitations on administrative costs for agencies that contract with BHASOs;
- maintain patient tracking information;
- collaborate with local government entities to avoid shifts of persons with mental illness into correctional facilities;
- assure that the special needs of older adults, individuals with disabilities, children, and low-income persons are met;
- work to expedite the enrollment of persons leaving correctional facilities and institutions for mental disease; and
- appoint a behavioral health advisory board to provide local oversight of the BHASO's activities and resolve significant concerns regarding service delivery and outcomes.

The Authority must define administrative costs and ensure that BHASOs do not exceed an administrative cost of 10 percent of available funds.

The BHASOs are responsible for providing services to clients who are not enrolled in Medicaid.

If there is no responsible party to pay for the legal costs for attorneys appointed for minors and adults under the Involuntary Treatment Act, the BHASOs are responsible for reimbursing the county.

Each BHASO must have an ombuds program that is independent of the BHASO and MCO.

Functions and Responsibilities Specific to a Managed Care Organization.
An "MCO" is defined as an organization with a certificate from the Office of the Insurance Commissioner that contracts with the Authority under a comprehensive risk contract to provide prepaid health care services to persons enrolled in managed care programs under Medical Assistance.

An MCO must have a sufficient network of providers to provide adequate access to behavioral health services for the residents of the regional service area. An MCO must maintain quality assurance processes. An MCO must contract with the BHASO within the regional service area for the administration of crisis services. The MCO must reimburse the BHASO for behavioral health crisis services provided to the MCO's enrollees.

Shared Functions and Responsibilities.
The Authority must establish a work group to determine how to manage access to adult long-term inpatient involuntary care and the Children's Long-Term Inpatient Program in the community and at Eastern State Hospital and Western State Hospital and provide advice on the integration process. In addition, the work group shall determine how to expand bidirectional integration through increased support for co-occurring disorder services, including recommendations related to purchasing and rates. The work group shall include representatives from the Department of Social and Health Services, the Department of Health, BHASOs, MCOs, the Washington State Association of Counties, community behavioral health providers, and the Washington State Hospital Association. The work group

shall provide its recommendations to the Office of Financial Management and the appropriate committees of the Legislature by December 15, 2019.

The Authority must establish a committee to provide ongoing coordination between state agencies, the counties, and the BHASOs to coordinate the behavioral health system. The committee must meet quarterly to address systemic issues. The committee includes representatives from the Authority, the Department of Social and Health Services, the Department of Health, the Office of the Governor, one representative from the BHASO per regional service area, and one county representative per regional service area.

The BHASOs must collaborate with the Authority and MCOs to develop and implement strategies to coordinate care with tribes and community behavioral health providers for persons with a history of frequent crisis system utilization.

The BHASOs and MCOs must develop agreements with the Department of Corrections and tribal, city, and county jails to accept referrals for the enrollment of confined persons prior to their release.

The BHASOs and MCOs must provide services to persons who are involuntarily committed under a less restrictive alternative if the person is either enrolled in Medicaid or is not enrolled in Medicaid or any other insurance programs and the BHASO has adequate available resources to provide the services.

Each MCO must work closely with designated crisis responders, BHASOs, and behavioral health providers to maximize the appropriate placement of enrollees in appropriate community services while ensuring that the enrollee receives the least restrictive level of care appropriate for the enrollee's condition.

The Authority must contract not only with counties, but also with BHASOs and MCOs to provide substance use disorder services ordered by a court.

If the counties within a regional service area have established an interlocal leadership structure to design and implement the fully integrated managed care model for the regional service area, tribes must be included in the interlocal leadership structure or its committees. If there is no interlocal leadership structure for the regional service area, the roles of the BHASOs, MCOs, counties, and tribes shall be determined by the Authority through negotiations with the tribes.

Additional Provisions.
The Authority must annually review and monitor the expenditures made by counties that are funded with the Criminal Justice Treatment Account (Account). Counties must repay any funds that are not spent in accordance with the Account requirements.

The Authority shall report to the Governor's Office and the appropriate committees of the Legislature every two years regarding its monitoring of expenditures by the community behavioral health service delivery system against appropriation levels.

The Authority and the Department of Health are prohibited from establishing initial documentation requirements for patients receiving care in a behavioral health agency which are substantially more burdensome than initial documentation requirements in primary care settings, unless required by federal law or federal funding requirements.

References to "chemical dependency" are changed to "substance use disorder." References to "designated mental health professional" and "designated chemical dependency specialist" are changed to "designated crisis responder." References to "licensed or certified service providers" are changed to "licensed or certified behavioral health agencies."

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on April 3, 2019.

Effective Date of Amended Bill: This bill takes effect on January 1, 2020, except for section 2009, relating to petitions for 180-day involuntary commitments of minors, which takes effect July 1, 2026, and section 1003, relating to the establishment of a work group regarding the management of access to adult long-term inpatient involuntary care, and section 5030, relating to the definition of "facility," which contain an emergency clause and take effect immediately.

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

(In support) This bill is important for making sure that Washington is integrating mental health, substance use disorder, and physical health to make sure the entire body is treated. This is a good bill and is necessary. One of the changes made in the Senate relates to contracting with the behavioral health administrative services organizations to show there is accountability and transparency in the system and ensuring that critical work is being done.

(Opposed) None.

Staff Summary of Public Testimony (Appropriations):

(In support) None.

(Opposed) None.

Persons Testifying (Health Care & Wellness): Senator Dhingra, prime sponsor; and Rashi Gupta, Governor's Policy Office.

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.