I. Introduction

The Adult Behavioral Health System Task Force ("task force") is established in state law pursuant to 2SSB 5732 (2013), as amended by 2SSB 6312 (2014), which expanded the mission and scope of the task force. This document represents the preliminary report of the task force. A final report from the task force is due on December 1, 2015. The law authorizing the task force expires on July 1, 2016.

II. Task Force Structure and Mandates

Membership

The Task Force has 11 voting members, and 4 official alternates. The membership consists of:

- Legislative members:
  - Senator Linda Evans Parlette (co-chair);
  - Representative Jim Moeller (co-chair);
  - Senator Jeannie Darneille; and
  - Representative Paul Harris.
- Executive members:
  - Kevin Quigley, Secretary, Department of Social and Health Services (DSHS);
  - Andi Smith, Senior Policy Advisor, Governor's Legislative & Policy Office; and
  - Dorothy Teeter, Director, Health Care Authority (HCA).
- County members:
  - Jill Johnson, Island County Commissioner;
  - Shelly O'Quinn, Spokane County Commissioner; and
  - Karen Valenzuela, Thurston County Commissioner.
- Tribal member:
  - Nancy Johnson, Colville Tribes.

The appointed alternate members are Senator Randi Becker, Representative Eileen Cody, Senator Annette Cleveland, and Representative Judy Warnick.

Statutory Mandates

The authorizing legislation for the task force imposes the following 13 mandates:

A. Make recommendations for reform concerning the means by which behavioral health services are purchased and delivered, including:

1	Guidance for the creation of common regional service areas for purchasing behavioral health services and medical care services by the DSHS and HCA, taking into consideration any proposal submitted by WSAC;	Due 9/01/14
2	Identification of key issues which must be addressed by DSHS to accomplish the integration of CD purchasing primarily with managed care contracts by April 1, 2016, including review of the results of any available actuarial study to establish provider rates;	

3	Strategies for moving towards full integration of medical and behavioral health services by January 1, 2020, and identification of key issues that must be addressed by HCA and DSHS in furtherance of this goal;	
4	A review of performance measures and outcomes developed pursuant to RCW 43.20A.895 and chapter 70.320 RCW;	Due 8/01/14
5	Review criteria developed by DSHS and HCA concerning submission of detailed plans and requests for early adoption of fully integrated purchasing and incentives;	
6	Whether a Statewide Behavioral Health Ombuds Office should be created;	
7	Whether the state chemical dependency program should be mandated to provide 24-hour detoxification services, medication-assisted outpatient treatment, or contracts for case management and residential treatment services for pregnant and parenting women;	
8	Review legal, clinical, and technological obstacles to sharing relevant health care information related to mental health, chemical dependency, and physical health across practice settings;	
9	Review the extent and causes of variations in commitment rates in different jurisdictions across the state;	

B. Make recommendations for reform concerning:

10	Availability of effective means to promote recovery and prevent harm associated with mental illness and chemical dependency;	
11	Availability of crisis services, including boarding of mental health patients outside of regularly certified treatment beds;	
12	Best practices for cross-system collaboration between behavioral health treatment providers, medical care providers, long- term care service providers, entities providing health home services to high-risk Medicaid clients, law enforcement, and criminal justice agencies;	
13	Public safety practices involving persons with mental illness and chemical dependency with forensic involvement.	

III. Summary of Topics Considered During 2014 Legislative Interim

The task force held six meetings in 2014. Documents and agendas relating to these meetings are available at http://www.leg.wa.gov/JointCommittees/ABHS/Pages/Meetings.aspx#Apr22. The paragraphs below contain a brief summary of the substantive issues discussed during the task force meetings.

A. *Regional Service Areas*

The task force fulfilled its mandate to receive recommendations on the creation of regional service areas from the Washington Association of Counties and to make its own recommendations to the Department of Social and Health Services and the Health Care Authority. The process began at the April meeting with a presentation on current agency efforts to establish regional boundaries for the purchase of services from several service delivery systems, including physical health, mental health, and chemical dependency. In June, the Task Force received a progress report from the Washington Association of Counties regarding the adoption of its recommendations. At this meeting several individual regional

support networks raised issues regarding the importance of recognizing the unique needs of communities and keeping locally-based service delivery systems, as well as several concerns about the need for more information to support the Association's decision.

In July, the Association delivered its recommendation to the task force which included two options for regional service area boundaries. The primary difference between the two maps (see Appendix __) are whether the Chelan-Douglas Regional Support Network is placed in the Spokane Regional Support Network's boundaries or the Greater Columbia Regional Support Network's boundaries. After reviewing the recommendations and hearing responses from the executive agencies and the public, the task force adopted its own recommendation, which is reported in section IV of this report.

B. *Review of Performance Measures*

In 2013, the Legislature passed legislation that required the Department of Social and Health Services and the Health Care Authority to work with a broad group of stakeholders to adopt standard performance measures to be included in contracts for services for chemical dependency, mental health, long-term care, and physical health care. In 2014, the Legislature directed the Task Force to review the performance measure that were the result of the agencies' process.

In its July meeting the Task Force heard about the agencies' activities related to the establishment of a steering committee with broad participation of stakeholders. The steering committee was assisted in its work by six workgroups that it had created (four related to performance measure development and two related to evidence-based practices and behavioral health workforce development). The process considered numerous currently used standardized measures and reduced them down to a list of fifty-one measures. The measures are intended to serve as a menu, not a mandate, to be used as appropriate for a particular purpose or setting. The steering committee will continue to be active as the measures are further defined and incorporated into contracts and quality improvement process efforts. The steering committee also adopted recommendations for selecting and implementing evidence-based practices, research-based practices, and promising practices as well as recommendations to build the behavioral health workforce by addressing financial barriers, directing the workforce to align treatment models with outcomes, and providing training for transforming practices in an integrated environment. The full report can be accessed at:
http://www.dshs.wa.gov/pdf/dbhr/WSIPP%20BHO%205732%20Report.pdf.

C. *Chemical Dependency Services Purchasing and Delivery*

In June, the Task Force heard presentations from staff, state and local agencies, and stakeholders to better understand how chemical dependency services are impacted by the development of regional service areas and the movement of those services into a managed care system. Currently, most Medicaid clients receive mental health services and physical health services through managed care arrangements, while chemical dependency services are delivered through a fee-for-service arrangement. Staff provided an overview of who is served by the state's alcohol and substance abuse program, the types of available services, the costs of the services, the geographic distribution of services, the impact of the Affordable Care Act on chemical dependency providers, and issues related to integrating mental health and chemical dependency services.

While many presenters spoke to the fact that investments in chemical dependency services will result savings in other areas (jails, emergency departments), a number of concerns were raised by several panels related to chemical dependency providers, chemical dependency treatment recipients, law enforcement-related representatives, and health plan representatives. As people have shifted from non-Medicaid chemical dependency programs to Medicaid, chemical dependency providers have had to accept reduced reimbursement rates for their services. There is a lack of capacity needed to serve those who need chemical dependency services. If behavioral health organizations are taking on risk for providing chemical dependency services in a managed care system, it is important that the actuarial analysis is sound and that there is adequate funding for both mental health and chemical dependency services. Not all chemical dependency services are available statewide, such as opiate substitution programs, and wraparound programs are essential. The nature of chemical dependency does not always lend itself to strict time limits placed on treatment programs. The most needy people do not always meet specific funding criteria to get them the most appropriate treatment. Questions remain as to which chemical dependency services will become part of the behavioral health benefit package, how network adequacy will be determined, and will there be changes required for data reporting. In rural areas the provision of services requires the establishment of partnerships with various service providers which allows for more complete care to the client and faster mobilization of services. There are several regulatory barriers related to unnecessary paperwork and reimbursement methods that do not recognize methods for treating clients with co-occurring disorders.

Treatment recipients identified gaps in funding for housing and job training and a lack of substance abuse resources in jails. Tribal members in need of treatment experience barriers when initial intake comes through the state, rather than the tribe, and can benefit from more culturally appropriate services.

Limited behavioral health resources and the lack of coordination between criminal justice systems, behavioral health systems, social supports system, and education impacts the criminal justice community. There is scientific research that shows that drug court programs work by providing wraparound services to the meet the needs of each of the individuals.

Health plans need to continue to screen for behavioral health conditions, operate off of a shared care plan with multi-disciplinary teams, link payments to performance measures, and work on reducing barriers to data sharing and building provider networks.

D. *Tribal-Centric Behavioral Health*

On September 19, 2014, the task force held a work session on Tribal-Centric Behavioral Health, hearing presentations from representatives of the Colville Confederated Tribes, Confederated Tribe of the Chehalis, Sauk-Suiattle Indian Tribe, and Upper Skagit Indian Tribe.

Colville Confederated Tribes are a combination of 12 culturally and geographically disparate tribes. The poverty rate is high. The tribes are highly impacted by transportation challenges. They are challenged by inadequate staffing, facilities, and the lack of an electronic health record system.

The Tsapowum Chehalis Tribe provides several behavioral health services to its members which are funded in part by federal grants, including trauma-informed counseling, offender re-entry, suicide prevention, and mental health and chemical dependency services.

The Sauk-Suiattle Tribe reports that it has had trouble interfacing with its regional support network, and getting the RSN to accept diagnoses of children needing care by its licensed mental health counselors. There is a lack of trust that integrated chemical dependency services will be extended to tribal members. Nine recommendations were provided to help ensure adequate access to treatment for tribal members, including deployment of culturally-sensitive care contracts which involve tribal providers and professionals at all levels of the treatment system.

A Tribal-Centric Behavioral Health report was commissioned in 2013. A survey conducted pursuant to development of the report recognized deficiencies in the ability to secure inpatient and residential treatment for tribal members. Medicaid reimbursements were found to fall short of costs. Only half of all tribes rated their relationship with RSNs as good or better. Recommendations from the report include exempting tribes from the RSN system, and allowing tribes to develop their own authorization procedures for inpatient and residential treatment. A need among the tribes for technical assistance and training was identified, as well as culturally-sensitive purchasing, and expansion of availability of telepsychiatry. Tribes request reciprocity with the state to honor involuntary commitment decisions made in tribal courts, and ask for tribally-certified professionals and facilities to become eligible for Medicaid reimbursement. Prevention services and co-occurring disorders should receive more attention

E. *Full Integration of Behavioral Health and Physical Health Purchasing*

The task force held a work session on July 18, 2014, regarding plans to begin fully-integrated purchasing of physical and behavioral health services in 2016 for Medicaid clients in "early adopter" regions of the state. Early adopter regions are regions that request to pilot full integration early in exchange for shared savings incentives, ahead of the state's target for full statewide integration in 2020. In other regions, Healthy Options managed care plans will coexist beside Behavioral Health Organizations in a common purchasing area. Certain populations, including Tribal members and individuals with 3rd party coverage, will continue to be exempt from managed care.

Standards for early adopter regions are being developed jointly by HCA and DSHS. Different models are currently being vetted in the regional service areas (RSAs) which have expressed interest: the Southwest Behavioral Health RSA (comprising Clark, Skamania, and Klickitat counties), King County RSA, and Pierce County RSA. One of the principal differences between early proposed models is whether the county will remain in the game as a partner with one or more managed care organizations as part of an integrated health network. State requirements for early adopter regions are due to be released in November 2014, with a contract implementation date of January 2016.

F. *State Purchasing of Mental Health, Chemical Dependency, and Physical Health Services*

The task force held work sessions on April 22, 2014, and September 19, 2014, exploring issues related to the state purchasing of health services for Medicaid clients and federal restrictions on state and local purchasing conducted with use of federal funds.

State purchasing of health care services is coordinated primarily by the Health Care Authority (HCA), which covers medical care and low intensity mental health care, and the Department of Social and Health Services (DSHS), which covers high intensity mental health care and chemical dependency services. Other state government agencies and public/private state partners also participate in purchasing behavioral health services. Ninety percent of HCA clients are enrolled in managed care

plans, administered through one of five managed care organizations (MCOs). The largest spending areas for chemical dependency services are county-managed services (42%), state-contracted residential services (22%), and tribal and support services (19%). Fifty-nine percent of chemical dependency services in fiscal year 2013 went to non-Medicaid adults and youth. Chemical Dependency services are provided on a fee-for service basis.

Mental health budget revenue ($1.86 billion for the 2013-2015 biennium) is over four times larger than the chemical dependency budget. Just over half the budget comes from the state general fund; other funding comes from federal sources, of which the largest source is Medicaid funds ($810 million in 2013-2015). State hospital expenses comprise 26% of the mental health budget. Community mental health services for enrollees who meet access to care standards are administered by 11 regional support networks (RSNs), which receive a capitation payment for all Medicaid enrollees in their service areas. Crisis services and non-Medicaid services are administered by RSNs through separate, non-Medicaid state contracts. Residential supports for RSN clients may be provided through federal block grant funds and unspent non-Medicaid allocations.

Federal Medicaid restrictions mandate that certain services be provided to all eligible clients, and exclude other services from purchasing with federal financial participation. Excluded services include room and board, services provided to clients who are ineligible for Medicaid, and services not included in the Medicaid state plan. Care provided in an "Institution for Mental Disease" (IMD) to individuals aged 21 to 64 is excluded, although a new waiver stating in October 2014 allows Medicaid funds to be applied to the cost of certain inpatient psychiatric stays in IMDs which are "in lieu of" more expensive covered hospital services. Services covered by Medicaid are taking up an increasingly large proportion of chemical dependency and mental health spending, rising in fiscal year 2015 to 69% of spending for chemical dependency services, and 82% of spending for mental health services.

G. *Supported Housing and Employment.*

The task force held work sessions on supported housing and supported employment on September 19, 2014. Supported housing is an evidence-based practice which is very useful for addressing chronic homelessness and disability. The housing provided is tied to reductions in costs for hospitalization, emergency room use, crisis and shelter services, incarceration, and detox. Housing reduces mortality while responding to the needs and preferences of consumers. 1811 Eastlake is an example of a successful supported housing project in Seattle, Washington, where savings from reduced use of collateral services far exceed the cost of providing housing. Costs for services associated with housing may be covered with Medicaid; other funding from federal, state, county, and local sources must be used to cover what Medicaid doesn't pay for. Successful programs provide mobile, multidisciplinary team-based models in conjunction with housing. Housing is a key determinant of health. A white paper developed by the Washington Low Income Housing Alliance and CSH proposes models for a statewide supported housing Medicaid benefit in which an initial investment of between $5 and $38 million would produce returns on investment that could be reinvested to sustain a robust supported housing program for up to 14,000 persons with housing needs and chronic illness or disability.

Supported employment is an evidence-based practice that recognizes that persons with severe mental illness want to work, although only a minority currently achieve employment. The goal is to provide clients with a mainstream job, paying at least minimum wage, in a work setting that includes persons who are not disabled. A service agency provides ongoing support to the employed person. Twenty-two

randomized controlled trials have demonstrated the effectiveness of the supported housing model in achieving employment and job retention. Significant savings are available if services are targeted to the right population. This model is effective for behavioral health clients, as well as sufferers from PTSD, homelessness, physical disabilities, older adults, and persons with criminal justice history.

H. *Psychiatric Boarding and Single-Bed Certifications*

The task force held a work session on September 19, 2014, to review psychiatric boarding and single-bed certifications. In August, 2014, the Washington Supreme Court decided the case of *In re D.W.*, which involved 10 involuntary psychiatric patients who asked the superior court in Pierce County to hold that their detention for treatment in uncertified beds is unlawful. On appeal, the state supreme court found that current Washington statutes and regulations do not authorize the state to temporarily certify treatment beds as a response to the overcrowding of certified facilities. In the wake of this decision, Governor Inslee authorized expenditure of up to $30 million from the state general fund to acquire up to 145 additional psychiatric treatment beds on an emergency basis. DSHS and other parties filed a joint motion to stay the issuance of the court's judgment until December 27, 2014, which was granted by the court. Emergency rule changes were enacted to give the state flexibility to issue certifications for commitment in safe locations where individualized treatment would be provided. DSHS is requesting increased data reporting from RSNs to determine the full scope of the need for treatment capacity to meet the demands of reducing psychiatric boarding, and has asked RSNs to develop proposals for deployment of new state funding in their jurisdictions to meet the capacity needs.

Representatives from the King, Pierce, and Spokane RSNs reported having difficulty transitioning to less reliance on psychiatric boarding. Spokane reported that 90% of its boarders are kept in seclusion and/or restraint. Some patients receive no psychiatric consultation during the boarding process, which averages 2-4 days, depending on client needs and other factors, including proximity to weekends and holidays. All RSNs report they are focusing on utilization management, both through efforts to free up beds by discharging patients sooner, and to divert all patients possible away from civil commitment into voluntary placements or less restrictive options.

I. *Jail and Community Mental Health Agency Collaborations*

On October 10, 2014, the task force held a work session on jail and community mental health agency collaborations. The task force reviewed a program in Clark County called the Jail Reentry Initiative. The Clark County Sheriff's Office partnered with Southwest Washington Behavioral Health and Community Services Northwest to provide outpatient chemical dependency, outpatient mental health, and supportive housing to jail inmate who are screening into the program. The sheriff provides access to the jail to treatment providers before release from custody, and the custody officer actively facilitate and encourage participation in the program. Specially trained custody officers and a specially designated holding area are provided. This program has been in operation since February 2014 and is awaiting evaluation.

The task force also reviewed the Community Re-Entry Program and Jail Transitions Program offered by Greater Lakes Mental Health in the Optum Pierce RSN. The former program targets individuals with 5 or more arrests in a 12-month period who also have a mental health problem or co-occurring disorder. Intensive community based wraparound services are provided by a multidisciplinary team, including mental health professional (MHPs), peers, nurses, and case managers. A 76% reduction in recidivism

has been observed in this program. The jail transition program embeds an MHP, peer specialist, and case manager in the jail for engagement with short term services upon release. Key components identified for success include a strong partnership between jail and community mental health personnel, access to the jail for treatment staff, good communication about release times and practices, and strong partnerships with other community providers (crisis, housing, community custody, chemical dependency treatment providers).

IV. Task Force Recommendation Concerning Regional Services Areas

On July 18, 2014, the task force adopted the following recommendation:

> I move that the Task Force adopt the recommendation for Regional Service Areas made by the Washington Association of Counties as its own recommendation, with the following addition: when designating Regional Service Area boundaries, the Health Care Authority and the Department of Social and Health Services must ask the governing board of the Chelan-Douglas Regional Support Network to state its preference between the maps and accept the decision, provided there is mutual agreement between the affected regional support networks.

Eleven members of the task force voted on this recommendation, with one Task Force member (DSHS Secretary Kevin Quigley) represented by a designated alternate. The vote was 11-0 on the recommendation. This recommendation was transmitted by letter to Governor Inslee following the meeting.

V. Preliminary Findings of the Task Force Regarding Opportunities and Challenges

See separate discussion matrix document for options for discussion at the task force meeting on November 14, 2014.

VI. Task Force Work Plan for 2015 Legislative Interim

According to the work plan for the task force, the following topics will be addressed during the 2015 Legislative interim:

- Issues related to full integration of behavioral health and medical services by 2020, including review of legal, clinical, and technological obstacles to sharing health care information across practice settings;
- Public safety practices concerning persons with behavioral health disorders and involvement in criminal justice system;
- Review of whether a Statewide Behavioral Health Ombuds should be created; and
- Review of the crisis mental health system, including the extent and causes of variations in civil commitment rates across jurisdictions.

Amendments to this work plan may be discussed during the task force meeting on November 14, 2014.

Appendix A

Alternative RSA maps recommended by WSAC.

Appendix B-D

Statements submitted by stakeholder work groups (if any).