SENATE BILL REPORT
SB 5432

As of February 1, 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: Senators Dhingra, Rivers, Cleveland, Darneille, O'Ban, Keiser, Conway, Das and Kuderer; by request of Office of the Governor.

Brief History:
Committee Activity: Behavioral Health Subcommittee to Health & Long Term Care: 1/25/19.

Brief Summary of Bill

- Removes behavioral health organizations from law.
- Establishes managed care organizations and behavioral health organizations to manage the community behavioral health system.
- Establishes a work group led by the Health Care Authority to determine how to manage access to long-term, involuntary commitment resources in the community and state hospitals and provide a report by December 15, 2019.
- Allows counties to form provider organizations that are fiscally and operationally separate from the operation of the health network.

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

Staff: Kevin Black (786-7747)

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: Behavioral Health Organizations. The County-Based Mental Health Services Act of 1989 established county-based regional support networks (RSNs) to locally administer state and federally-funded mental health services for persons with serious mental illness. By 2016, RSNs evolved into behavioral health organizations (BHOs) which receive a capitated payment to cover the mental health needs for those Medicaid clients in their regional service area who have a level of impairment that meets access-to-care standards, and to cover the substance use disorder treatment needs of all Medicaid clients. BHOs also serve the behavioral health needs of patients who do not qualify for Medicaid and provide services which are not within the Medicaid state plan, such as residential treatment, to the extent that limited, but flexible, state-appropriated funding allows. The most prominent non-Medicaid service provided by BHOs is crisis services, which include a crisis line and team of designated crisis responders to respond to emergencies and administer involuntary commitments. BHOs pay for the court costs of involuntary treatment and manage a range of state-mandated programs from mobile crisis and assertive community treatment teams to Ombuds services to behavioral health advisory boards that include input from persons and families with lived experience of behavioral health disorders.

Movement to Integrated Health Care. In 2014, the Legislature enacted 2SSB 6312 which declared state policy to fully integrate behavioral health services with physical health for Medicaid clients in a single managed care plan by January 1, 2020. These managed care plans must be offered in nine purchasing regions consisting of a single county or group of counties that combine to form a regional service area. Regional service areas were given the option to provide integrated managed care prior to 2020. Six regions have either accomplished this or declared an intention to do so later in 2019. Three final regions plan to complete health integration on time in 2020. The model of full integration chosen by the Health Care Authority (HCA) depends on the procurement of Medicaid services through a risk-bearing prepaid contract in each region from three to five managed care organizations (MCOs) operated by private insurance carriers. Additional non-Medicaid services, including crisis services, are procured in each region from a behavioral health administrative services organization (BH-ASO), which may be a private insurance carrier or a county or group of counties that elects to provide non-Medicaid services within the region.

State Hospital Bed Allocations. The state provides state hospital beds to meet the adult long-term involuntary commitment (long-term ITA) needs of state residents. These beds are allocated without charge to BHOs based on a formula that considers population and the incidence of mental illness. If a BHO exceeds its state hospital bed allocation, it is required to reimburse HCA for its excess bed use. One half of the reimbursements are retained by the state and one half are distributed to BHOs that are below their bed allocations. In regions that are early adopters of full integration, HCA has split the former BHO's bed allocation among the MCOs and BH-ASO.

Summary of Bill: References to BHOs and their supporting structure are removed from the code effective January 1, 2020. The duties of HCA as the state behavioral health authority are consolidated and defined, including the duty to contract with MCOs and BH-ASOs. MCOs and BH-ASOs are established and defined as the entities delivering community behavioral health services and crisis services. Duties and powers for MCOs and BH-ASOs are established by allocating them from the former BHOs. A partial list of reallocated duties are as follows:

Duties of Former BHO	Allocated to MCO	Allocated to BH-ASO
Administer crisis services		X
Provide adequate access to behavioral health services	X	
Provide adequate network of crisis services providers		X
Coordinate state hospital discharges		X
Collaborate to ensure no adverse shift of persons with mental illness into jails and prisons		X
Accept enrollment of eligible persons leaving jail or prison	X	X
Maintain a behavioral health advisory board to provide local oversight		X
Provide for a behavioral health Ombuds office in each regional service area		X
Contract with courts to provide drug court services	X	X
Reimburse counties for costs related to involuntary commitment		X

The state's method for allocating state hospital beds is repealed effective January 1, 2020. HCA must establish a work group to determine how to manage access to adult long-term ITA in the community and state hospitals and provide recommendations to the Office of Financial Management and the Legislature by December 15, 2019.

Rules are provided for counties within a regional service area to collaborate, based on mutual agreement, to provide BH-ASO services. HCA is required to collaborate with such counties to determine feasibility. Counties within a regional service area are permitted to create a licensed provider organization to meet BH-ASO contract requirements, as long as the provider operation has a clear separation of powers, duties, and fiscal responsibilities from the BH-ASO.

HCA must allow tribes to participate in an interlocal leadership structure, upon request. HCA must establish a committee consisting of executive agencies, the Office of the Governor, and representatives of the BH-ASO and county government from each regional service area to meet quarterly to address systemic issues and to coordinate the behavioral health system.

A requirement that limits the administrative cost of BHOs to no more than ten percent of available funds is decodified and this requirement is not applied to MCOs or BH-ASOs.

References to mental health services are changed to behavioral health services, and new references to the obligation providing substance use disorder services are incorporated throughout the code. An expanded role is created for tribes in the administration of behavioral health services. References to chemical dependency are changed to substance use disorder. Outdated references are removed, and technical corrections are made to reflect modern practices.

Appropriation: None.

Fiscal Note: Requested on January 20, 2019.

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

Effective Date: January 1, 2020, except for section 1003 which is subject to an emergency clause and effective immediately.

Staff Summary of Public Testimony: PRO: This bill is an important step in the right direction. Having one system to address physical and behavioral health needs will be good for our communities and help countless people get the help they need and stay healthy. This bill implements a legislative mandate to complete integration by 2020. As we removed the words BHO, we had to make policy decisions as to where responsibilities would lie. The bed allocation methodology is something we still need to look at in an in-depth conversation that pulls together stakeholders with data and history. The interlocal leadership structure falls under BH-ASOs; we did not eliminate this function. We recognize counties want to continue talking about what happens when they want to be providers. Counties are partners in this effort; we recognize they have to stay involved. We need to do a better job of using clear terms to define our health care systems; we will provide written suggestions. Accountability and transparency of appropriated resources will continue to be important. Integration of physical and behavioral health benefits the entire person. We look forward to continued partnership with the state. Please add MCOs to the workgroup in the bill. The MCOs see themselves as a partner to assist bridging the schism between policy and implementation. We need to to build a bridge between physical and behavioral health which is seamless for the client. MCOs have strict guidelines limiting profit to 3 percent. There are caps on the medical loss ratio and administrative spend. We want to tweak the language around how county-run systems can directly provide behavioral health services. Counties want to stay engaged because they bear risk through their justice system and other services. County operated behavioral health providers are a critical part of the system. We need an oversight and compliance system that's uniform. Funding for ITA court costs remains important. When we introduce metrics we need to make sure they apply equally to all. Guidelines relating to administrative costs and profits must be appropriate and uniform for all actors.

OTHER: Behavioral health must be integrated at the service level, not just the funding level. Clients with co-occurring disorders need to be able to get the care they need from the same providers in the same location in a fully integrated way. This is a national best practice. Please increase incentives and requirements to integrate mental health and substance use services through co-location or full integration, including dual diagnosis enhanced treatment. We need to focus on outcomes and pay for clients to get better, not just for services provided.

Persons Testifying: PRO: Senator Manka Dhingra, Prime Sponsor; Rashi Gupta, policy advisor to Governor Inslee; Meg Jones, Association of Washington Healthcare Plans; Juliana Roe, Washington State Association of Counties; Brad Banks, Behavioral Health Organizations; Brian Enslow, Amerigroup; Andrea Davis, Coordinated Care; Joan Miller, Washington Council for Behavioral Health; Lindsey Grad, SEIU Healthcare 1199NW.

OTHER: Alicia Ferris, Community Youth Services.

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