SENATE BILL REPORT
SB 5045

As of February 21, 2019

Title: An act relating to integrating risk for long-term civil involuntary treatment into managed care.

Brief Description: Integrating risk for long-term civil involuntary treatment into managed care.

Sponsors: Senators O'Ban and Wagoner.

Brief History:
Committee Activity: Behavioral Health Subcommittee to Health & Long Term Care: 2/14/19.

Brief Summary of Bill

- Requires the Health Care Authority (HCA) to develop a risk model that fully integrates risk for long-term inpatient care into managed care organization contracts by July 1, 2023.
- Requires HCA and the Department of Social and Health Services to lead a stakeholder process to develop a detailed transition plan by January 1, 2021.
- Allows long-term inpatient care for involuntary patients to be provided by state hospitals or willing and able facilities certified to provide such care.
- Empowers managed care organizations or other entities responsible for the cost of care to designate a facility to provide court-ordered long-term inpatient care.

SENATE COMMITTEE ON BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE

Staff: Kevin Black (786-7747)

Background: Long-Term Inpatient Care. Long-term inpatient care is voluntary or involuntary inpatient treatment for a mental disorder or substance use disorder which extends for periods of 90 days or more. Involuntary treatment is provided to persons who are court-ordered to receive treatment based on a behavioral health disorder causing them to present a

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likelihood of serious harm or to be gravely disabled, and whose needs, or the needs of public safety, cannot be met in a less restrictive setting.

Responsibility for Long-Term Inpatient Care for Involuntary Patients. Managed care organizations and, until January 1, 2020, behavioral health organizations are pre-paid, risk-bearing managed care health plans that provide for the behavioral health needs of Medicaid clients and a limited number of non-Medicaid clients. These entities receive a capitated payment to provide for the clients' medically necessary health care needs which are covered by the Medicaid State Plan. Long-term inpatient care for involuntary patients is excluded from this capitated rate, and care for adult patients is provided instead at one of two state hospitals, Western State Hospital or Eastern State Hospital. Such care may also be provided at a community facility that receives a single-bed certification, or at one of a limited number of certified, contracted community facilities.

State Hospital Bed Allocations. Use of beds at the adult state hospitals is managed by means of bed allocations provided to each behavioral health organization, or managed care organizations and behavioral health administrative services organizations in regions that have moved to integrate behavioral health into managed care in advance of the statewide January 1, 2020 deadline. These entities are not charged for their use of state hospital beds unless they exceed their bed allocations, in which case they are required to pay for the cost of their excess bed use out of their non-Medicaid funding. Half of these payments are retained by the state hospitals and half is distributed as an incentive to entities who use fewer beds than their state hospital bed allocations. For many years the state hospitals have routinely run wait lists for civil treatment, which cause delays in the admission of patients who are eligible for this care.

Consultant Reports Related to the Risk for Long-Term Involuntary Care. In 2016, the Governor directed the engagement of consultants to study creation of a transition plan to change the current financing structure for long-term involuntary inpatient care in his partial veto message relating to ESSB 6656. In November 2016, a report entitled "Washington Mental Health System Assessment: Final Alternative Options and Recommendations Report" was provided by PCG Health and recommended that Washington State create a risk model by December 31, 2017, placing managed care organizations at risk for the cost of long-term inpatient care for involuntary patients by January 1, 2020. The Legislature funded the development of this risk model and the Governor again engaged PCG Health, who provided a report entitled "Inpatient Psychiatric Care Risk Model Report" on December 28, 2017. This report affirmed the recommendation for Washington State to move the risk for long-term involuntary inpatient care into managed care, and provided further analysis and recommendations.

Summary of Bill: The bill as referred to committee not considered.

Summary of Bill (Proposed Substitute): HCA must develop and implement a risk model that fully integrates risk for long-term inpatient care into managed care organization contracts by July 1, 2023. The risk model must include geropsychiatric patients and patients with intellectual and developmental disabilities and apply to all new and current individuals committed to long-term inpatient care. Managed care organizations must compensate at a minimum based on fee-for-service per diem rates.

HCA and the Department of Social and Health Services (DSHS) must lead a stakeholder process to consider issues related to the risk model and develop a detailed transition plan by January 1, 2021. The transition plan must include:

- consideration of risk allocation for adults who receive services from the long-term care and developmental disabilities systems;
- development of acuity-based payment rates, billing, and reimbursement mechanisms for use of state hospitals;
- development of appropriate payment rates for community hospitals and community facilities;
- consideration of patient safety and ways to mitigate transition risks; and
- recommendations for the timing and staging of implementation.

The transition plan must be finalized by December 1, 2021, after an opportunity for input by the Legislature and external stakeholders. The stakeholder process must include:

- interested members of the Legislature;
- HCA, DSHS, and the Department of Health;
- the Washington State Hospital Association;
- the Washington State Association of Counties;
- managed care organizations and behavioral health administrative services organizations;
- the Association of Washington Health Care Plans; and
- The Washington Council on Behavioral Health.

Long-term inpatient care for involuntary patients may be provided by a state hospital or a willing and able facility certified to provide such care. Treatment must be provided at a facility directed by the managed care organization or other entity responsible for the payment. The designation of a facility must not delay the transfer of the person out of a short-term inpatient facility if there is a bed available. Prior authorization must not be required for long-term inpatient care for involuntary patients.

Appropriation: None.

Fiscal Note: Requested on February 5, 2019.

Creates Committee/Commission/Task Force that includes Legislative members: Yes.

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

Staff Summary of Public Testimony on Proposed Substitute: PRO: This is a bill that has been introduced before, anticipating the moment we are in. We need to build out capacity to provide long-term inpatient care at the community level. If we are going to do that, which seems to be a bipartisan commitment, we have to figure out how to build out the risk. To provide continuity of care we should invest in the whole continuum, not just pieces. Since we have decided to invest through MCOs for care up to the 90-day period, it makes abundant sense to place the MCOs at risk for the whole continuum of care. When we do, we will see more investment in improved community services, so that more expensive long-term care is not needed. A behavioral health organization (BHO) once told me they don't worry about

patients who are at Western State Hospital, because the BHO is not fiscally responsible. This is the wrong mindset. We need to align the incentives to make sure the full continuum of care is properly financed so the right investments can be made upstream. Thank you for including community provider representatives in the stakeholder process. The integration of long-term inpatient care into managed care should not come at the expense of outpatient care. With this bill community agencies will be fully engaged.

OTHER: We support this concept. It makes sense to support the full continuum of care within managed care. We have ideas for technical corrections around when the risk should transfer into managed care. The year 2023 is doable, but it should start with the calendar year instead of the state fiscal year to match the rest of the rate-setting process. There should be thresholds baked in requiring sufficient community bed capacity to be developed before the risk is moved. We support the creation of the workgroup to manage this complicated process. We need to have community capacity before we take on the risk. Using fee-for-service rates as a floor allows the actuaries to build the risk model before the plans have experience with the history of encounters and services. MCOs would likely move to a more value-based contract structure within several years. Community providers who are funded for the whole continuum care may be able to transition patients faster, because of their experience providing the whole continuum. This bill would fundamentally change the risk structure. We agree this could make sense at the right time, but timing and sequence matters. We should require a planning process, or at least sufficient resources. This bill does not ensure this will happen. Please incorporate needed state hospital improvements from the underlying bill. This is the right direction to head over time. We are happy to be part of this conversation. This vision has been correct for several years, but we are concerned about the pace. MCOs do not invest to create facilities, we build programs that use networks that have been built by others. The infrastructure must be there. This is a multiyear, multipronged process. Building capacity could take six to nine years. If you transition the system with the supports not in place you risk embodying the blockages in the current system. We need to be able to discharge people if we are at risk for their care. The process called for is good. We need to start planning, but it is premature to judge the appropriate implementation date.

Persons Testifying: PRO: Senator Steve O'Ban, Prime Sponsor; Abby Moore, Washington Council for Behavioral Health.

OTHER: Chris Bandoli, Washington State Hospital Association; Len McComb, Community Health Plan of Washington; Andrea Davis, Coordinated Care; Caitlin Safford, Amerigroup; Celia Jackson, King County.

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