



## WASHINGTON STATE LEGISLATURE

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December 16, 2014

Dear Governor Inslee, Secretary of the Senate, and Chief Clerk of the House of Representatives,

As the co-chairs of the Adult Behavioral Health System Task Force, we are pleased to notify you that the Task Force has completed its first year of work. Enclosed, please find a copy of the *preliminary* report of the Task Force, submitted pursuant to chapter 338, section 1, Laws of 2013 (uncodified), and chapter 225, section 1, Laws of 2014 (uncodified).

We look forward to continuing this discussion with Task Force members and stakeholders next interim.

Sincerely,

Senator Linda Parlette  
12<sup>th</sup> Legislative District

Representative Jim Moeller  
49<sup>th</sup> Legislative District

Members of the Adult Behavioral Health System Task Force:

Representative Paul Harris  
Senator Jeannie Darneille  
Representative Eileen Cody (Alternate)  
Representative Judy Warnick (Alternate)  
Senator Randi Becker (Alternate)  
Senator Annette Cleveland (Alternate)  
Andi Smith, Senior Policy Advisor, Governor's Legislative & Policy Office  
Kevin Quigley, Secretary, Department of Social and Health Services  
Dorothy Teeter, Director, Health Care Authority  
Karen Valenzuela, Thurston County Commissioner  
Jill Johnson, Island County Commissioner  
Shelly O'Quinn, Spokane County Commissioner  
Nancy Johnson, Colville Tribes

# Adult Behavioral Health System Task Force Preliminary Report

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SUBMITTED TO THE GOVERNOR AND THE LEGISLATURE  
DECEMBER 2014

## 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.

\*On November 14, 2014, Karen Valenzuela was replaced by Kevin Bouchey, Yakima County Commissioner.

### 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 (Association) 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 Association 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 A) is 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 copy of the report is attached as Appendix E, and can be found at:

<http://www.dshs.wa.gov/pdf/dbhr/5732%20Tribal%20Centric%20Behavioral%20Health%20Report.pdf>

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 3<sup>rd</sup> 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 difficulties transitioning to less reliance on psychiatric boarding. Spokane has a significant amount of psychiatric boarding which is not reported in single bed certification statistics. Spokane reported that 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. Ninety percent of its boarders are kept in seclusion and/or restraint. Both Spokane and King lack the present capacity to convert all boarding based on overcrowding to permanently certified beds. 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**

On November 14, 2014, the Task Force considered a number of proposals and adopted the following findings:

##### Endorsed by the Task Force

- 1) State agencies should openly share information about actuarial rate development with stakeholders and be open to feedback from chemical dependency and mental health providers. Actuarial costs should not just be based on historic utilization, service penetration, and rates. *Source:* Chemical Dependency Integration Work Group. *Preliminary Fiscal Impact Estimate:* No impact. *Comment:* Rates must be based on sound actuarial methodology.
- 2) The state should maintain financial support for CD services that are not reimbursable by Medicaid, including sobering, outreach, childcare, and services to individuals ineligible for Medicaid. *Source:* Chemical Dependency Integration Work Group. *Preliminary Fiscal Impact Estimate:* No impact to maintain current levels. *Comment:* Don't destroy what we have.
- 3) DSHS and HCA should share procurement documents and draft contracts developed for early adopter regions with the Early Adopter/Full Integration Work Group for comment before they are released. *Source:* Early Adopter/Full Integration Work Group. *Preliminary Fiscal Impact Estimate:* No impact.
- 4) DSHS and HCA should lead a process to align regulations across chemical dependency, mental health, and physical health care in order to reduce administrative burdens. *Source:* Early

Adopter/Full Integration Work Group. *Preliminary Fiscal Impact Estimate:* Administrative costs of \$25,000 - \$100,000.

- 5) The state should collaborate with the Attorney General's Office and stakeholders to develop standardized privacy guidelines under HIPAA and 42 CFR part 2 that facilitate bi-directional care coordination. *Source:* Chemical Dependency Integration Work Group. *Preliminary Fiscal Impact Estimate:* Administrative costs of \$25,000 - \$100,000.
- 6) The state should maintain financial support for facility-based chemical dependency services so that the available number of beds are not reduced. *Source:* Chemical Dependency Integration Work Group. *Preliminary Fiscal Impact Estimate:* No impact to maintain current levels.
- 7) The state should collaborate with stakeholders to undertake a detailed comparison of mental health and chemical dependency regulations, and recommend standardization where appropriate. *Source:* Chemical Dependency Integration Work Group. *Preliminary Fiscal Impact Estimate:* Administrative costs of \$25,000 - \$100,000.
- 8) DSHS should provide an analysis of the impact of proposed budget cuts on behavioral health integration. *Source:* Chemical Dependency Integration Work Group. *Preliminary Fiscal Impact Estimate:* No impact.
- 9) Agencies, purchasers, and providers should actively pursue statewide policies and funding to support the workforce development activities needed to a) train the current workforce to deliver integrated services; b) ensure there will be a future workforce capable of meeting integrated health care needs; and c) ensure a diverse and culturally competent workforce. *Source:* Early Adopter/Full Integration Work Group. *Preliminary Fiscal Impact Estimate:* No impact. *Comment:* This issue can be referred to the Workforce Training and Education Coordination Board.
- 10) DSHS should prioritize reduction of violence at state hospitals using evidence-based and best practices. *Source:* Public Safety/ITA Work Group. *Preliminary Fiscal Impact Estimate:* DSHS has three-part, \$11.5 million agency request for the FY 2015-17 budget related to this issue.
- 11) HCA and DSHS should specify how crisis services and other non-Medicaid services are to be provided and funded in regional services areas that ask to become early adopters of full integration and do not contemplate county participation in a Behavioral Health Organization. *Source:* Public Safety/ITA Work Group. *Preliminary Fiscal Impact Estimate:* Unknown- costs will depend on policy decisions in the bill. *Comment:* Costs should be monitored in counties adjacent to early adopter regions.
- 12) Cultural competency training should be required for RSN staff working with American Indian and Alaskan native populations. *Source:* Tribal Centric Behavioral Health Report. *Preliminary Fiscal Impact Estimate:* Unknown.

#### Endorsed in Principle; More Information Needed

- 13) Executive agencies should build service reimbursement rates that support integrated care models. For example, rates should allow for billing of primary care, mental health, and chemical dependency services on same day; allow for extra time needed to serve complex populations, and provide rates that reflect the care received (e.g., chemical dependency residential treatment providers may bill for psychiatric care, but rate is based on chemical dependency

services only). *Source:* Early Adopter/Full Integration Work Group. *Preliminary Fiscal Impact Estimate:* Unknown-requires further detail to provide estimate. DSHS has \$6.9 million agency request for the FY 2015-17 budget related to the cost to adjust the CD Medicaid reimbursement rate.

- 14) Access to chemical dependency involuntary (ITA) services should be expanded by increasing the number of residential ITA beds, implementing secure detox beds, and increasing rates paid to providers. *Source:* Public Safety/ITA Work Group. *Preliminary Fiscal Impact Estimate:* Unknown-impact will depend on the size of the rate increase and number of new beds.
- 15) The state should create (or purchase) an integrated data reporting system for mental health and chemical dependency providers that combines the strengths of the existing separate data systems. *Source:* Chemical Dependency Integration Work Group. *Preliminary Fiscal Impact Estimate:* DSHS has \$703,000 agency request for the FY 2015-17 budget to begin this work. *Comment:* The data system should be designed to integrate mental health, chemical dependency, and physical health care across DSHS and HCA, to apply after full integration in 2020. A full cost estimate is needed to show what it would take to complete this project.
- 16) State agencies should develop a data system/data sharing plan and funding mechanism to allow for real time data sharing. *Source:* Early Adopter/Full Integration Work Group. *Preliminary Fiscal Impact Estimate:* Unknown-requires further detail to provide estimate.
- 17) A supported housing benefit should be added to the Medicaid state plan. *Source:* Work session on supported housing. *Preliminary Fiscal Impact Estimate:* Likely to be over \$1 million, but requires further definition and actuarial analysis.
- 18) A supported employment benefit should be added to the Medicaid state plan. *Source:* Work session on supported employment. *Preliminary Fiscal Impact Estimate:* Likely to be over \$1 million, but requires further definition and actuarial analysis.

#### More Information Needed to Make a Recommendation

- 19) The state should provide a comprehensive CD service package that provides rapid access to billable services comparable to those included in the mental health Medicaid state plan. These would include case management, peer services, recovery supports, and medication monitoring/management. *Source:* Chemical Dependency Integration Work Group. *Preliminary Fiscal Impact Estimate:* Potentially significant, but estimates cannot be made until benefit package is clearly defined and actuarial study is complete. *Comment:* Cost estimates are needed for proposed benefit expansions.
- 20) The Legislature should expand availability of peer services by addressing credentialing barriers such as criminal history while ensuring consumer and community safety. *Source:* Public Safety/ITA Work Group. *Preliminary Fiscal Impact Estimate:* Unknown-requires further data to provide estimate.
- 21) DSHS should conduct a feasibility study to structure one or more residential programs that will serve tribal members. DSHS should develop a tribal evaluation and treatment facility, crisis triage, dual diagnosis beds, or a combined service facility. *Source:* Tribal Centric Behavioral Health Report. *Preliminary Fiscal Impact Estimate:* Unknown-requires further detail to provide estimate.

22) DSHS should develop a plan to divert people with dementia, traumatic brain injuries, and other cognitive impairments from ITA beds into more appropriate placements. *Source:* Public Safety/ITA Work Group. *Preliminary Fiscal Impact Estimate:* Administrative costs of \$25,000 - \$100,000 to develop the plan. Costs of community resources needed will depend on details of the plan.

## **VI. Task Force Work Plan for 2015 Legislative Interim**

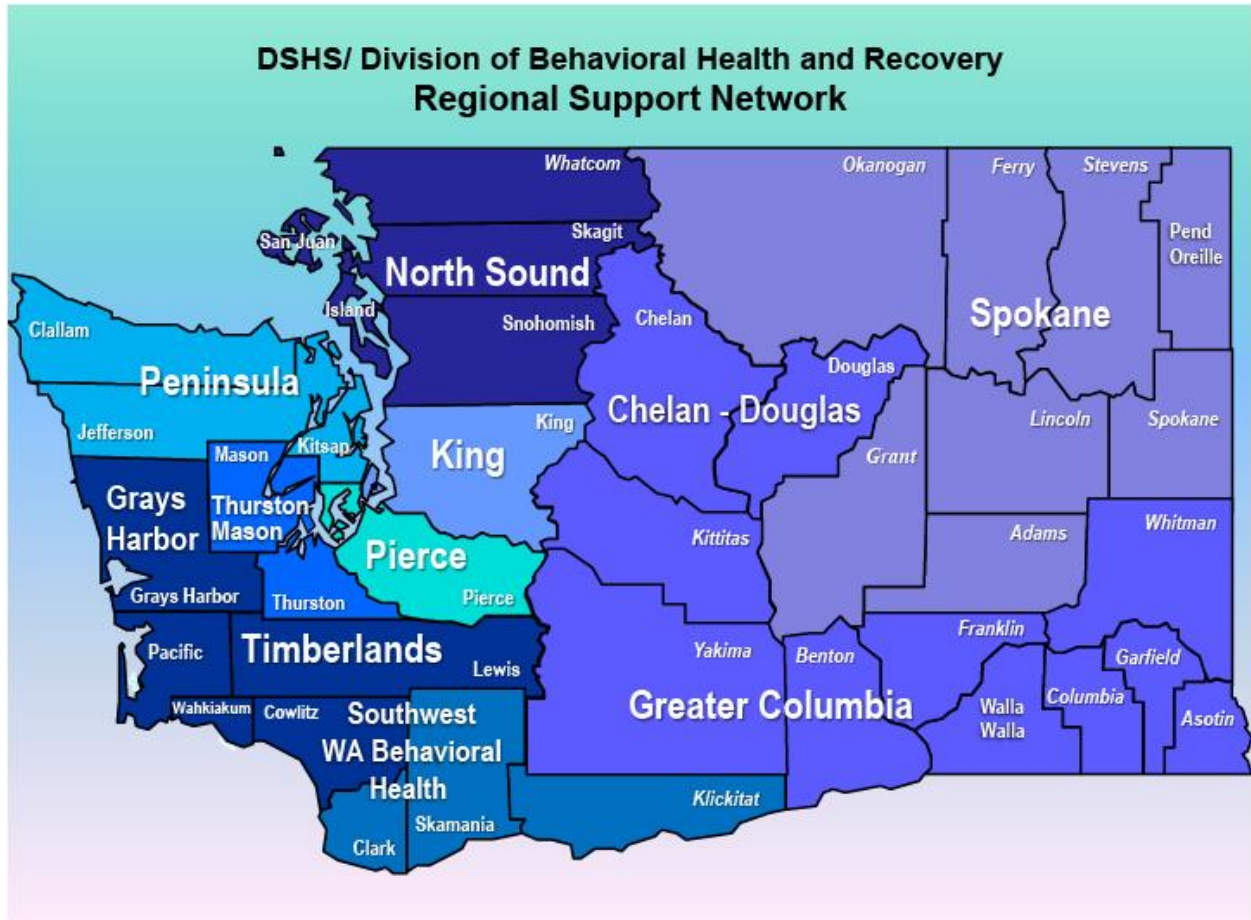
According to the work plan for the Task Force, the following topics will be addressed during the 2015 Legislative interim:

- 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;
- Review of the crisis mental health system, including the extent and causes of variations in civil commitment rates across jurisdictions;
- Whether the state should consider a phased approach to full integration that has timelines flexible enough to allow regions to proceed at various paces; and
- Lessons from other states which are on a similar path towards health care integration.

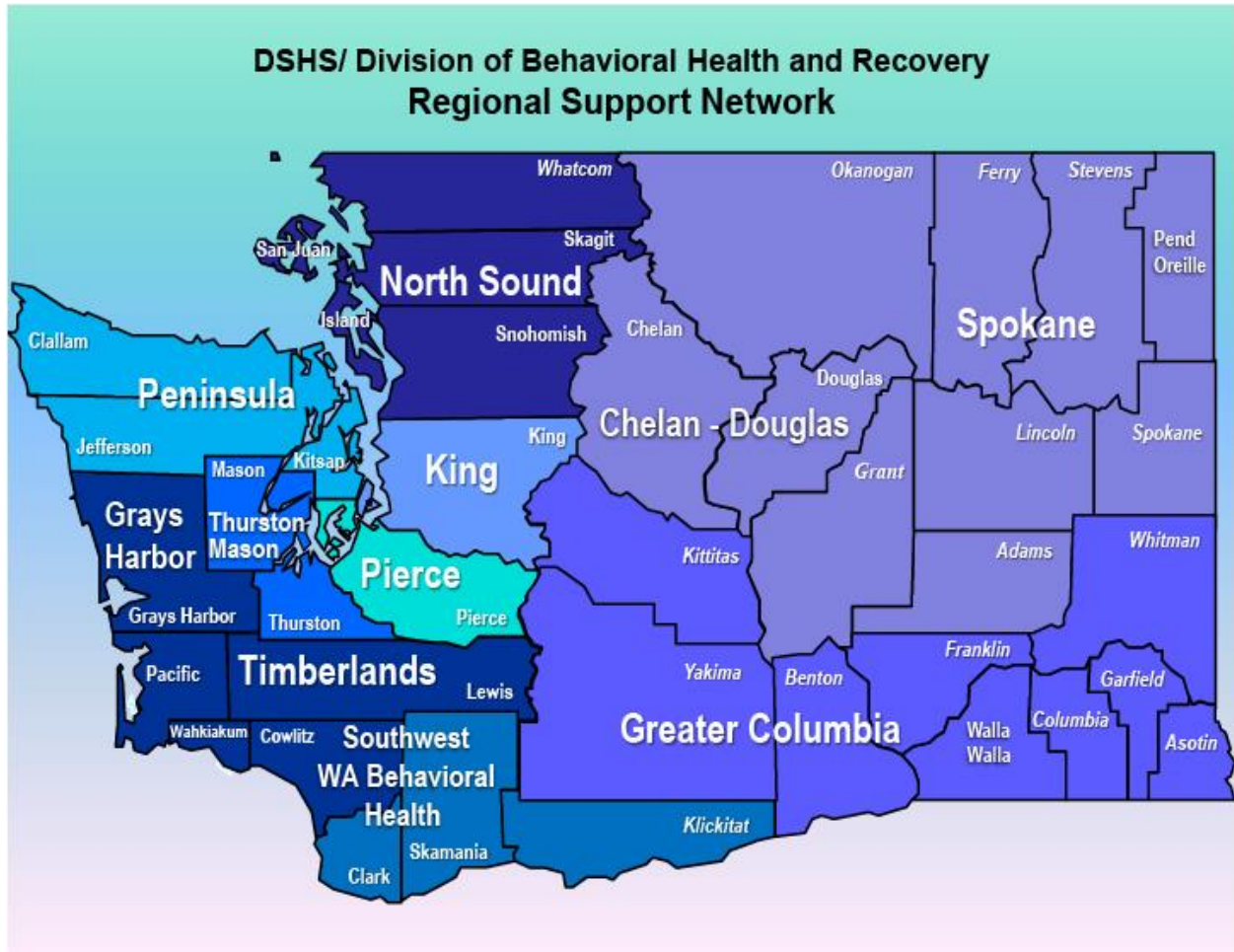
Appendix A

The following alternative regional support area map recommendations were submitted by the Washington State Association of Counties (WSAC) and approved by the Task Force.

**WSAC Proposed Map #1 (CDRSN merge with GCRSN)**



**WSAC Proposed Map #2 (CDRSN merge with Spokane RSN)**



## Appendix B

**The following materials were submitted to the Task Force by the Chemical Dependency Integration Work Group, and approved for inclusion as an appendix to the Task Force's preliminary report. Inclusion does not imply endorsement by the Task Force, except as indicated in the body of the report.**

Adult Behavioral Health Systems Task Force  
Chapter II – Integration of Chemical Dependency (CD) purchasing with managed care contracts  
Chemical Dependency Integration Work Group

The CD Integration Workgroup appreciates the opportunity to present a summary of their findings to the Adult Behavioral Health Taskforce that need consideration prior to behavioral integration in April, 2016. The Chemical Dependency Integration Workgroup has met five times and has cross sector and geographic representation from both substance abuse and mental health areas of focus. The group consists of providers, counties, plans, and state agencies. The workgroup has worked in accordance with the two other Behavioral Health workgroups and appreciated their cooperation.

**Vision statement:** True clinical integration is where multiple care providers who are working with a client (patient) utilize a “shared treatment plan” where in each clinician shares clinical needs, treatment goals/objectives, client progress/challenges in order that all have an understanding of the total persons clinical plan. Integration is not simply co-location or blending funding.

### Tasks:

- A. Identify key issues which must be addressed DSHS/DBHR and HCA to accomplish integration of CD (chemical dependency) purchasing with managed care contracts;
- B. Recommend whether BHO managed care contracts should mandate purchase of specified CD (chemical dependency) services;
- C. Identify effective means to promote recovery and prevent harm associated with mental illness and CD (chemical dependency);
- D. Review detailed plan criteria developed for county authorities wishing to serve as BHO's.

### Findings:

- A. A Comprehensive Chemical Dependency Benefit is integral to an integrated behavioral health system
  - a. The foundation for a treatment system is what services are allowed and compensated for. A service package that is not comprehensive will not allow for services to be provided that will benefit an individual fully and will keep services as is. In an integrated behavioral health system under the Affordable Care Act it is imperative that parity in mental health and substance abuse occur.
    - i. The workgroup has been in concert since the first meeting that the benefit package should include.
      1. Outreach/ engagement
      2. Pre-treatment/ interim services



3. Integrated crisis response services
4. Case management/care transitions (care coordinators/ navigators)
5. Peer services
6. Recovery supports
7. Withdrawal management\*
8. Outpatient treatment\*
9. Intensive outpatient treatment (IOP)\*
10. Residential treatment (Short and Long Term)\*

\*These modalities should include Medication Assisted Treatment

The more comprehensive the Medicaid benefit is, the cheaper it will be for the state, due to the federal portion of the match. For newly eligible people, which are a majority of substance abuse populations, this is covered by the federal government currently at 100%.

- ii. In addition to Medicaid funding, the state needs to maintain Grant in Aid to cover current non-Medicaid activities, i.e. sobering, outreach, childcare, detox and residential treatment in IMD facilities and services to new immigrants, undocumented individuals and others not on Medicaid.

#### **B. Actuarial Rate Study**

- a. State agencies should openly share information about actuarial rate development and be open to feedback from stakeholders. It is imperative that state agencies not base actuarial rates on artificially capped, historically low rates, but that they take into consideration a fair and accurate wage to be able to enhance our work force and the cross training that will need to take place to have a functioning integration.

#### **C. Laws and Regulations**

- a. The state should collaborate with stakeholders to undertake a detailed comparison of MH (mental health) and CD (chemical dependency) regulations, and recommend standardization where appropriate.
- b. The state should collaborate with the Washington State Attorney General's Office and stakeholders to develop standardized privacy guidelines under HIPAA and 42 CFR part 2 that facilitate bi-directional care coordination.

#### **D. Integrated Data Collection System**

- a. The state should create (or purchase) an integrated data reporting system for MH (mental health) and CD (chemical dependency) providers that combines the strengths of the existing data systems. Input into the system design should come from stakeholders representatives that would utilize the system.

#### **E. Proposed Budget Cuts**

- a. DSHS should provide an analysis of the impact of proposed budget cuts on behavioral health integration.

- F. The state should continue to pursue, through CMS, a waiver or exception to the IMD rules for chemical dependency as the chemical dependency treatment funding moves from fee for service to managed care.

**Additional Considerations:**

It is our recommendation that we take into consideration the people that we serve and the providers that will be providing the services. Integration needs to be manageable and able to navigate during transition so that those that need the services can access them and those that will be providing them are able to do so in a seamless manner.

We would also like to echo the recommendation of our colleagues in the Public Safety/Involuntary Treatment Act Work Group that the legislature adequately fund involuntary chemical dependency treatment, including secure detox and residential facilities. We also recommend that the legislature determine what changes to the chemical dependency ITA system are needed to ensure that chemically dependent individuals who are gravely disabled or a danger to themselves or others can receive lifesaving treatment.

CD Benefits funding Matrix – Understanding how current services are being paid.

Benefits Requested to be included in the BHO package:	State - GIA (Bars Code - description)	Medicaid	Comments
<p><b>Outreach/Engagement</b> (State - GIA is already paying for these services, we are asking for them to be included in the Medicaid benefit package.)</p>	<p><b>566.3X Community Intervention and Referral Services</b></p> <ul style="list-style-type: none"> <li>• 566.31 Intervention and Referral</li> <li>• 566.32 Alcohol/Drug Information School</li> <li>• 566.33 Opiate Dependency/HIV Services</li> <li>• 566.36 Interim Services</li> <li>• 566.37 Outreach</li> <li>• 566.39 Brief Intervention</li> </ul>		
<p><b>Pre-treatment/Interim Services</b> (State - GIA is already paying for these services, we are asking for them to be included in the Medicaid benefit package.)</p>	<p><b>566.3X Community Intervention and Referral Services</b></p> <ul style="list-style-type: none"> <li>• 566.31 Intervention and Referral</li> <li>• 566.32 Alcohol/Drug Information School</li> <li>• 566.33 Opiate Dependency/HIV Services</li> <li>• 566.36 Interim Services</li> <li>• 566.37 Outreach</li> <li>• 566.39 Brief Intervention</li> </ul>		
<p><b>Integrated Crisis Response Services</b> (State - GIA is already paying for these services, we are asking for them to be included in the Medicaid benefit package.)</p>	<p><b>566.4X Triage Services</b></p> <ul style="list-style-type: none"> <li>• 566.41 Crisis Services</li> <li>• 566.42 Acute Detoxification Services</li> <li>• 566.43 Sobering Services</li> <li>• 566.44 Involuntary Commitment -</li> <li>• 566.45 Sub-Acute Detoxification Services</li> </ul>		<p>Although, in some counties, there is not access to these services, or enough in the State –GIA money allocated to the county to provide them.</p> <p><b>ITA</b> – State GIA only covers the costs to identify and evaluate for ITA. These costs include case finding, investigation activities, assessment activities and legal proceedings.</p>

Benefit:	State - GIA (Bars Code - description)	Medicaid	Comments
<b>Case Management/Care Navigators</b>	<b>566.6X Support Services</b> <ul style="list-style-type: none"> <li>• 566.63 Case Management –</li> </ul>	Same rules apply here for Medicaid and State - GIA	However, they cannot be case managed by any other agency and we can only bill 5 hours per month. This is very difficult to track.
<b>Peer Services</b>			There is currently no funding. However, some ATR (Access to Recovery) dollars have been used for this service. Those dollars are only available in a few counties state wide.
<b>Recovery Supports:</b> (State - GIA is already paying for these services, we are asking for them to be included in the Medicaid benefit package.)	<b>566.6X Support Services</b> <ul style="list-style-type: none"> <li>• 566.61 Therapeutic Childcare Services</li> <li>• 566.62 Transportation</li> <li>• 566.63 Case Management</li> <li>• 566.67 Child Care Services</li> <li>• 566.69 Pregnant, Post Partum, or Parenting (PPW) women’s Housing Support Services</li> </ul>		We would like to enhance the types of Support Services that we can provide to clients.
<b>Withdrawal Management</b> (State - GIA is already paying for these services, we are asking for them to be included in the Medicaid benefit package.)	<b>566.4X Triage Services</b> <ul style="list-style-type: none"> <li>• 566.41 Crisis Services</li> <li>• 566.42 Acute Detoxification Services</li> <li>• 566.43 Sobering Services</li> <li>• 566.44 Involuntary Commitment</li> <li>• 566.45 Sub-Acute Detoxification Services</li> </ul>		Although, in some counties, there is not access to these services, or enough in the State – GIA money allocated to the county to provide them.

Benefit:	State - GIA (Bars Code - description)	Medicaid	Comments
<p><b>Outpatient Treatment</b></p> <p>Services are paid by both the State-GIA and Medicaid. Those that do not qualify for Medicaid and meet low income criteria can be treated under the State – GIA dollars.</p>	<p><b>566.5X Outpatient Treatment Services &amp; 566.7X Assessment</b></p> <ul style="list-style-type: none"> <li>• 566.53 Adult Group Therapy</li> <li>• 566.54 Adult Individual Therapy</li> <li>• 566.55 PPW Group Therapy</li> <li>• 566.56 PPW Individual Therapy</li> <li>• 566.57 Youth Group Therapy</li> <li>• 566.58 Youth Individual Therapy</li> <li>• 566.59 opiate Substitution Treatment Services</li> <li>• 566.70-74 Assessment (Adult, Youth, PPW)</li> <li>• 566.75 DUI Assessment</li> <li>• 566.76 Brief Therapy</li> <li>• 566.77 Screening Test/Urinalysis</li> <li>• 566.78 Expanded Assessment (Adult and Youth)</li> <li>• 566.79 TB Skin Test</li> </ul>	<ul style="list-style-type: none"> <li>• Assessments – includes DUI and Expanded</li> <li>• Group Therapy</li> <li>• Individual Therapy</li> </ul> <p>(Includes, Adult, Youth, and PPW)</p>	<p>Medicaid does not pay for all of the services that State – GIA does – asking to include the same level in the benefit package. Some services, such as Urine Drug screens, CD providers cannot bill to Medicaid, but if a Lab confirmation is requested, the lab can bill for that.</p>
<p><b>Intensive Outpatient Treatment</b></p> <p>Services are paid by both the State-GIA and Medicaid. Those that do not qualify for Medicaid and meet low income criteria can be treated under the State – GIA dollars.</p>	<p><b>566.5X Outpatient Treatment Services &amp; 566.7X Assessment</b></p> <ul style="list-style-type: none"> <li>• 566.53 Adult Group Therapy</li> <li>• 566.54 Adult Individual Therapy</li> <li>• 566.55 PPW Group Therapy</li> <li>• 566.56 PPW Individual Therapy</li> <li>• 566.57 Youth Group Therapy</li> <li>• 566.58 Youth Individual Therapy</li> <li>• 566.59 opiate Substitution Treatment Services</li> </ul>	<ul style="list-style-type: none"> <li>• Assessments – includes DUI and Expanded</li> <li>• Group Therapy</li> <li>• Individual Therapy</li> </ul> <p>(Includes, Adult, Youth, and PPW)</p>	<p>Medicaid does not pay for all of the services that State – GIA does – asking to include the same level in the benefit package.</p> <p>Some services, such as Urine Drug screens, CD providers cannot bill to Medicaid, but if a Lab confirmation is requested, the lab can bill for that.</p>

	<ul style="list-style-type: none"> <li>• 566.70-74 Assessment (Adult, Youth, PPW)</li> <li>• 566.75 DUI Assessment</li> <li>• 566.76 Brief Therapy</li> <li>• 566.77 Screening Test/Urinalysis</li> <li>• 566.78 Expanded Assessment (Adult and Youth)</li> <li>• 566.79 TB Skin Test</li> </ul>		
<b>Residential Treatment (Short and Long Term)</b>	<b>566.8X Residential Treatment and Group Care Enhancement Services</b> <ul style="list-style-type: none"> <li>• 566.81 Intensive Inpatient Residential Treatment Services</li> <li>• 566.82 Long Term Care Residential Treatment Services</li> <li>• 566.83 Recovery House Residential Treatment Services</li> <li>• 566.8X Group Care Enhancement</li> <li>• 566.88 Hepatitis Aids Substance Abuse Program (HASAP)</li> </ul>	Pays for 16 beds or under facilities	566.81-83 refer <b>ONLY</b> to the CJTA (criminal justice treatment act) funds.  State GIA or Block Grant are used to pay for larger agencies.

## Appendix C

The following materials were submitted to the Task Force by the Early Adopter/Full Integration Work Group, and approved for inclusion as an appendix to the Task Force's preliminary report. Inclusion does not imply endorsement by the Task Force, except as indicated in the body of the report.

### Early Adopter/Full Integration Work Group

#### Executive Summary

The Early Adopter/Full Integration Work Group was formed to assist the Adult Behavioral Health Task Force meet their charge of "providing recommendations for full integration of behavioral health and medical services by 2020, or by 2016 in "early adopter" regions."

**Desired Outcome:** Ensure the design of an integrated service delivery model that provides for a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population ([www.integration.samhsa.gov](http://www.integration.samhsa.gov)).

**Top Priorities:** To date the team has identified 6 key topics for immediate review. Of the 6 key topics, the top 3 priorities are:

- Payment reform to support integrated care models including benefit development and rate design
- Alignment of regulations across CD/MH/primary care to reduce administrative burdens and create consistencies that support integrated care and;
- DSHS and HCA are requested to share procurement documents and draft contracts with the team for comment before such documents are released.

The Work Group requests that the state agencies and legislative task force pay special attention to the timelines for moving to full integration to ensure that they are realistic, reflect the differing states of readiness across the state, and recognize the interconnectedness of the components of integration such that key elements are in place (i.e., data systems in place, rules are aligned) prior to the start date.

**Progress to Date:** The Work Group met 5 times between July and September. The group approached the project with a diverse team of individuals representing a range of interests and sectors including: direct service providers (chemical dependency, mental health, and primary care), NAMI, County, RSN, public health, agency staff (DSHS, HCA) and legislative staff. The team worked cooperatively to identify an extensive range of topics related to the development and financing of a fully integrated system of care. The topics identified included a range of items that were sorted into the following categories: clinical, finance, programmatic, performance monitoring, regulatory, and process orientated. The team has been systematically reviewing each item, discussing the issues, concerns and opportunities, and making recommendations related to potential solutions including assigning needed actions where appropriate.

**Next Steps:** The team will continue to convene over the next several months and work through each of the remaining 26 topics, plus any new topics that emerge, using the established methodology. A number of very critical topics remain outstanding which include, but are not limited to, integration with other specialty programs such as PACT, E&T, detox, residential, and supportive employment; management of client/provider complaints; transitory clients and service availability; 42 CFR Part 2 barriers; workforce development specific to the provision of integrative services; consolidation and/or standardization of WACs for MH, CD and Medical; Health Information Exchange; issues of cultural and

linguistic competence and payment reform. The work groups hopes to provide detailed analysis of the remaining topics along with specific recommendations to the Task Force when it is reconvened in 2015.

**Coordination with Task Force:** The Work Group recognizes that time is of the essence and we wish to support the legislative task force in the best way possible. We are open to feedback on our work to date as well as any direction or redirection of our efforts that the task force deems necessary to achieve its goals.



**Early Adopter/Full Integration Work Group  
Work Plan**

<b>Issue/Concern/Request</b>	<b>Category</b>	<b>Resolution Ideas Opportunities</b>
<p>Financial integration does not mean clinical integration. How do we ensure a model that leads to clinical service delivery integration and better outcomes for clients?</p>	<p>Clinical</p>	<p>Principles/key components of integrated clinical care identified:</p> <ul style="list-style-type: none"> <li>• Provide flexibility in models: Integrated clinical care can happen anywhere – primary care, behavioral health, community settings <ul style="list-style-type: none"> <li>○ Multiple models can achieve integration, examples include: <ul style="list-style-type: none"> <li>Co-location where appropriate</li> <li>Full service provider</li> <li>Unique collaborative relationships that aren't co-located</li> </ul> </li> <li>○ Ensure models that include bi-directional care (PC in BH and BH in PC)</li> </ul> </li> <li>• Ensure continuity of care (keeping provider, keeping meds)</li> <li>• Ensure a robust, interoperable data system: real-time sharing of data is critical for care coordination ( a functional HIE that avoids data entry duplication) <ul style="list-style-type: none"> <li>○ Single, shared care plan</li> <li>○ Single problem list</li> <li>○ Single medication list</li> </ul> </li> <li>• Care coordination is a key component of integrated care model <ul style="list-style-type: none"> <li>○ There are many levels of care coordination</li> <li>○ Some high needs recipients need face to face, outreach</li> <li>○ The committee would like to define a floor requirement for care coordination by plans</li> </ul> </li> <li>• No wrong door – there should be basic screening (contrasted with assessment) at any portal (PC, MH CD) with accountability for referral and warm handoff</li> <li>• Language and cultural competency</li> <li>• Outreach is an expectation and is compensable</li> <li>• Peer support services are integral to the service delivery model</li> <li>• Care is team-based and includes a broad range of disciplines</li> </ul>

## Early Adopter/Full Integration Work Group Work Plan

Issue/Concern/Request	Category	Resolution Ideas Opportunities
		<ul style="list-style-type: none"> <li>• The system is outcome-driven and assures an ability to track outcomes and create accountability across systems and organizations</li> <li>• An integrated system is person-centered and driven by the needs and preferences of clients served</li> </ul>
What does seamless and access look like?	Clinical	<ul style="list-style-type: none"> <li>• Develop strategies that support an assisted referral and mechanisms of accountability to ensure a linkage happened               <ul style="list-style-type: none"> <li>○ Examples include: supportive, warm hand off from one provider to another; transporting client; data systems that flag when a follow up appointment did not occur etc.</li> </ul> </li> </ul> <p>Access looks like:</p> <ul style="list-style-type: none"> <li>• Adequate provider network under contract with adequate rates including paypoints necessary to effectively deliver integrated care</li> <li>• Clients and patients get into providers within a timely manner (as specifically benchmarked and measured by service, i.e. psychiatry with flexibility built in considering capacity within the system)</li> </ul>
Need to emphasize face to face care coordination (vs. telephonic)	Clinical	Define levels of care coordination (reference Duals demonstration project contract as a potential model, based on health home model) that include high touch, face to face care coordination with clients with the highest, most complex needs
Are there other benefits that might be added to improve outcomes, gain efficiency and effectiveness of the service system	Clinical	<p>Key services:</p> <ul style="list-style-type: none"> <li>• MH benefit for people who don't meet access to care should have access to the full continuum of care available through the Medicaid benefit including: full range of assessment and screening, individual and group therapy, medication evaluation and management, case management, peer support functions, community-delivered services, etc.</li> <li>• CD benefit should include a full continuum of services as detailed by the CD Integration Work Group</li> </ul>

**Early Adopter/Full Integration Work Group  
Work Plan**

Issue/Concern/Request	Category	Resolution Ideas Opportunities
		<ul style="list-style-type: none"> <li>• Recovery support services are an essential part of the continuum</li> <li>• A multi-disciplinary Care Team Approach must be available and funded</li> <li>• Outreach, engagement, screening, and referral needs to include outreach and pre-intake engagement and be compensable</li> <li>• Consultative models (telemedicine, tele psychiatry)</li> <li>• Interpreter services</li> <li>• Transportation services</li> </ul>
How do we support clinical models that include/allow for bi-directional care (PC in BH and BH in PC)	Clinical	<ul style="list-style-type: none"> <li>• Education and outreach to primary care and behavioral health about various models and access to resources</li> <li>• Screening in all locations (medical in BH, BH in medical)</li> <li>• Require that plans are able to support multiple models of bi-directional integration and don't rule out any of them.</li> </ul>
How do we ensure a payment model that allow for bidirectional integration (BH in PC and PC in BH)?	Finance	<ul style="list-style-type: none"> <li>• Look at agreements with CMS regarding billing codes for same day services provided within mixed delivery settings (need to reference HIC/PIC and CPT codes to address specific barriers to same day services reimbursement under capitation)</li> <li>• Operationalize value-based funding</li> <li>• Create payment models that supports seeing BH clients because they take more time, no show more often, are more complex (i.e. actuarial rates for clinics that have established integrated care/primary care enhancement payments, etc)</li> <li>• Require that plans are able to support multiple models of bi-directional integration and don't rule out any of them.</li> </ul>

**Early Adopter/Full Integration Work Group  
Work Plan**

<b>Issue/Concern/Request</b>	<b>Category</b>	<b>Resolution Ideas Opportunities</b>
Local resources – counties bring significant local dollars and match money toward MH and CD services; how do we ensure services funded by Medicaid are integrated with locally funded services? How can it be used to best compliment the system in full integration?	Finance	Develop strategies to ensure coordination between managed care plans and local counties, philanthropy, and other funders to assist with aligning resources toward common goals/outcomes
Payment models for co-occurring disorders treatment	Finance	Do an across system look across primary care, CD, MH to do actuarial work to determine what co-occurring treatment costs are and project the population to be served and the mechanism to reevaluate population needs and rates in a timely manner.
Payment for services delivered in integrated care settings	Finance	
How are the CD capitated rates determined and do they cover the full needed benefit (not just what is currently delivered)	Finance	
Need to look at where costs are and who is at risk for those costs – how do we shift the financial incentives within the systems to support health and well-being? Need to create models that share risk across sectors so that everyone has skin in the game	Finance	
Integration and coordination of Crisis Services and ITA for MH and CD – Where will these services sit	Program	

**Early Adopter/Full Integration Work Group  
Work Plan**

<b>Issue/Concern/Request</b>	<b>Category</b>	<b>Resolution Ideas Opportunities</b>
– MH ITA is County responsibility by law		
Coordination with State Hospitals – how will these be paid for in new model given Medicaid can't pay for state hospital stays; also discharge and transition services back to community are paid for with non-Medicaid and/or local dollars; caution about putting incentives in the right place to avoid cost shifting	Program	
Integration and coordination with Offender Reentry and Community Safety (ORCS) – funded outside of Medicaid	Program	
Integration/coordination with other specialty programs such as PACT, E&T, detox, residential, supported employment, etc.	Program	
TR law suit for children's mental health services; how will full integration be impacted by the settlement and changes to children's mental health	Program	
Federal Block Grant – where does that fit? MH & CD block grant dollars used differently	Program	
CD Prevention Services – currently paid for with non-Medicaid dollars	Program	

**Early Adopter/Full Integration Work Group  
Work Plan**

<b>Issue/Concern/Request</b>	<b>Category</b>	<b>Resolution Ideas Opportunities</b>
Medicaid Personal Care – how will this be integrated and paid for in full integration model?	Program	
Diversion services currently funded with non-Medicaid dollars and/or local money	Program	
Integration and coordination with Residential Services (both MH and CD)	Program	
Supported Housing – how is paid for and supported	Program	
There needs to be a process in place to ensure that the full integration model is reducing health disparities in the region	Performance Monitoring	
Ensuring adequate level of outreach, engagement, screening and referral services to identify populations in need of specific services, especially most vulnerable SMI, homeless, etc.	Performance Monitoring	
Counties are concerned that client/provider complaints will not be adequately resolved in a timely fashion and such complaints will be brought to the county (thru executive and/or legislative branch). Counties (and RSAs and/or ACHs) need a role in quality	Performance Monitoring	

**Early Adopter/Full Integration Work Group  
Work Plan**

<b>Issue/Concern/Request</b>	<b>Category</b>	<b>Resolution Ideas Opportunities</b>
assurance and monitoring, need access to data, process that they are involved in for complaint investigation and resolution.		
Clients who don't receive adequate services will end up in jail or other county funded services.	Performance Monitoring	
Baseline utilization in each service area needs to be identified and then monitored. What if it drops but money doesn't? Will we be able to determine why?	Performance Monitoring	
How to manage clients who border RSA's and may want to access services in another region?	Performance Monitoring	
What is the role of the ACH in achieving the desired outcomes?	Performance Monitoring	
How do we measure integration?	Performance Monitoring	
42 CFR Requirements around CD creates barriers to integration	Regulatory	
Work Force development – full integration creates need for new types of positions (care coordination/peer support/community health workers, as well as the need to	Regulatory	

**Early Adopter/Full Integration Work Group  
Work Plan**

<b>Issue/Concern/Request</b>	<b>Category</b>	<b>Resolution Ideas Opportunities</b>
ensure current staff are trained to provide integrated care Also need training capacity in EBPs <ul style="list-style-type: none"> <li>• College &amp; University Training</li> <li>• Current Work Force Training</li> </ul>		
Consolidating and/or standardizing WACs for MH, CD and Medical	Regulatory	
IMD issues – who is at risk and pays for stays in an IMD – how do we reduce cost shifting	Regulatory	
Health Information Exchange – includes sharing information across providers; client registries for care coordination	Data	
Who owns data, has access to data, etc.	Data	
Concerned that timelines are too aggressive and communities and providers may not be ready to make the shift that quickly	Process	
Ensure the state allows some flexibility in regional models to ensure the best clinical model for a community/beneficiaries	Process	
Role of client voice, advisory boards, patient engagement strategies	Process	



**Early Adopter/Full Integration Work Group  
Work Plan**

<b>Issue/Concern/Request</b>	<b>Category</b>	<b>Resolution Ideas Opportunities</b>
Tribes		
Issues of cultural and linguistic competence		
<ul style="list-style-type: none"> <li>• Uninsured, underinsured (who do you see and how do you get paid for serving them?)</li> </ul>		

# Initial Summary of the Full Integration/Early Adopter Work Group

Adult Behavioral Health Task Force  
October 10, 2014

Presented by:  
Susan McLaughlin, Ph.D.  
King County Department of Community and Human Services

# Membership

- ▶ Mental Health Treatment Providers
- ▶ Substance Abuse Treatment Providers
- ▶ Community Health Clinics
- ▶ NAMI
- ▶ County Representatives
- ▶ Regional Support Networks
- ▶ Local Public Health
- ▶ Health Plan Representatives
- ▶ Agency (DSHS/HCA) staff
- ▶ Legislative Staff

# Process

- ▶ Five meetings since July
- ▶ Identified key issues and concerns related to integration
  - Clinical
  - Finance
  - Programmatic
  - Performance Monitoring
  - Regulatory
  - Process Oriented
- ▶ Making recommendations based on each issue/concern

# Defining Integration

Integrated care is “the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.”

# Key Principles of Integrated Care

- ▶ Person-centered
- ▶ Flexible models of care
- ▶ Recovery, resiliency, and wellness oriented
- ▶ Adequate/sustainable networks and access
- ▶ Outcomes and accountability

# Benefits and Rates

- ▶ Support a full continuum of care
- ▶ Benefit structures & coverage policies that support integration
- ▶ Outreach and engagement is compensable
- ▶ Rates support integrated and team based care models
- ▶ Mechanisms in place to allow for reimbursement of integrated PC/MH/CD care
- ▶ Operationalize value-based purchasing and test pilot models

# Work Force Development

## ▶ Current Workforce

- Integrated care
- Care coordination
- Health/wellness support

## ▶ “New” Workforce

- Integrated care will bring the need for new types of positions – CHW; peer support; care managers; dual certified

## ▶ Future Workforce

- Partnering with technical and trade schools, colleges, universities and other educational and non-traditional training programs to ensure a future workforce



# Core Elements of an Integrated System

- ▶ Interoperable data system/decision support tool that allows for real-time sharing of data
- ▶ Leveled care coordination based on client need
- ▶ Multi-disciplinary care team approach
- ▶ Universal screening in all sectors – no wrong door
- ▶ Psychiatric consultation
- ▶ Telemedicine, including telepsychiatry
- ▶ Extension services – collaborative quality improvement, best practice training & dissemination, support for standardized practice

# Specific Recommendations

- ▶ **Aligning WACs**
  - Administrative activities
  - Intake/assessment
  - Treatment plan
  - Crisis/ITA
- ▶ **Develop a data system/data sharing plan**
  - Real time data sharing and mechanism for funding
- ▶ **Review Full Integration RFP before it goes out**

# Other Key Considerations

- ▶ **Timeline**
  - Every region is in a different place – allow for flexible timelines and the possibility of phasing into a fully integrated system
- ▶ Early adopter regions are pilots not the model for all regions
- ▶ Create mechanisms to ensure continuity of care
- ▶ Ensuring the right mix of providers – essential community provider network
- ▶ Medicaid Waiver

## Appendix D

The following materials were submitted to the Task Force by the Public Safety/Involuntary Treatment Act Work Group, and approved for inclusion as an appendix to the Task Force's preliminary report. (Minor changes were made from the original document that was presented to the Task Force.) Inclusion does not imply endorsement by the Task Force, except as indicated in the body of the report.

# ADULT BEHAVIORAL HEALTH TASK FORCE

## Public Safety/ITA Workgroup

### Summary Report November 14, 2014

Involuntary treatment is an important part of the continuum of care  
and sometimes is the *only* viable option to keep a person safe.

## **WORKGROUP MEMBERSHIP (attended at least one meeting)**

Pioneer Center North

Public Defenders

Mental Health and Recovery Advocates

King County Alcoholism and Substance Abuse Administrative Board

King County Mental Health and Administrative Board

King County Mental Health Advisory Board

National Alliance on Mentally Illness (NAMI) Washington

Optum Health

Pioneer Human Services

Senate Human Services and Corrections Staff

Spokane RSN

Southwest Washington RSN

Coordinated Care

Washington State Institute for Public Policy

Washington Community Mental Health Council

Cowlitz County Health & Human Services

### **A. TASK FORCE CHARGES RELATED TO PUBLIC SAFETY AND INVOLUNTARY TREATMENT**

- The extent and causes of variations in involuntary commitment rates in different jurisdictions across the state;
- Availability of crisis services, including boarding of mental health patients outside of regularly certified treatment beds;
- 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; and
- Public safety practices involving persons with mental illness and chemical dependency with forensic involvement.

## B. OUR VALUES

- ✓ We support a treatment philosophy that values the belief that people can and do recover.
- ✓ We support a continuum of care that emphasizes prevention and provides intensive services when appropriate.
- ✓ We support integration, adequate staffing, peer support, safe facilities and training without reducing capacity.

## C. TOP THREE RECOMMENDATIONS

1. **The *Legislature* should expand chemical dependency ITA services by increasing the number of beds and the rate for residential ITA. Additionally implementing secure detox would facilitate admission into services.**

The Chemical Dependency ITA rate at Pioneer Center North and Pioneer Center East is *one fifth* the cost of providing Mental Health ITA at Western and Eastern State; there has not been a rate increase since 2002; and Pioneer subsidizes the program. In 2011 a WSIPP study noted that there was a net benefit to society and tax payers from a 2006 secure detox pilot, but there are no secure detox facilities in our state.

2. ***DSHS* should prioritize reduction of violence at state hospitals using evidence-based and best practices.**

Use of evidence-based practices and other best practices will reduce violence at state hospitals and other treatment facilities.

3. **The *Legislature* should expand availability of peer services by addressing credentialing barriers such as criminal history while ensuring consumer and community safety.**

Peer counselors provide validation and hope to clients; broaden the workforce, and bring risk reduction and cost savings to the system.

## D. OTHER ISSUES

### Mental health and chemical dependency standardizations:

- The group did not have consensus agreement on this issue but it was brought up as a concern. The chemical dependency statute (RCW 70.96A.145) states that prosecutors "may" pursue involuntary chemical dependency cases. In the mental health statute (RCW 71.05.130), it states that prosecutors "shall" pursue involuntary mental health cases. As a result, some counties will not take contested chemical dependency cases, thereby calling into question the integrity of the chemical dependency involuntary system.
- Integrate 24/7 crisis response for mental health and chemical dependency.
- Streamline mental health and chemical dependency commitment timelines. It is currently 12 hours for chemical dependency and 10 hours for mental health.
- Create an exemption for chemical dependency court filing fees. This is a barrier to get people into treatment especially in smaller counties.

### Non-Medicaid Services:

- 2SSB 6312 did not specify how crisis services, ITA, and other non-Medicaid services will be funded in regional service areas that will not have a carve out Behavioral Health Organization (BHO) under early adopter models. The legislature should specify the entities responsible for oversight and contracting for these services. This issue is specific right now to the Southwest Washington Region, which wishes to pursue an early adopter option but will quickly be a concern for all the regions.

### Diversions to more appropriate care:

- DSHS needs to develop a plan to divert people with dementia, traumatic brain injuries and other cognitive impairments from the mental health ITA system.

## ACKNOWLEDGEMENTS

We are grateful for the opportunity to provide input to the Adult Behavioral Health Task Force. The Task Force has received a tremendous amount of information and material and we have tried to keep our points succinct and concise. We are also grateful for the assistance of Kevin Black, Senate Human Services and Corrections staff for attending every meeting and providing us guidance on our recommendations.

## Appendix E

On November 14, 2014, the Task Force voted to include the Tribal Centric Behavioral Health Report, dated November 30, 2013, as an appendix to its preliminary report.

**Report:**

<http://www.dshs.wa.gov/pdf/dbhr/5732%20Tribal%20Centric%20Behavioral%20Health%20Report.pdf>



## **Report to the Legislature**

# **Tribal Centric Behavioral Health**

2SSB 5732, Section 7 Chapter 388 Laws of 2013

November 30, 2013

**Health Care Authority and  
Department of Social and Health Services  
Behavioral Health and Service Integration Administration  
PO Box 45050  
Olympia, WA 98504-5050  
360-725-2261**



Tribes of Washington State

Recognized American Indian Organizations

Health Care Authority

Washington State Department of Social & Health Services



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# Executive Summary

## Context

In September 2009, during the Washington State Tribal Mental Health Conference, the vision of a Tribal Centric Mental Health System began. During this meeting Assistant Secretary Doug Porter acknowledged what the Tribes of Washington had known and experienced since the inception of the Regional Support Networks—a Managed Care system without a requirement to acknowledge and constructively work with Tribal Governments cannot adequately respond to, and appropriately serve, American Indians and/or Alaskan Natives (AI/AN). Since that meeting, through the formation of a Tribal Centric Workgroup, the Tribes and the Department of Social and Health Services (DSHS) have strived to address these matters. Over the years the work has grown to move from solely a mental health focus to an integrated behavioral health model which encompasses both mental health and chemical dependency treatment. The membership of the Tribal Centric Workgroup includes DSHS staff, Health Care Authority (HCA) staff, and Tribal representatives appointed through the American Indian Health Commission (AIHC) and the DSHS Indian Policy Advisory Committee (IPAC).

Recent data analysis indicates that while 19 percent of American Indian/Alaskan Native Medicaid eligibles live on Triballand, 81 percent reside outside of a reservation, with a majority of that population living either along the I-5 corridor or in the greater Spokane area. Accordingly, with this geographic distribution across the state, the RSNs are the primary source of outpatient mental health services for AI/AN Medicaid enrollees.

Based on SFY 2011 data, an estimated 15,331 (19.8 percent) of the 77,140 AI/AN Medicaid enrollees received mental health services through the RSNs. Tribal mental health programs provided services to 3,458 (23 percent) of all Medicaid AI/AN who received mental health services during the same period. Of this number, 831 (5 percent) individuals received services from both Tribal and RSN provider programs. Of those who received mental health services, 11,042 (72 percent) AI/AN received mental health services only through the RSN system.<sup>1</sup>

## Tribal Centric Workgroup Recommendations

Over the last eighteen months of bi-monthly meetings the Tribal Centric Behavioral Health Workgroup has identified issues, reviewed problems and explored multiple solutions to problems. The Workgroup addressed not only those issues surfaced at the 2009 meeting, but also emerging concerns regarding the provision of mental health services and the interface

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<sup>1</sup> Please note that these figures only reflect Medicaid encounters. The Department does not track Veterans Administration services, Medicare only services, private insurance services, IHS services, or services funded directly by Tribes.

between tribal providers, Tribes, individual American Indians and Alaskan Natives, and the RSN system.

The Workgroup identified the defining characteristics that should exemplify a Tribal Centric Behavioral Health System. Those characteristics should demonstrate:

- The value and importance of individual choice.
- The value and importance of AI/AN individuals having access to Tribal and urban Indian programs providing behavioral health services.
- Mandatory changes to RSNs and how they relate with the Tribes and AI/AN individuals.
- Required cultural competency training for RSN and state hospital staff working with the AI/AN population.
- Coordinated and centralized communications between DSHS and HCA in policy development and designing, and modifying billing and reporting procedures.
- Conducting a feasibility study for structuring one or more residential programs. The study should determine what type of facility would best serve AI/AN population (freestanding evaluation and treatment (E&T), crisis triage, dual diagnosis beds, or a combination of all three).

The Workgroup membership strongly voiced that individual choice should be a guiding value of any future system. Workgroup members also emphasized that the future system should also allow AI/AN individuals to continue to have direct access to Tribal and urban Indian behavioral health programs. Those AI/AN individuals who have chosen to receive services through the existing RSN system, or its successor, should be able to continue to receive those services if they so choose. They should be able to do this without disruption and without having to be subjected to an opt-in or opt-out process so that they can continue receiving care.

The Workgroup stipulated that to adequately and appropriately serve the AI/AN population, especially those Tribal members living on reservations, the RSNs must make serious and significant changes in the way they interact with Tribes and Tribal members. The Department should aggressively monitor and verify that RSNs are following the recommended changes to insure that meaningful change actually occurs. The Department should implement corrective actions and penalties for those RSNs who do not insure that AI/AN consumers are afforded the same access, rights and benefits available to all other Medicaid eligibles within the RSN. Additionally, RSNs must comport themselves with Tribes in a manner honoring their government-to-government relationship.

## Background

Washington has an estimated 193,000 AI/AN people residing in the State (see Table 1). The AI/AN population is approximately 2.9 percent of the total state population and 3.9 percent of the total 4.9 million AI/AN populations in the United States. Washington has the sixth largest AI/AN population in the country, with California (662,000 AI/N population) having the largest population, followed by Oklahoma (482,000) and Arizona (334,000).

	Total		Uninsured		
	Number	% Total	Number	% Total	% Uninsured
Under 138%	67,836	35.2%	20,743	48.2%	30.6%
138% - 400%	77,350	40.1%	17,379	40.4%	22.5%
Over 400%	47,989	24.6%	4,877	11.4%	10.2%
Total	193,175	100.0%	43,000	100.0%	22.3%

Source: Fox-Boerner 33 State Database for American Indians and Alaska Natives, Alone and in Combination. American Community Survey. 2008-2010 pooled data.

A significant proportion of Washington’s AI/AN population resides in urban areas. Forty-one percent (78,600 ACS estimate) of Washington’s AI/AN population reside in the Seattle-Tacoma-Bellevue Metropolitan Statistical Area (MSA) and six percent (12,400 ACS estimate) reside in the Spokane MSA.

Recent data indicates that approximately 43,000 (22 percent) of the AI/AN people in Washington were uninsured and 55,500 (29 percent) had Medicaid coverage. Washington’s 2010-2011 overall uninsured rate for nonelderly was 16.2 percent.<sup>2</sup> In comparison to 33 other states with reservations, Washington had the eleventh lowest uninsured rate and the twelfth highest Medicaid rate among the 33 States.<sup>3</sup>

The Affordable Care Act’s (ACA) Medicaid expansion and Exchange tax credit subsidies can provide health coverage for a significant number of AI/AN people living in Washington. A recent GOA report estimated that over 31,000 AI/AN in Washington will be eligible for the 2014 Medicaid expansion, and over 50,000 will be eligible for tax credit subsidies available through the Washington Health Benefit Exchange.<sup>4</sup>

<sup>2</sup> Source: “The Uninsured A Primer”, Kaiser Commission on Medicaid and the Uninsured (October 2012).

<sup>3</sup> Source: American Community Survey. Report prepared by Fox-Boerner and the California Rural Health Board funded by the Centers for Medicare and Medicaid Services. The population estimates are based on 2008-10 pooled data.

<sup>4</sup> Source: GAO Report – 13-553. “Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment”, (September 2013).

## **Washington Tribes**

There are 29 federally recognized Tribes in Washington. The Tribal reservations are clustered in the western portion of the State, with three reservations on the eastside (see Exhibit 1). Those eastside reservations are, however, the first, second and fourth geographically largest reservations. These Tribes are also the Tribes with an Indian Health Services presence.

While Tribal membership is not public information, Washington's Tribes reported providing health care to 66,000 AI/AN people in 2012 (see Exhibit 2). The Yakima Indian Nation had the largest user population (12,800) and the Hoh Tribe had the smallest (26). The average user population across the 29 Tribes was 2,280, with four of the Tribes accounted for 50 percent of the total user population.

## **American Indian/Alaskan Native Service Delivery System**

As required under Federal trust responsibilities, treaty rights and federal law, the federal government has a responsibility for providing health care for tribal members and other AI/AN people. The Johnson O'Malley Act of 1934 affirmed the federal government's financial responsibility for Indian health services. It authorized the Secretary of the Department of Interior to contract with state and local governments and private organizations to provide educational, medical, and other assistance to American Indian people who no longer lived on the reservation. The Indian Health Services (IHS) was created in 1955 as an agency in the Department of Health & Human Services (HHS).

The Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638, ISDEAA) changed the Indian health care delivery system forever by allowing Tribes the authority to assume the responsibility for administering their own health programs. In order to do so, Tribes entered into contracts with the federal government to operate health programs that were provided by IHS. The Act also made grant funds available to Tribes for planning, developing, and operating health programs. Subsequent federal legislation further expanded the concepts of P.L. 93-638 by authorizing Tribes to enter into self-governance compacts negotiated with IHS to assume responsibility for service delivery and resource management.

Washington's Tribes are national leaders in self-governance. Twenty-eight of the Tribes have 638 operated programs, two Tribes have both 638 and IHS operated programs and one Tribe is only IHS operated (see Exhibit 3).

## **Indian Health Services**

Indian Health Services is the primary source of funding for tribal and urban Indian



health programs. It provides federal appropriations that are used to provide direct medical and specialty care services to eligible AI/AN people. In addition to ambulatory primary care services, dental care, mental health care, eye care, substance abuse treatment programs and traditional healing practices are financed through direct service funding.

The IHS Contract Health Service (CHS) program provides funding for services that are not directly provided by the Tribal programs. The CHS program provides funds that are used to purchase inpatient and specialty care services from private health care providers where no IHS or Tribal direct care facility exists. CHS is not an entitlement program and an IHS referral does not imply that the cost of care will be paid. If IHS or a Tribe is requested to pay, then a patient must meet residency requirements, notification requirements, medical priority, and use of alternate resources.

Nationally, an estimated 75 percent of Tribal CHS programs are funded at 45 percent of forecasted need.<sup>5</sup> Because of this severe underfunding, IHS has special rules dealing with its eligibility and provider payments.<sup>6</sup>

The Pacific Northwest does not have an IHS hospital or specialist services. Tribes must purchase all inpatient care and the vast majority of specialty care from private health care providers using CHS dollars. Many Washington Tribes have operated under Priority 1 for many years, meaning CHS funds are so limited, they can only be used to purchase health care that will save life or limb.

## **Medicaid**

Washington's Medicaid program currently covers 1.2 million people, about 15 percent of all Washington residents and nearly one-half of all children. While there is not a full accounting of AI/AN enrollment in Medicaid due to self-reporting and under-reporting, an estimated 40,000 AI/AN people are enrolled in the program.

Medicaid is the second largest source of coverage for AI/AN people and, excluding IHS funding, it is the largest public health insurance program for Indian people. While published data is not available, a 2005 GAO study and available Tribal participation data reported that Medicaid payments were the largest non-IHS source for Washington's Tribal health

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<sup>5</sup> Source: Indian Health Services' December 30, 2010, Dear Tribal Letter.

<sup>6</sup> The IHS CHS medical priority of care is determined as levels, I, II, III, IV, and V. The funding and volume of need by the population have required that most Area can only be provided through CHS authorization the highest priority medical services - Level I. These medical services are generally only emergency care service, i.e., those necessary to prevent the immediate threat to life, limb, or senses. The IHS Medical Priorities Levels are: I. Emergent or Acutely Urgent Care Services; II. Preventive Care Services; III. Primary and Secondary Care Services; IV. Chronic Tertiary Care Services; and V. Excluded Services.

programs, and that Medicare was another federal funding source.<sup>7</sup> In their 2005 study, the GAO visited 13 Tribal facilities. While the amount of reimbursements that facilities obtained varied, Medicaid revenue accounted for about one-quarter (range from two percent to 49 percent) of budgeted direct service revenue for health clinics.

Washington's Tribes have aggressively sought third party payment strategies. All but one of the Tribes have contracted with the state Medicaid agency to be providers in order to access Medicaid financing to help provide health services to tribal members (see Exhibit 3). Twenty-six of the Tribes have Medicaid contracted medical program, 27 Tribes have mental health programs and 26 Tribes have chemical dependency programs. Twenty-four Tribes have both medical and mental health programs, and 26 Tribes have both mental health and chemical dependency programs.

In state fiscal year (SFY) 2011, Tribal programs provided care to approximately 30,600 Medicaid enrollees. Of this total, 20,400 (67 percent) were AI/AN enrollees and 10,200 (33 percent) were non-natives (see Exhibit 4). The Tribes received \$52.2 million for Medicaid health care services—\$40.9 million (78 percent) for AI/AN enrollees and \$11.2 million (22 percent) for non-natives. Medical services accounted for \$17.7 million (34 percent), mental health services were \$13.5 million (25 percent) and chemical dependency services were \$12.1 (23 percent).

### **Medicaid AI/AN Mental Health System**

Washington's current Medicaid mental health service system is complex (see Exhibit 5). There are two sets of mental health benefits and three different ways that these services are provided. The services are administered by two different state agencies—the Department of Social and Health Services and the Health Care Authority. For AI/AN people, the system is further complicated because AI/AN individuals and their family members can receive Medicaid funded outpatient mental health services directly from their IHS or 638 contract/compact Tribal programs, as well as through the RSN system and/or the Healthy Options program if they have elected to enroll in managed care.

### **Mental Health Service Benefits**

The Medicaid program has two sets of outpatient mental health services for AI/A and non-native people enrolled in Medicaid. Currently, under what is referred to as *medical mental health services*, adult Medicaid enrollees may have access to a limited mental health benefit. Adults have access to 12 mental health therapy visits per year plus medication management—the therapy services must be provided by a psychiatrist. Child Medicaid enrollees currently may have access to outpatient services from a psychiatrist or other

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<sup>7</sup> Source: GAO Report 05-789, "Indian Health Services: Health Care Services Are Not Always Available to Native Americans" (August 2005).

licensed mental health professional specializing in serving children. Unlike adults, children are eligible for up to 20 visits per year, including medication management. Adult and children's management of mental health drugs by physicians and ARNPs does not have limitations. The *medical mental health services* are administered by HCA. Beginning January 2014, Medicaid will adopt ACA parity provisions that eliminate visit limits for adults and children and expand the types of mental health providers who can provide adult mental health services.

Under what is referred to as the *rehabilitative mental health services*, Medicaid enrollees have access to 19 different "treatment or service modalities" (see Exhibit 5). Importantly, these services include crisis services. Unlike the *medical mental health benefit*, these services do not have specific limits on the number of visits. Services may be provided as long as the client presents with medical necessity for care. However, persons can only get these services if they meet *Access to Care Standards* and have a covered mental health diagnosis.<sup>8</sup> These services are administered by DSHS through the RSNs.

### **Mental Health Service Delivery**

Most Medicaid enrollees are required to be enrolled in, and receive their medical care, through managed care contracted health plans (Healthy Options Program). The managed care plans are also responsible for providing limited outpatient medical mental health outpatient visits and medication through the Healthy Options plan. AI/AN Medicaid enrollees are not required to enroll in a managed care plan to receive their health care. They can go directly to their IHS/638 Tribal programs, urban Indian health programs or to any other health provider with a Medicaid contract. This includes *medical mental health services*.

While AI/AN people can get mental health services through the two urban Indian health programs, the current Medicaid program restricts the services that the urban programs can provide. In the existing system, the urban programs must contract with their local RSN to be able to provide the rehabilitative mental health services. Otherwise, they can only provide the more limited *medical mental health services*. Tribal programs can provide rehabilitative mental health services to AI/AN people and their non-native family members without having to contract with an RSN.

Medicaid enrollees must obtain *rehabilitative mental health services* through their local RSN, which is a local government managed care program. RSNs operate as Pre-Paid Inpatient Health Plans (PIHPs) and provide outpatient services to reduce the need for inpatient care. AI/AN Medicaid enrollees can also go to their IHS/638 Tribal programs to obtain outpatient mental health services. They do not have to meet the RSN *Access to Care Standards* to receive the services at IHS/638 facilities. Currently, AI/AN Medicaid enrollees can only access

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<sup>8</sup> *Rehabilitative mental health services* provided by IHS and 638 contract/compact facilities are not subject to rehabilitative *Access to Care Standards*. Instead, they must meet the general medical necessity standard, which is less rigorous standard of acuity allowing for more persons to have access to this level of care.

inpatient psychiatric services through their RSN. This is also true for all other Medicaid enrollees in Washington.

RSNs are responsible for the inpatient mental health service costs for all Medicaid enrolled consumers living within the RSN. This includes Medicaid enrollees participating in other managed care plans, RSN enrollees and AI/AN individuals covered by Medicaid.

Unless they have contracted with Tribal or urban Indian health programs, the RSN system typically does not have culturally appropriate services for AI/AN people. In part this is due to a limited number of Indian mental health professionals, who most often work for Tribal or urban Indian programs.

### **American Indian/Alaskan Native Health & Mental Health Disparities<sup>9</sup>**

While Washington's Tribes have achieved improvements in health status, AI/AN people continue to experience disproportionate health disparities in comparison to the states' general population.

The life expectancy of an AI/AN individual is lower than any other population in Washington.<sup>10</sup> In the *Washington State Vital Statistics Report of 2008*<sup>11</sup>, mortality data was assessed over a five-year period from 2000–2006, using ten (10) leading causes of death. The outcomes were disheartening for AI/AN people: (a) AI/AN males and females had the lowest life expectancy of any other population in Washington (71 and 75 years of age, respectively); (b) AI/AN age-adjusted mortality rates (1,187.5 per 100,000) exceeded all other groups, and was significantly higher than whites ((897.6 per 100,000); and, (c) From 1990–2006, there were significant decreases in age-adjusted mortality rates for Whites, Blacks, and Asian/Pacific Islanders, yet no significant downward trend was seen in AI/AN male rates, and AI/AN females experienced a 1.3 percent increase per year in mortality rates.

The leading causes of death for AI/AN include: (a) heart disease; (b) cerebrovascular disease; (c) unintentional injuries; (d) cancer; (e) diabetes mellitus; and, (f) chronic liver disease and cirrhosis. AI/AN people are much more likely (nearly twice) to die in middle age (25-65) than the general population. Conversely, only 45 percent of AI/AN people die after 65 compared to 74 percent of the general population.<sup>12</sup> Suicide is also much more common among AI/AN people than the general population.

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<sup>9</sup> Source: Mental illness diagnosis and chemical dependence need is from DSHS Integrated Client Database data by the DSHS Research and Data Analysis Division.

<sup>10</sup> Source: American Indian Health Commission's *Tribal Analysis for Washington State Health Benefits Exchange & Health Care Authority*, report (April 1, 2012).

<sup>11</sup> Washington State Department of Health, Center for Health Statistics. *Vital Statistics 2006 Report*. November 2008.

<sup>12</sup> *Chronic Disease Profile*, Washington State Department of Health, December 2011, p. 7.

Medicaid enrolled AI/AN individuals have a significantly higher incidence of mental illness diagnoses than Medicaid non-natives. Across all ages, AI/AN (35 percent) enrollees have a 67 percent higher incidence of mental illness diagnoses than non-natives (21 percent) enrollees (see Table 2 and Exhibit 5). This is reflected in mental health prescription drug utilization, with AI/AN enrollees (31 percent) having 47 percent higher usage than non-natives (21 percent).

AI/AN Medicaid enrollees have a higher incidence of diagnosed mental illness across all age groups, including children, adults and persons 65 and older (see Table 2 and Exhibit 6).

Diagnoses of mental illness for AI/AN children (24 percent) was 125 percent higher than for non-native children (11 percent). AI/AN children (15 percent) also have an 84 percent higher usage of being prescribed psychotropic medications than non-native children (8 percent).

AI/AN Medicaid enrollees have a significant higher need for chemical dependency treatment services than non-natives. Across all ages, AI/AN (19 percent) have a 155 percent higher incidence of diagnosed chemical dependency than non-natives (8 percent). (Please see Table 2 and Exhibit 6.) Medicaid eligible AI/AN children and seniors have over twice the need than non-natives.

Indicators ( FY 2010 - 2011)	Total All Ages			
	AI/AN		Non-Natives	
	Total	Percent	Total	Percent
<b>Any MI diagnoses</b>	27,339	35.4%	258,643	21.2%
Psychotic	3,712	4.8%	36,305	3.0%
Mania & Bipolar	7,666	9.9%	75,619	6.2%
Depression	14,864	19.3%	142,437	11.7%
Anxiety Disorder	15,156	19.6%	124,840	10.2%
ADHD	3,512	4.6%	29,176	2.4%
Adjustment disorder	3,792	4.9%	23,326	1.9%
<b>Any Psychotropic Rx</b>	23,716	30.7%	254,928	20.9%
<b>Any MI Dx or Psychotropic Rx</b>	33,155	43.0%	339,531	27.8%
<b>Alcohol/drug Treatment Need</b>	15,003	19.4%	93,079	7.6%
<b>Co-occurring MI and AOD Tx Need</b>	10,741	13.9%	65,867	5.4%
<b>Population:</b>	<b>77,140</b>		<b>1,220,945</b>	

## Mental Health Treatment Utilization <sup>13</sup>

Given that Medicaid AI/AN enrollees have a higher incidence of being diagnosed with mental illness than non-natives, it is consistent to find that AI/AN enrollees also have a higher utilization of mental health services. In SFY 2011, Medicaid AI/AN utilization of RSN services was 333.4 units/1000 member-months (MM) compared to 194.7 units/1000 MM for non-natives—71 percent greater utilization (see Table 3 and Exhibit 7). Inpatient psychiatric hospital admissions for AI/AN were 66 percent greater than non-natives—41.9 admissions/1000 MM for AI/AN compared to 25.3 admissions/1000 MM for non-natives. Prescriptions for psychotropic medication was also 52 percent greater—244.3 prescriptions/1000MM for AI/AN clients compared to 160.4 prescriptions/1000 MM for non-natives.

Medicaid eligible AI/AN children (age 0-20) had a 130 percent greater utilization of RSN services than non-native children (206.4 services/1000 MM as opposed to 89.8 services/1000 MM). (See Exhibit 7) They had a 106 percent greater incidence of being prescribed psychotropic medications as well—94.7 prescriptions/1000 MM compared to 45.9 prescriptions/1000MM for non-natives. AI/AN children also had a 165 percent greater psychiatric hospital admission rate than non-natives—13.3 per 1000 MM compared to 5.0 per 1000MM for non-natives.

AI/AN adults (age 21-64) have a 21 percent greater utilization of RSN services than non-natives—561.2 services/1000 MM for AN/AN compared to 465.6 services/1000 MM for non-natives (see Exhibit 7). AI/AN adult prescription drug utilization was 15 percent greater than for non-natives, and inpatient hospitals services utilization was 23 percent greater.

Senior (age 65 and older) Medicaid AI/AN enrollees used slightly less RSN services than non-natives, while having a 17 percent higher mental health prescription drug and a 95 percent higher inpatient hospitalization rate (see Exhibit 7).

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<sup>13</sup>Source: Analysis of DSHS Integrated Client Database data by the DSHS Research and Data Analysis Division

<b>Table 3</b>				
<b>SFY 2011 MEDICAID MENTAL HEALTH SERVICE UTILIZATION</b>				
Service Category	Total All Ages			
	AI/AN		Non-Natives	
	Total Served	Units Per 1000 MM	Total Served	Units Per 1000 MM
<b>Any DBHR-MH Service</b>	12,009		104,461	
Any RSN Outpatient Service	11,873	333.4	103,343	194.7
Psychiatric Inpatient	894	41.9	7,613	25.3
<b>Any HCA-paid MH Service</b>	19,801	507.4	218,995	335.5
Tribal MH Encounters	3,458	63.4	5,195	4.6
Medical Benefit OP Visits	2,569	18.8	29,770	14.6
Any Psychotropic Rx	19,083	244.3	208,916	160.4
<b>Any DBHR-MH or HCA-paid MH Service</b>	24,128		256,298	
Total Population Size	77,140		1,220,945	
Total Member Months (Medicaid only)	774,351		12,099,136	
Total Member Months (Medicaid + SMH)	774,659		12,102,529	

As described above, Medicaid AI/AN enrollees had a higher utilization of RSN services than non-natives—15.4 percent of Medicaid AI/AN enrollees used RSN services compared to 8.5 percent of non-natives. This could have been attributed to the population group only using crisis services. However, this was not the case. Only 495 (4.2 percent) of the 11,873 AI/AN who used RSN services received only crisis services; 1,991 (16.8 percent) services both crisis services and other RSN services; and, 9,387 (79.1 percent) of the total AI/AN user group received outpatient services other than crisis services (see Table 4).

<b>Table 4</b>				
<b>SFY 2011 AI/AN RSN USER POPULATION</b>				
Service Category	Total All Ages			
	Total Served	% of Total Pop.	% of Total RSN User Pop.	Units Per 1000 MM
<b>Any RSN Outpatient Service</b>	11,873	15.4%	100.0%	333.37
Used Crisis Services alone without other outpatient	495	0.6%	4.2%	0.90
Used other outpatient services without Crisis services	9,387	12.2%	79.1%	229.64
Used both Crisis and other outpatient services	1,991	2.6%	16.8%	102.82
Total Population Size	77,140			
Total Member Months (Medicaid only)	774,351			
Total Member Months (Medicaid + IMD SMH months)	774,659			

Prior geo-network analysis indicates most Medicaid AI/AN enrollees do not live on the reservations. However, they do reside in the Tribes' IHS Contract Health Services District Areas (CHSDA). Given this geographic diversity, it is important to know where they receive mental health services in order to know where to focus system improvements. Based on SFY 2011 utilization, 76 percent of Medicaid AI/AN enrollees received their outpatient services through the local RSN, while 6 percent received outpatient services through both Tribal programs and RSN services, and 18 percent received care only at Tribal programs (see Table 5). This suggests that improving RSN access to care and requiring the RSNs to provide culturally appropriate services is critical. This is even more the case because the RSN system is currently responsible for providing crisis and inpatient psychiatric care.

Table 5			
SFY 2011 Medicaid AI/AN, Statewide, All Ages			
(Unduplicated Count)			
	Number	% Received MH Service	%Total AI/AN Pop
AI/AN Who Only Received RSN Outpatient Services	11,042	76.2%	14.3%
AI/AN Who Only Received Tribal Program MH Outpatient Services	2,627	18.1%	3.4%
AI/AN Who Received Tribal & RSN Outpatient Services	831	5.7%	1.1%
AI/AN Who Received Any Outpatient MH Service	14,500	100.0%	18.8%
Total AI/AN Medicaid Clients	77,140		100.0%
NOTE: MH outpatient services do not include mental health drugs or medication management.			
NOTE: Any MH outpatient service includes services provided by a Tribal program, RSN, Medicaid FFS or Health Options program.			

## Tribal Centric Workgroup History

The Tribal Centric Behavioral Health Workgroup has met twice monthly since August 2012. Prior to that, meetings were held monthly and bi-monthly, beginning in 2009. During these meetings Workgroup members identified mental health delivery system strengths and deficits and developed strategies for problem resolution.

## System Strengths

One of the major system strengths cited by the Workgroup is the State's implementation of mental health services through the IHS encounter rate. Workgroup members emphasized Washington's institution of the *Clinical Family* designation as a significant system asset.



This designation allows non-Native members of AI/AN families to receive mental health services from Tribal providers at the IHS encounter rate. The designation helps address those situations in which successful treatment of a AI/AN client may need to include treatment of non-Native family members.

Workgroup members also emphasized as a system strength, that, for the IHS mental health encounter rate, there is no limitation on the frequency, intensity and duration of services as long as medical necessity is present. Additionally, they cited that Tribes have the flexibility in how they serve their clients, and are able to develop programs so that they can meet the enrollee where they are; mentally, physically, emotionally and spiritually.

Workgroup members also stated that they wanted this report to call-out and identify as a strength the longstanding strong working relationship with the Tribes and the DSHS Division of Behavioral Health for chemical dependency services.

### **System Deficits**

A review of past and current concerns and complaints about the mental health system demonstrated that the problems typically revolve around RSN services and access to those services—primarily crisis services, involuntary treatment services and voluntary hospitalization.

In response to these and other concerns DSHS undertook the following changes:

- DSHS (OIP and DBHR) worked with Tribes and AIHC in the development of a Tribal Attestation process for mental health programs. This became essential to address because both the Memorandum of Agreement between IHS and the Healthcare Financing Administration (currently known as the Center for Medicare and Medicaid Services) and federal statute stipulates that while states may not require tribal provider programs to be licensed through the state, those programs must meet applicable state law for providing Medicaid services.
- DBHR established Tribal Liaison access with its toll-free line so that Tribes could easily access the Liaison to request intervention in access issues related to RSN services, focusing on crisis access, hospitalization and involuntary treatment act services.
- DSHS and HCA responded to billing and Medicaid concerns from Tribal Mental Health programs by conducting multiple trainings on billing mental health services, Medicaid rules, state plan services and documenting medical necessity.

## **Planning Process**

During the months of July and August 2013, the Tribal Centric Workgroup membership identified a group of consistently attending Workgroup members who had expertise in Tribal behavioral health and the public mental health service delivery system. On August 20, 2013 a full day planning meeting was held. During this highly structured meeting, participants wrote an outline for this report and identified the Workgroup recommendations and strategies for change. A follow-up meeting was held on August 21 with available group members. The report was then drafted and distributed to the planning group members for feedback. Edits were incorporated into the report and a fuller draft was distributed to the entire Tribal Centric Workgroup for feedback. After the brief feedback period the draft document was disseminated to the Office of Indian Policy's Tribal leadership and behavioral health distribution list for feedback and comment. That draft was discussed at the first Roundtable.

DSHS conducted a second Roundtable and again incorporated the comments and feedback into the report. A third draft was distributed to the Tribes for the October 12 Consultation. A final Tribal feedback review session was held at the November 5 Tribal Centric Behavioral Health meeting. This report includes comments and guidance that were voiced during the Consultation Meeting and subsequent Tribal Centric Workgroup meeting, as well as any feedback and document revisions received through November 7, 2013.

## **Implementation**

There are multiple unknown and unknowable factors confounding the Tribal Centric Behavioral Health planning process. The major unknown is the communication received from the Center for Medicare and Medicaid Services (CMS) regarding concerns as to the way in which Washington State procures Medicaid managed care mental health services through its 1915 (b) waiver. An additional significant unknown is the impact of the implementation of the Affordable Care Act January 1, 2014. The ACA brings two huge variables into play: the Medicaid expansion and the implementation of parity. Finally there are the pending recommendations of the State Health Care Innovation Plan (SHCIP) which is investigating improving Washington's health outcomes by better integrating physical and behavioral health care.

These unknowns present the Workgroup with an opportunity to weigh in with those tasks and to ensure that as the responses to CMS and the SHCIP grant are developed, providing appropriate services to AI/AN Medicaid consumers as well as interfacing effectively with Tribes and Tribal programs is an integral feature to the proposed systems as opposed to an afterthought.

HCA staff from the SHCIP grant team have been especially engaging in assuring that the Tribal Centric Planning Process and the SHCIP will inform one another in affording the

Tribes and the state the opportunity to leverage the strengths of both activities in developing a comprehensive system.

## **Tribal Centric Behavioral Health Workgroup Recommendations**

The Workgroup identified multiple major milestones to measure progress in the implementation of Tribal Centric Behavioral Health. These high-level milestones are as follows:

Establish an ongoing Workgroup for clear communication with Tribes, Tribal Provider Agencies, HCA and DSHS as regards billing, encounter reporting, service documentation and compliance with Medicaid rules. Anticipated start date for Workgroup: January 21, 2014.

Establish a standing committee to meet with the DSHS, including representatives from the Behavioral Health Service Integration Administration (BHSIA), the Indian Policy Advisory Committee (IPAC) and the American Indian Health Commission (AIHC) and selected representatives from RSNs to review and revise RSN contract terms to ensure equitable and consistent access to all levels of mental health treatment and RSN network comportment to the values of Tribal Centric Behavioral Health. Anticipated start date: January 15, 2014.

Require that all RSNs who have Tribal land within their catchment area have at least one Tribal representative on the RSN's governing board with full voting rights. Anticipated implementation date: July 1, 2014.

Establish a team, which will include BHSIA staff, and representatives from IPAC and AIHC to review RSN compliance with new contract terms and recommend corrective action to the Department as needed. Anticipated implementation date: March 1, 2014.

Develop a mechanism to coordinate planning activities between the Tribal Centric Behavioral Health Workgroup and the SHCIP Team, HCA staff and BHSIA staff. Implementation: Immediate and ongoing.

As illustrated in the Background Section of this report, the RSN managed care system is the primary source of outpatient mental health services for AI/AN enrollees and currently is the only source of inpatient services for all Medicaid enrollees. There is currently no viable, economically feasible, statewide alternate existing service system for AI/AN people. In this context, the Tribal Centric Behavioral Health System Workgroup recommends that the project work to leverage and improve the RSNs, or their successor's, ability to provide equitable and timely access to culturally appropriate mental health services for AI/AN Medicaid enrollees.

The Tribal Centric Behavioral Health System Project's Workgroup identified the following additional strategies to improve the working of the RSN system with Washington's AI/AN population. These strategies include:

- Require RSNs to have Tribal Liaisons who are trained by the Tribe, Indian Policy Advisory Committee or the American Indian Health Commission. The Tribal Liaison function would be an additional duty assigned to an already existing RSN staff.
- Review and revise the RSN *Access to Care Standards* list of covered diagnoses to insure coverage for historical trauma and its resultant disorders, in all their complexity for AI/AN people.
- Require RSNs to provide timely and equitable access to crisis services. This would include requiring RSNs to contract with Tribal and urban Indian mental health programs that are willing and able to provide crisis services.
- Require RSNs to develop protocols, in conjunction with each Tribe in their catchment area, for accessing tribal land to provide crisis and Involuntary Treatment Act (ITA) services. These protocols would include coordinating the outreach and debriefing the crisis/ITA review outcome with the tribal mental health provider within twenty four hours.
- Require DSHS to assist tribal programs to train and have Designed Mental Health Professionals (DMHP) who can detain AI/AN for involuntary (ITA) commitments.<sup>14</sup>
- Require RSNs to contract with Tribal DMHPs, when a Tribal provider is willing and able, or if a Tribal practitioner can be recruited, to serve AI/AN people.<sup>15</sup>
- Obtain necessary statutory and/or regulatory changes that will allow Tribal Courts to make ITA commitments for Tribal members of other AI/AN on Tribal lands.
- Require RSN contracted and DBHR credentialed licensed psychiatric care hospitals and Evaluation & Treatment (E&T) facilities to notify and coordinate AI/AN discharge planning with the Tribes and urban Indian health programs.
- Require state psychiatric hospitals to notify and coordinate discharge planning with Tribes and urban Indian health programs.
- As part of 2SSB 5732, Tribal representatives will participate in developing culturally appropriate evidence-based and promising AI/AN practice treatments that RSNs will be required to provide.
- Obtain state funding to conduct a feasibility study for one or more E&T/crisis triage facilities to service AI/AN people needing inpatient psychiatric care.
- Require that all RSNs and their provider networks that provide services to AI/AN consumers meet minimal cultural competency standards to be established through a joint AIHC/OIP/Washington Behavioral Health Council and Departmental Workgroup.

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<sup>14</sup> Each Tribal behavioral health program has different capacities. Under a government-to-government relationship, each Tribe will determine whether or not the Tribe is willing and/or has the capacity to provide crisis or DMHP services.

<sup>15</sup> DSHS may be requested by individual Tribes to facilitate and monitor the process to insure that the process and product comports with government-to-government standards.

The Tribal Centric Behavioral Health System Project's Workgroup additionally identified several strategies to maintain, support and improve Tribes and urban Indian health programs ability to serve their members and other AI/AN individuals. These include:

- Continuing to use the IHS encounter rate to reimburse tribal mental health and chemical dependency programs.
- Continuing to allow Tribal and urban Indian health programs to directly provide mental health services to clinical family members of Tribal members.
- DSHS/HCA should contract with adult and child consulting psychiatrists to provide medication consultation services to tribal and urban Indian health programs.
- Developing and promoting a system for tribal mental health providers to obtain specialty psychiatric consultations with: child psychiatrists, psychiatrists certified in addictionology and geriatric psychiatrists.
- DSHS and HCA should establish an ongoing project with Tribes and urban Indian health programs to develop culturally appropriate evidence-based and promising AI/AN practice treatments. Program development should include a plan for reimbursement for providing the service.
- DSHS and HCA should work with the Tribes to develop treatment modalities and payment policies for persons with co-occurring conditions.
- DSHS should seek state funds to pay Tribal programs for chemical dependency services provided to non-natives.

In addition to the above strategies and recommendations, the Workgroup membership requested that this report emphasize three critical concerns regarding the interface between Tribes, Tribal providers and the RSN system: voluntary inpatient authorization, a lack of DMHP responsiveness, and the lacking of a mutual respect for Tribal mental health professionals on the part of the RSN provider networks.

Tribal Workgroup members report that there are occasions when RSN authorization for hospitalization occurs and the RSNs pays for the hospitalization, but there are an equal number of occasions when the authorization does not occur. Regrettably, the outcome when hospitalization does not occur usually results in tragedy. While Tribes have experienced and skilled mental health professionals, often Tribal programs do not have the staffing resources for twenty four hour crisis service coverage. Frequently RSN crisis responders do not explain that the RSN inpatient authorization process is for payment only and that RSNs do not have the authority to deny access to medical and behavioral health hospitalizations. In other words, RSNs can only authorize or deny payment, they cannot make admission decisions for hospitals.

As mentioned above, the relationship between the Tribes and the RSNs and state hospitals is disjointed. This is most readily evidenced by the lack or delay of response from DMHPs. Challenges include accessing hospitalization from referrals, limited beds, culturally responsive services, and lack of discharge coordination. There is a lack of a comprehensive model of

care for delivery of services. It is recognized that there is a lack of psychiatrists for tribal communities, and many are too small to employ one full time.

It is essential that whatever the Behavioral Health System for Washington State becomes, there needs to be a recognition of Tribal Mental Health professionals, programs and the services they provide. There is a need for continued education of the public to address the stigma that Mental Health clients receive for their condition that could be from illness or historical trauma.

The new system should include an orientation or training to educate RSN provider networks and State Hospitals as regards the nature of the government-to-government relationships when working with Tribes, cultural competency and the importance of mutual respect for tribal mental health professionals.

DSHS and HCA should establish an ongoing Workgroup to ensure that clear and consistent communication between the state and Tribes helps to define the new Tribal-Centric approach.

The State should work with the Tribes to conduct a feasibility study to explore the development of two regional Tribal residential programs with the capacity to function as Evaluation and Treatment Centers (E&T) and/or crisis triage center to serve AI/AN people needing emergency psychiatric inpatient care. Appropriate and early intervention will greatly decrease the need for long-term hospitalization at our state hospitals.

### **Culturally Appropriate Evidence Based Practices and Promising Practices**

There are limited Evidence Based Practices (EBPs), Promising Practices or Research Based Practices that have been tested in tribal communities. The range of Washington's tribal communities—urban, rural and frontier—adds another level of complexity to finding EBPs that have been adequately normed for tribal communities. What is known is that a “cut and paste” approach to services does not work. EBPs are expensive to implement and maintain. For any EBP to be effective there has to be ongoing fidelity monitoring and technical assistance—this is an additional cost to the actual service provision. For those practices that may exist, other barriers come into play including conflicts with the primary funding streams that Tribes use for providing behavioral health services, including; Indian Health Services, Medicaid, Tribal and State.

There needs to be an explicit acknowledgement that each Tribe knows what works best in a tribal community and that a pilot project or study that works in one tribal community may not necessarily be easily replicated in another. Each Tribe in Washington has its own rich and unique history, culture and traditions. It is essential for the development of culturally appropriate and responsive providers for behavioral health services that includes interaction with the Tribes directly.

## **DSHS Recommendations**

DSHS recommends that its participation in, and commitment to, the development and implementation of a Tribal Centric Behavioral Health system continue for the foreseeable future. Additionally, if the legislature determines that DSHS conduct a procurement for mental health services as a result of the CMS letter, DSHS recommends that the Tribal Centric Workgroup be involved in the procurement process. DSHS also recommends that the Tribes be formally involved in developing the procurement through the formal consultation process.

The Behavioral Health and Service Integration Administration requests one full time staff at DBHR to respond to Tribal concerns regarding access to RSN services, including crisis and inpatient, and issues with state hospitals. This position would also be responsible for monitoring RSN implementation of contract changes identified in this report. The position would also work with OIP, IPAC and AIHC to provide training for RSNs and state hospital employees to work with Tribes. The position would also work with government-to-government partners in developing training and implementing a process for credentialing provider agencies as being proficient in working with AI/AN population.

DSHS requests funding to conduct a Feasibility Study with the Tribes to determine the most appropriate vehicle for decreasing hospitalizations. This could take the form of regional Tribal E&Ts, regional crisis/triage centers or a combination of the two. The outcome should be based on working with Tribes to accurately identify the need and to develop a strategy to create the structure to meet those needs.

## **Fiscal Impacts**

The fiscal impact will be relatively limited. Behavioral health services provided to AI/AN Medicaid consumers through Tribal providers is 100 percent FMAP. RSN services are included in the RSNs' Medicaid rate, given that all of a given RSN's Medicaid eligibles are included in the PMPM payment, whether or not the Medicaid eligible is AI/AN or living on Tribal land. Please see the following tables for Fiscal Impact.

Additional costs would revolve around RSN contract monitoring and the position requested in the previous section of this report. If crisis triage and/or E&T programs were established, there would be start-up costs with capital expenditures and ongoing operational costs for non-Native consumers. The E&T costs would be offset by a projected decrease in the number of AI/AN inpatient psychiatric services provided through the RSN system and a decrease in long-term stays at the state hospitals. Additionally, given that freestanding E&T services are considered as an outpatient service in the Medicaid State Plan, services could be billed as IHS Medicaid encounters under the encounter rate for AI/AN Medicaid eligibles, if the facility was on Tribal land or an urban Tribal program on the IHS facility list. For patients

with co-occurring chemical dependency disorders, the potential exists for billing both a mental health and a chemical dependency encounter for the two separate treatment interventions.

## Milestones, Fiscal Impacts and Implementation Dates

The following tables depict the overall recommendations, with proposed timeframe and estimated fiscal impacts.

### RSN Related Tribal Workgroup Recommendations

	Timeframe	Currently in RSN State Rate	Currently in RSN Medicaid Rate	Fiscal Impact
Define and clarify role and scope of RSN governing boards. Require RSNs to include Tribal representatives in their decision and policy making boards.	7/1/2014	No	No	No
Require RSNs to identify an RSN staff member as a Tribal Liaison.	7/1/2014	No	No	No
Review and revise the RSN <i>Access to Care Standards</i> and list of covered diagnoses to insure that historical trauma and its resultant disorders, in all their complexity for AI/AN people.	3/1/2014	No	Yes <sup>16</sup>	No
Require RSNs to provide timely and equitable access to crisis services for AI/AN. This would include requiring RSNs to contract with Tribal and urban Indian mental health programs that are willing and able to provide crisis services.	7/1/2014	Yes	Yes	Potential
Require RSNs to contract with Tribal DMHPs to serve AI/AN people on Tribal Land. (If Tribal DMHPs available and willing to contract with RSN)	7/1/2014	Yes	Yes	Yes
Require RSN contracted and DBHR credentialed licensed psychiatric care hospitals and Evaluation & Treatment (E&T) facilities to notify and coordinate AI/AN discharge planning with the Tribes and urban Indian health programs.	3/1/2014	No	No	Yes
As part of 2SSB 5732, Tribal representatives will participate in developing culturally appropriate evidence-based and promising AI/AN practice treatments for that RSNs will be required to provide.	3/1/2014	No	No	Potential
Require that all RSNs and their provider networks who provide Medicaid encounters to AI/AN consumers meet minimal cultural competency standards to be established through a joint AIHC/OIP/Washington Behavioral Health Council and departmental Workgroup.	9/1/2014	No	No	Potential

<sup>16</sup> Mental disorders resulting from historic trauma are already included in the list of covered diagnoses. However, the disorder must be severe enough to meet test of medical necessity.



## Tribal 638 Program and Urban Program Recommendations

	Timeframe	State Funded	Medicaid Funded	Estimated Cost
Continue to use the IHS encounter rate to reimburse Tribal mental health and chemical dependency programs.	Ongoing	No	Yes	No
Continue to allow Tribal and urban Indian health programs mental health services to clinical family members of Tribal members.	Ongoing	No	Yes	No
DSHS/HCA should contract with an adult and child consulting psychiatrists to provide medication consultation services to Tribal and urban Indian health programs.	Not Determined	Yes	No	Yes
DSHS and HCA should establish an ongoing project with Tribes and urban Indian health programs to develop and reimburse for culturally appropriate evidence-based and promising AI/AN practice treatments.	Begin 7/1/2014	Yes	No	Yes
DSHS and HCA should work with the Tribes to develop treatment modalities and payment policies for persons with co-occurring conditions.	Begin 7/1/2014	No	Yes through separate encounter rates.	No
DSHS should seek state funds to pay Tribal programs for chemical dependency services provided to non-natives.	Ongoing	Yes	Yes After Medicaid Expansion	Potential
Require state psychiatric hospitals to notify and coordinate discharge planning with Tribes and urban Indian health programs.	3/1/2014	Yes	No	No
Obtain necessary statutory and/or regulatory changes that will allow Tribal Courts to make ITA committals for Tribal members.	Submit to 2015 Legislature	No	No	No
DSHS should assist Tribal programs to train and have Designed Mental Health Professionals (DMHP) who can detain AI/AN for involuntary (ITA) commitments.	7/1/2014	Yes	No	Yes

## DSHS Recommendations

	Timeframe	State Funded	Medicaid Funded	Fiscal Impact
DBHR dedicated FTE to provide technical assistance to Tribes and monitor Tribal relations in RSN contracts.	7/1/2014	Yes	No	Yes
DBHR use 2SSB 5732 appropriations to contract or employ a dedicated FTE to assist with implementation of the report's recommendations.	1/1/2014	Yes	Yes	2013-2015 Appropriation
Obtain state funding to conduct a feasibility study for one or more E&T facilities to service AI/AN people needing inpatient psychiatric care.	7/1/2014	Yes	No	Yes

## Conclusion

Given that there will be a number of reports received from November 2013 through June 2015, the Department, Health Care Authority and Tribes note that this report is the first

submission. There remain many unknowns that are currently being worked on; therefore we collectively commit to submit a subsequent report on June 30, 2014 and June 30, 2015 to report on developments, progress and any additional legislative action that is necessary.

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