HOUSE BILL REPORT
HB 1477

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to the implementation of the national 988 system to enhance and expand behavioral health crisis response and suicide prevention services statewide by imposing an excise tax on certain telecommunications services.

Brief Description: Implementing the national 988 system to enhance and expand behavioral health crisis response and suicide prevention services.

Sponsors: Representatives Orwall, Davis, Ortiz-Self, Callan, Simmons, Johnson, J., Goodman, Ryu, Ormsby, Valdez, Frame, Berg, Bergquist, Harris-Talley, Chopp, Macri, Peterson and Pollet.

Brief History:

Committee Activity:

Health Care & Wellness: 2/4/21 [DP].

Brief Summary of Bill

- Directs the Department of Health to designate crisis hotline centers that meet standards related to technology and the ability to identify and deploy community crisis resources for persons experiencing a behavioral health crisis.
- Requires behavioral health administrative services organizations to have community-based rapid crisis response services for persons who contact the 988 Crisis Hotline in need of stabilization services.
- Establishes a 988 Crisis Hotline System Director to provide direction and oversight in the implementation and administration of the 988 Crisis Hotline and behavioral health crisis system.
- Creates an implementation coalition to monitor the implementation of the 988 Crisis Hotline System and the improvements to behavioral health crisis services.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

- Establishes the Statewide 988 Behavioral Health Crisis Response Line Tax on phone lines to fund the crisis hotline centers and response services.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 10 members: Representatives Cody, Chair; Bateman, Vice Chair; Bronoske, Davis, Macri, Maycumber, Riccelli, Simmons, Stonier and Tharinger.

Minority Report: Without recommendation. Signed by 4 members: Representatives Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Harris and Ybarra.

Staff: Christopher Blake (786-7392).

Background:

Behavioral Health Crisis Services.
Crisis mental health services are intended to stabilize a person in crisis to prevent further deterioration, provide immediate treatment and intervention, and provide treatment services in the least restrictive environment available. Substance use disorder detoxification services are provided to persons to assist with the safe and effective withdrawal from substances. Behavioral health crisis services include: crisis telephone support, crisis outreach services, crisis stabilization services, crisis peer support services, withdrawal management services, and emergency involuntary detention services.

Behavioral health administrative services organizations (BHASOs) are entities contracted with the Health Care Authority to administer certain behavioral health services and programs for all individuals within a regional service area, including behavioral health crisis services and the administration of the Involuntary Treatment Act. In addition, each BHASO must maintain a behavioral health crisis hotline for its region.

National Suicide Prevention Hotline.
The Substance Abuse and Mental Health Services Administration (SAMHSA) partially funds the National Suicide Prevention Lifeline (Lifeline). Lifeline is a national network of about 180 crisis centers that are linked by a single toll-free number. Lifeline is available to people in suicidal crisis or emotional distress. When a person calls the number, the call is routed to a local crisis center based upon the caller's area code. Counselors at the local crisis center assess callers for suicidal risk, provide crisis counseling services and crisis intervention, engage emergency services when necessary, and offer referrals to behavioral health services. In addition, the SAMHSA and the Department of Veterans Affairs have

established the Veterans Crisis Line which links veterans with suicide prevention coordinators. In Washington, there are currently three local crisis centers participating in Lifeline.

In October 2020, Congress passed the National Suicide Hotline Designation Act of 2020 (Act). The Act designates the number 988 as the universal telephone number within the United States for the purpose of accessing the National Suicide Prevention and Mental Health Crisis Hotline system that is maintained by Lifeline and the Veterans Crisis Line. In addition, the Act expressly authorizes states to collect a fee on commercial mobile services or Internet protocol-enabled voice services for: (1) ensuring the efficient and effective routing of calls made to the 988 National Suicide Prevention and Mental Health Crisis Hotline to an appropriate crisis center; and (2) personnel and the provision of acute mental health crisis outreach and stabilization services by directly responding to calls to the crisis centers.

Summary of Bill:

Crisis Hotline Centers.
The Department of Health (Department) must designate one or more crisis hotline centers to provide crisis intervention services and crisis care coordination to persons who access the 988 Crisis Hotline within Washington. Prior to becoming recognized as a crisis hotline center, an entity must be designated as a crisis hotline center by the Department. Once a crisis hotline center is designated, it must contract with the Department to receive reimbursement for providing crisis hotline services.

To provide crisis intervention services and crisis coordination, a crisis hotline center must meet several standards. The crisis hotline center must participate in the National Suicide Prevention Lifeline network and meet operational, clinical, reporting, and quality improvement standards established by the Department. Crisis hotline centers must be able to deploy both crisis and ongoing services, including mobile crisis teams and co-responder teams. Crisis hotline centers must collaborate with managed care organizations, behavioral health administrative services organizations, and other health care payers to coordinate linkages for persons who contact the 988 Crisis Hotline with ongoing care needs. Crisis hotline centers must communicate across crisis and emergency response systems to coordinate access to crisis receiving and stabilization services for persons who access the 988 Crisis Hotline. Crisis hotline centers must also meet Department standards for serving high-risk and special populations with the goal of promoting behavioral health equity for all populations. Lastly, crisis hotline centers must use technology that is interoperable between the state's crisis and emergency response systems, such as 911 systems, emergency medical services systems, other nonbehavioral health crisis services, and the National Suicide Prevention Lifeline.

Crisis hotline centers must operate a technologically advanced behavioral health crisis call

center system with the capacity to: (1) receive crisis assistance requests through phone calls and other methods of communication; (2) access real-time information from behavioral health payers for the coordination of behavioral health crisis services; (3) assign and track local responses to behavioral health crisis calls; (4) arrange appropriate same-day, next-day, and follow-up appointments for persons contacting the crisis hotline center; (5) track and provide real-time bed availability information to crisis responders and persons in crisis; and (6) assure follow-up services to individuals accessing the 988 Crisis Hotline.

Crisis Response Services.
Each behavioral health administrative services organization (BHASO) must have community-based rapid crisis response services for persons who contact the 988 Crisis Hotline in need of stabilization services. The crisis response services must be provided by enhancing and expanding mobile rapid response crisis teams. Mobile rapid response crisis teams are teams that include peers and provide professional, on-site, community-based interventions such as outreach, de-escalation, stabilization, resource connection, and follow-up support for persons experiencing a behavioral health crisis. Mobile rapid response crisis teams may either be jurisdiction-based or embedded in emergency medical services and must collaborate with local law enforcement and include police as co-responders when public safety is an issue and law enforcement assistance is necessary. In addition, specialized mobile rapid response crisis teams must be created to respond to the unique needs of youth and geriatric populations. The Health Care Authority (Authority) must consult with tribes to create tribal mobile rapid response crisis teams.

Medicaid managed care organizations, the BHASOs, and health plans must assign a care coordinator to, and provide same-day and next-day appointments for, their enrollees or clients who seek services from the behavioral health crisis system.

Before July 16, 2022, the Authority must develop a plan for the equal statewide distribution of crisis stabilization services and beds, peer respite services, and behavioral health urgent care. Crisis services administered by the BHASOs must include adult, youth, and geriatric mobile rapid response crisis teams; crisis stabilization services; and peer respite services. Crisis receiving and stabilization services, short-term residential facilities, and peer-operated respite services must meet minimum expectations and best practices adopted by the Authority. By July 1, 2026, the BHASOs must provide for the availability of an adequate network of secure withdrawal management and stabilization services to ensure access to treatment, investigation, transportation, court-related and other services under the Involuntary Treatment Act.

The responsibility for payment of crisis services is established for managed care organizations, the BHASOs, the Authority, and private health care plans. Every fiscal biennium the Legislature must appropriate funds to managed care organizations, the BHASOs, and the Authority to reimburse providers of crisis services. In addition, the Department must provide adequate funding for the expected increase in call volume to the state's crisis hotline centers.

Administrative Coordination.
The Governor must appoint a 988 Crisis Hotline System Director (Director) to provide direction and oversight in the implementation and administration of the 988 Crisis Hotline and behavioral health crisis system components. The Director must assure coordination between the 988 Crisis Hotline, the crisis hotline centers, and the 911 emergency communications system; assure proper communication between crisis hotline centers and behavioral health crisis services; review the adequacy of training for crisis hotline personnel and 911 operators, with respect to their interactions with the crisis hotline center; oversee the coordination and adequacy of behavioral health crisis services; assure that Authority contracts with managed care organizations and the BHASOs support the behavioral health crisis system; and oversee the collaboration between the Department and the Authority with respect to their roles in the behavioral health crisis system.

The State Enhanced 911 Coordination Office must collaborate with the Department to assure consistency and equity of care for individuals in crisis whether they call 911 or 988.

The Department and the Authority must provide an annual report of the 988 Crisis Hotline's usage and call outcomes, as well as information about crisis services, including mobile rapid response crisis teams and crisis stabilization services. The report must also include information about fund deposits to and expenditures from the Statewide 988 Behavioral Health Crisis Response Line Account (988 Account). Beginning in 2023, the report must be submitted each November to the Governor and the appropriate committees of the Legislature.

Implementation Coalition.
The Governor is directed to establish an implementation coalition to enhance and expand behavioral health and suicide prevention crisis services in Washington. The William D. Ruckelshaus Center or another neutral party is responsible for providing staff support and facilitation services to the implementation coalition.

The membership of the implementation coalition includes at least 50 members. Members represent interests including the Legislature, executive branch agencies, local government, health carriers, behavioral health providers and facilities, recipients of and family members of recipients of crisis response services, family members of persons killed by law enforcement during a behavioral health crisis, peer support service providers, behavioral health crisis stabilization experts, crisis hotline centers, the BHASOs, community mental health and substance use disorder agencies, behavioral health advocates, law enforcement, police accountability groups, local health jurisdictions, physicians, and hospitals. In addition, the Governor must request the participation of a person representing the interests of tribal governments. All members may vote, except those representing the executive branch.

The implementation coalition must make recommendations on: (1) the implementation and

monitoring of the progress of the 988 Crisis Hotline in Washington; and (2) statewide improvement of behavioral health crisis response services. Specifically, the implementation coalition must report on:

- a recommended vision for an integrated crisis network, including an integrated 988 Crisis Hotline and crisis hotline centers, mobile crisis response units, crisis stabilization facilities, an integrated involuntary treatment system, peer and respite services, data resources, and a youth tip line;
- a workplan for implementing local response calls to the 988 Crisis Hotline;
- a workplan to implement mobile crisis teams and crisis receiving and stabilization services;
- the implementation of the new statewide behavioral health crisis call center system;
- the identification of the behavioral health challenges that the 988 Crisis Hotline will address in addition to suicide response, mental health, and substance use crises;
- the identification of intercepts with law enforcement and the 911 system and training to assure that the 988 Crisis Hotline and the 911 system are coordinated;
- standards of accountability within the integrated network;
- recommendations for ensuring equity in services for diverse cultures and communities;
- the allocation of funding responsibilities for same-day appointments, next-day appointments, and care coordination;
- a public relations campaign to highlight the 988 Crisis Hotline; and
- the recommended composition of a statewide behavioral health crisis response oversight board.

The implementation coalition must report to the Governor and the appropriate committees of the Legislature by December 1, 2021, with a preliminary report, and by November 1, 2022, with a final report.

Statewide 988 Behavioral Health Crisis Response Line Tax.
The Statewide 988 Behavioral Health Crisis Response Line Tax (988 Tax) is imposed on all radio access lines and interconnected voice over internet protocol (VoIP) service lines. A radio access line is a telephone number assigned to or used by a subscriber for two-way local wireless voice service from a radio communications company, including cellular telephone service, personal communications services, and network radio access lines. A VoIP service line is a service that enables real-time, two way voice communications using a broadband connection. The 988 Tax amount for each of these lines is gradually increased so that the 988 Tax is 30 cents per line per month between October 1, 2021, and December 31, 2022; 50 cents per line per month between January 1, 2023, and June 30, 2024; and 75 cents per line per month beginning July 1, 2024.

Proceeds from the 988 Tax must be deposited into the 988 Account. The 988 Account is an appropriated account in the State Treasury. Money from the 988 Account may only be used for the routing of calls from the 988 Crisis Hotline to an appropriate crisis hotline center and for personnel and the provision of acute behavioral health, crisis outreach, stabilization

services and follow-up case management.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date: The bill takes effect 90 days after the adjournment of the session in which the bill is passed, except for section 201, relating to the implementation coalition, which takes effect immediately, sections 301 through 305, relating to the Statewide 988 Behavioral Health Crisis Response Line Tax, which take effect January 1, 2022, and section 402, relating to definitions, which takes effect July 1, 2022.

Staff Summary of Public Testimony:

(In support—from testimony on HB 1182, which is identical to HB 1477 except for the title, on January 28, 2021) Much happens in behavioral health care at the point of crisis and this bill provides an opportunity to take a closer look at the system. The 988 number is an opportunity to make the behavioral health crisis system stronger. There will be a significant increase in call volume once the change to the 988 number occurs because of the easier access, and there must be increased funding to support the necessary staff and technology to accommodate this. The current crisis system does not work for everyone and is inefficient and overly complex, inadequately funded, and has too few workers. When people have the courage to call for help, they must be helped. Thoughts of taking one's life can be impulsive and fleeting moments where rapid and supported interventions are urgently needed. This bill's vision of the 988 system and these call centers is to support people in crisis from the point of first contact and make sure that they receive a call, triage, a warm handoff, a rapid response, and following up to make sure they received services. This bill assures there will be quick access to openings for continuum-of-care options. Instead of giving out a phone number and hoping that the next call is made, the call center will discern the most promising service package for the caller with current knowledge about resources, such as bed availability. There is a need to create technologically advanced care systems. This bill would be a game changer by getting peer supports for people in crisis and their families to connect them with the services they need. This bill will help the new 988 service reach its full potential by linking people experiencing behavioral health crises with appropriate community-based supports before they end up in an emergency department, a prison, or possibly putting themselves or others at risk.

Over the past decade, deaths by suicide have increased by over 36 percent in Washington with 5,000 lives lost in the past five years. Suicide is the leading cause of death for Washingtonians under the age of 25. Suicide rates are higher among veterans; American Indians and Alaska Natives; lesbian, gay, bisexual, transgender, and queer youth; and people in rural areas.

Some people may be concerned about calling 911 in a mental health crisis and a tool like 988 is a component of dismantling structural and systemic racism. The holes in the safety net leave people in standoffs with law enforcement, when they should be in the care of a counselor. This is a great compromise between communities of color, mental health professionals, and police departments. There needs to be coordination and training of all parties, including the 911 system and law enforcement.

(Opposed) None.

(Other) This bill sets up a crisis hotline that is separate from the current system, which is not practical. Counties already have existing behavioral health crisis hotlines that are governed by the Health Care Authority (Authority) and have processes and relationships with existing providers. The Authority should oversee the system so there is not an additional layer of cost and administrative burden from multiple state agencies. There are concerns about moving oversight of the crisis lines to a statewide official and an agency that is different than the one that oversees all of the other behavioral health services in the state.

The overhaul of the crisis delivery system is not beholden to the same time frame as the implementation of the 988 number, so there should be further discussions and planning. There is no planning stage for the centralized platform that is the basis of the mandate on hospitals, primary care, and other behavioral health providers to provide real-time bed and service availability. It is important to step back and inventory what is already in place and working in order to thoughtfully build capacity and ensure that when people call 988 there will be help at the other end. The timing of the bill's requirements must be realistic and achievable with respect to system changes, hiring, training, and cost. There should be more representation by behavioral health administrative services organizations in the implementation coalition. Even after 988 is implemented, there will still be suicide calls coming to the 911 system and, conversely, calls to 988 that belong with 911, so it is essential to assure that the two programs are connected and coordinated from the very beginning to ensure consistency.

The bill needs to be scaled so that it can be successful. This could create too broad of a system that cannot meet the regional needs of individuals, especially in rural areas. The underlying issues of behavioral health funding, workforce supply, and housing solutions also need to be addressed. Crisis services need to be funded on a capacity basis, rather than a fee-for-service basis. It is not clear how the state will provide the funding for the workforce, technology, and infrastructure needed to implement the bill. This would be very difficult to comply with because providers do not hold appointments open for same-day services. This bill shifts some of the systemic shortfalls on to health plans. There should be a more targeted approach of working at the regional crisis hotline level to bolster their capacity at the regional level and meet the needs that the 988 requirements will demand, as well as building up the emergency department and jail diversion efforts.

Persons Testifying: (In support) Representative Orwall, prime sponsor; Laura Van Tosh,

Washington Legislative and Policy Advocates; Jennifer Stuber, Forefront Suicide Prevention at the University of Washington; Abraham Dairi; David Johnson, Crisis Connections; Nancy Belcher, King County Medical Society; Paula Sardinas, Washington Build Back Black Alliance; and Patricia Morris, Volunteers of America Western Washington.

(Other) Adam Wasserman, Washington Military Department, Emergency Management Division; Joan Miller, Washington Council for Behavioral Health; Katie Kolan, Washington State Hospital Association and Washington State Psychiatric Association; Chris Bandoli, Association of Washington Healthcare Plans; Juliana Roe, Washington State Association of Counties; Brad Banks, Behavioral Health Administrative Services Organization; Joe Valentine, North Sound Behavioral Health Administrative Services Organization; Lindsey Grad, Service Employees International Union Healthcare 1199 Northwest; Jessica Shook, Washington Association of Designated Crisis Responders; and Keri Waterland, Health Care Authority.

Persons Signed In To Testify But Not Testifying: Tanya Aggar, Washington State Parent Teacher Association; Phoebe Walker, Associated Students of the University of Washington, Seattle; Hannah Sieben, University of Washington Graduate and Professional Student Senate; Sam Locke; Karl Hatton, Washington Association of Public-Safety Communications Officials-National Emergency Number Association; Wren Hudgins; Eric Bruns; James McMahan, Washington Association Sheriffs and Police Chiefs; Aundrea Jackson, Crisis Connections; Gerry Keegan, Cellular Telecommunications Industry Association; Justine McClure, American Foundation for Suicide Prevention; and Tim Krivanek.