FINAL BILL REPORT
E2SSB 5432

C 325 L 19
Synopsis as Enacted

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).

Senate Committee on Health & Long Term Care
Senate Committee on Behavioral Health Subcommittee to Health & Long Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness
House Committee on Appropriations

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

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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.

The Office of Forensic Mental Health Services. The Office of Forensic Mental Health Services is a division of the Department of Social and Health Services established in 2015 to prioritize accuracy, prompt service, quality assurance, and service integration in the area of forensic mental health. The director of the Office must be at least the level of a deputy assistant secretary, have a specific budget allocation, and have operational control over forensic evaluation services. Specific duties of the director include training and certification of forensic evaluators, liaison with system partners, and promotion of congruence between state hospitals and coordination with community interventions.

Summary: 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 with stakeholders including BH-ASOs, at least two MCOs, the Washington State Association of Counties, community behavioral health providers, and the Washington State Hospital Association to provide the following recommendations:

- how to manage access to adult long-term ITA and the Children's Long-term Inpatient Program in the community and state hospitals until such a time as the risk may be fully integrated in MCO contracts;
- how to guide the risk integration process; and
- how to expand bidirectional services through increased support of co-occurring disorder services, including recommendations related to purchasing and rates.

The work group must 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. No BH-ASO may contract with itself as a behavioral health agency, or contract with a behavioral health agency that has administrative linkages to the BH-ASO, in any manner that would give the agency a competitive advantage in obtaining or competing for contracts. A county or group of counties may contract with a county-run BH-ASO to provide designated crisis responder services, initial crisis services, criminal diversion services, hospital reentry services, and criminal reentry services. The county-administered service must have a clear separation of powers and duties from a county-run BH-ASO and follow suitable accounting procedures to ensure the funding is traceable and separate from other funds.

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.

HCA must report to the Governor's Office and the Legislature by December 1st of every even-numbered year concerning community behavioral health system expenditures against appropriation levels.

Neither HCA nor the Department of Health may provide initial documentation requirements for patients receiving care in a behavioral health agency which are substantially more time-consuming to complete than initial documentation requirements in primary care settings.

The statutory authority of the director of the Office of Forensic Mental Health Services at DSHS is reduced by removing language requiring the director to be at least on the level of a deputy assistant secretary, and removing language granting a specific budget allocation, operational control over forensic evaluation services, problem-solving authority, oversight of data collection, and authority to promote congruence across state hospitals.

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.

Votes on Final Passage:

Senate	46	2	
House	95	0	(House amended)
Senate	49	0	(Senate concurred)

Effective: January 1, 2020
May 9, 2019 (Sections 1003 and 5030)
July 1, 2026 (Section 2009)