



## WASHINGTON STATE LEGISLATURE

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December 29, 2015

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, established pursuant to chapter 338, section 1, Laws of 2013 (uncodified), and chapter 225, section 1, Laws of 2014 (uncodified), we are pleased to notify you that the Task Force has completed its work. The Task Force held eleven meetings between 2014 and 2015, and benefitted from the assistance of over 100 persons who provided testimony, information, or participated in stakeholder work groups. Enclosed, please find a copy of the final report of the Task Force. We appreciate the opportunity to examine these issues with the other Task Force members and the committed group of knowledgeable stakeholders who contributed to this effort.

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)  
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  
Kevin Bouchey, Yakima County Commissioner  
Jill Johnson, Island County Commissioner  
Shelly O'Quinn, Spokane County Commissioner  
Nancy Johnson, Colville Tribes

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# Adult Behavioral Health System Task Force Final Report

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SUBMITTED TO THE GOVERNOR AND THE LEGISLATURE  
DECEMBER 2015

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## **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 final report of the Task Force. A preliminary report from the Task Force was released on December 16, 2014. 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 (April-October 2014)
  - Kevin Bouchey, Yakima County Commissioner (November 2014-December 2015)
- Tribal member:
  - Nancy Johnson, Colville Tribes.

The appointed alternate members are Senator Randi Becker, Representative Eileen Cody, Senator Annette Cleveland, and Representative Judy Warnick (2014). At various meetings the executive members have been represented by designated alternates as permitted by law, including Jane Beyer and Carla Reyes for Kevin Quigley, Bob Crittenden for Andi Smith, and MaryAnne Lindeblad for Dorothy Teeter. For the adoption of this final report in December 2015, the following alternates participated in the voting: Bob Crittenden for Andi Smith, and Carla Reyes for Kevin Quigley.

## Statutory Mandates

The Task Force's authorizing legislation 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 Department of Social and Health Services (DSHS) and the Health Care Authority (HCA), taking into consideration any proposal submitted by the Washington State Association of Counties (WSAC);
2	Identification of key issues which must be addressed by DSHS to accomplish the integration of chemical dependency (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;
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. Stakeholder-Led Work Groups**

Pursuant to statutory direction, the Task Force formed subcommittees led by invited stakeholders to inform the work of the Task Force. These work groups met diligently, and their deliberations and reports enriched and informed the work of the Task Force. The work groups include the:

- Public Safety / Involuntary Treatment Act Work Group, co-chaired by Clifford Thurston and Cassandra Ando (NAMI Washington), which met only during 2014;
- Chemical Dependency Integration Work Group, co-chaired by Mindy Greenwood (Cascade Mental Health) and Brad Finegood (King County Department of Community and Human Services); and
- Full Integration / Early Adopter Work Group, co-chaired by Rick Weaver (Comprehensive Mental Health) and Joe Roszak (Kitsap Mental Health Services).

Final reports from the Chemical Dependency Integration Work Group and the Full Integration / Early Adopter Work Group are included in Appendix A and B.

#### **IV. Summary of Topics Considered by Task Force**

The Task Force held six meetings in 2014 and five meetings in 2015. Information about 2014 Task Force meetings, including documents and agendas, are available at <http://leg.wa.gov/JointCommittees/ABHS/Pages/default.aspx>. Information about 2015 Task Force meetings are available through Committee Meeting Documents at <https://app.leg.wa.gov/CMD/meeting.aspx?ca=abhs>. The paragraphs below contain a brief summary of topics examined during the Task Force meetings.

##### *A. Regional Service Areas*

In 2014, the Task Force received recommendations on the creation of regional service areas from the Washington State Association of Counties (WSAC), and fulfilled its statutory obligation to make its own recommendation to the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) in July 2014. In meetings in April, June, and July, the Task Force heard presentations on current agency efforts to establish regional boundaries for the purchase of physical health, mental health, and chemical dependency services, progress reports WSAC regarding its effort to develop recommendations, and reports from individual regional support networks raised issues regarding the importance of locally-based service delivery systems that recognize the unique needs of communities. Concerns were raised about the need for more information to support the WSAC's decision.

In July, WSAC delivered its recommendation to the Task Force which included two options for regional service area boundaries (see Appendix D). The primary difference between the two maps 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 the WSAC recommendation as its own recommendation, with an additional message reported in section V of this report.

##### *B. Review of Performance Measures*

In 2013, the Legislature passed legislation that required DSHS and HCA 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 2014 meeting the Task Force heard about the agency 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 51 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 2014, 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 about investments in chemical dependency services resulting in savings in other areas (jails, emergency departments), a number of concerns were raised by panels of 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*

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

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

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

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

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

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

The Task Force held a work sessions in July 2014 and four times in 2015 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 were developed jointly by HCA and DSHS. Different models were vetted in regional service areas (RSAs) which expressed interest: the Southwest Behavioral Health RSA, King County RSA, and Pierce County RSA. One of the principal differences between early proposed models is the role of counties in the situation when one or more managed care organizations are implementing an integrated health network. State requirements for early adopter regions were released in November 2014, with a contract implementation date of January 2016.

Ultimately, only the Southwest Behavioral Health RSA elected to become an early adopter county starting in 2016. The task force heard reports from the RSN Administration, providers, and MCOs in the region relating to discussions and preparations for full integration. This RSA submitted policy recommendations to the Task Force which were incorporated into the discussion of reform recommendations for this final report.

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

The Task Force held work sessions in April and September 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 HCA, which covers medical care and low intensity mental health care, and 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 in September 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 and maintain fidelity to evidence based models. This model is effective for behavioral health clients, including people with PTSD, people who are homeless, those with physical disabilities, older adults, and people with criminal justice history.

#### **H. Psychiatric Boarding and Single-Bed Certifications**

The Task Force held a work sessions in September 2014 and June 2015 and received a written briefing in December 2015 related to psychiatric boarding and single-bed certifications. By way of background, the Washington Supreme Court decided the case of *In re D.W.* in August 2014, 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 26, 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.

Representatives from the King, Pierce, and Spokane RSNs reported in 2014 having difficulty transitioning to less reliance on psychiatric boarding. Spokane reported that in 2014 90% of its boarders are kept in

seclusion and/or restraint. Some patients received no psychiatric consultation during the boarding process, which averages 2-4 days, depending on client needs and other factors, including proximity to weekends and holidays. All RSNs reported 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.

In 2015, the Legislature passed Engrossed Second Substitute Senate Bill 5649 which authorized a new single bed certification standard requiring provision of timely and adequate mental health treatment to detainees during the boarding process, and increasing data reporting requirements. The Task Force heard concerns that a substantial number of hospitals decline to provide single bed certification services under this standard, although data provided by DSHS in December 2015 shows that the number of hospitals willing to take single bed certifications increased from 36 to 62 in 2015, and that as a consequence some prospective patients are turned away without services. Policy recommendations related to this issue were considered by the Task Force in preparing this Final Report.

#### *I. Jail and Community Mental Health Agency Collaborations*

The Task Force held work sessions on jail and community mental health agency collaborations in October 2014 and October 2015. In 2014, 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 was awaiting evaluation as of last year.

In 2014 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, and chemical dependency treatment providers).

The 2015 work sessions spotlighted the Familiar Faces initiative in King County, the operations of the Law and Justice Council in Spokane, and the partnership in Snohomish County between Snohomish County Human Services and United Health Care to accomplish outreach and jail transition services planning. These initiatives all involve extensive cross systems study and collaboration to identify opportunities for system improvement and obstacles to sharing information. The Familiar Faces program aims to improve intakes and assessments and create diversion opportunities with a focus on persons who exceed four jail bookings within one year. The planning process starting in 2013, and the goal is to have accomplished significant gains and shifts by 2020. Snohomish County is in the early stages of sharing health information with United

Health Care, who sends an outreach worker to engage selected jail inmates inside the institution and in the critical weeks following release.

Several presenters during the October 2015 meeting urged the state to update its systems to allow for suspension instead of termination of Medicaid services for jail and prison inmates. HCA and the Department of Corrections (DOC) presented regarding their efforts to enroll persons in Medicaid services before leaving the institution. Several obstacles exist, such as the inability to access Medicaid services while in work release, and in communicating with outside family members (DOC only enrolls exiting offenders if they are single due to program obstacles). Policy recommendations from the October 2015 work sessions were incorporated in the discussion of recommendations for this Final Report.

#### *J. Behavioral Health Workforce*

In July 2015 the Task Force held a meeting to focus on the need to build a behavioral health workforce that is sufficient to meet client demands and that is trained to work in an integrated environment. A representative of the Workforce Development workgroup of the 5732 Steering Committee presented the recommendations of that group to the Task Force. The workgroup focused on meeting the behavioral health needs of clients and how to integrate behavioral health into the larger health care system. The Workforce Training and Education Coordinating Board discussed the difficulty of tracking behavioral health workforce data and the potential information that an employer survey could provide. Another panel discussed options for training physical health care providers and behavioral health care providers to work in integrated settings and provide bi-directional care. The panel identified financial and regulatory barriers to recruiting and retaining an appropriate work force, including clinical models, licensing requirements, updating curricula, partnership between academia and practitioners, and rates considerations. A third panel discussed opportunities for expanding the use of telepsychiatry to relieve provider shortages and providing enhanced expertise through new models of care that include outpatient psychiatric evaluations, hospital-to-hospital emergency department consultations, and hospital to inpatient hospital models. Telepsychiatry can be used to relieve psychiatric boarding issues as well. Finally, a panel presented regarding the need for peer support services and training. The panel discussed the benefits of including peers as part of the treatment team and the ability of peer services to quickly build trust with clients and establish them on the path to recovery.

#### *K. Sharing of health information across practice settings*

On November 13, 2015, the Task Force held a work session to discuss obstacles that some providers have faced when trying to share different types of patient information with health care providers in other care settings. The Health Care Authority discussed some of the work that it has undertaken to assist the sharing of health information to facilitate the integration of care. The Health Care Authority is in the process of forming an interagency workgroup to discuss health care privacy. The workgroup will attempt to develop common definitions and understandings of privacy and confidentiality requirements. Once the workgroup has established itself, the agencies intend to invite participation from stakeholders. The Health Care Authority is also developing a clinical data repository to allow health care providers to access a patient's health care information across practice settings and provider groups in real-time.

The work session also included testimony from behavioral health providers who described the problems that they have had with sharing chemical dependency information with other providers. Federal confidentiality laws restrict the sharing of chemical dependency information in such a way that even behavioral health providers who offer care for persons with co-occurring disorders must bifurcate the chemical dependency records so that mental health providers on staff may not access the data. The providers expressed concern over the implications of these laws on patient care and administrative efficiency.

#### *L. Recent research in behavioral health.*

In October and November 2015, the Task Force heard presentations from the Washington State Institute for Public Policy (WSIPP) concerning recent studies that have implications for behavioral health policy. One study reviewed in October tested a static risk instrument used to predict the commission of future crimes by prison offenders to determine if the instrument would be capable of predicting criminal behavior by civil and forensic involuntary mental health populations. The instrument did show predictive capacity that would allow involuntary mental health patients to be classified based on risk of future violent and nonviolent criminal behavior.

In November, the Task Force reviewed data showing regional variations in investigation, non-emergency detention, commitment, and less restrictive orders for the civil involuntary mental health population. The involuntary detention rate varies from 27% in Clark County to 60% in King County. The number of involuntary commitment cases being heard in Washington state courts have increased over each of the past five years.

#### *M. Utilization of Behavioral Health Ombuds Services*

In December 2015, the Task Force heard a panel presentation from two regional support network (RSN) Ombuds about the use of Ombuds services in Washington State. Ombuds services are provided by contract in each RSN. The Ombuds is an expert in local services which are available and is independent from the RSN. They participate in RSN quality assurance planning by giving feedback through monthly, quarterly, and annual reports based on client encounters and services provided throughout the year.

The Ombuds presenting look forward to providing chemical dependency Ombuds services upon the formation of behavioral health organizations in April 2016. They recommend that the Ombuds remain independent of the RSNs/BHOs and that the contracted Ombuds be a person with lived experience of behavioral health disorders as individuals or through family.

Public comment included a recommendation that the State establish a centralized behavioral health Ombuds services similar to the long term care Ombuds service.

### **V. 2014 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 designated alternate Jane Beyer. The vote was 11-0 on the recommendation. This recommendation was transmitted by letter to Governor Inslee following the meeting.

## **VI. Task Force Recommendations for Reform of the Adult Behavioral Health System**

On December 11, 2015, the Task Force voted on final recommendations for reform of the adult behavioral health system.<sup>1</sup> The following items 1-21 were designated either "Support High Priority" or "Support" by the Task Force.<sup>2</sup>

The Task Force also adopted this introductory statement: The state, behavioral health organizations, Medicaid managed care organizations, and early adopter regions need to support and adopt new practice models that increase collaboration between diverse and unconventional practice settings such as primary care, behavioral health care, pharmacists, care coordinators, schools, jails, and a patient's family and community supports. Special programs are needed to engage clients who are hard to serve and to target the highest utilizers of health and public welfare systems who drive the highest costs. Health care management must be unified without "carve outs" to ensure that responsible entities provide fully integrated services at the clinical level.

### **Support High Priority**

#### **Related to Funding Behavioral Health Systems**

- 1) In order to accomplish the vision of Medicaid expansion we need stable and adequate rates. The Legislature should increase Medicaid and non-Medicaid funding to a level that covers the full cost of providing behavioral health services. Inadequate rates are a major challenge to the system. The drop in rates in the past session and the planned drop going forward greatly impact recruitment and retention. **Fiscal impact:** indeterminate.<sup>3</sup> **Comment:** Bob Crittenden offers a caveat that

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<sup>1</sup> The Task Force adopted preliminary recommendations in its Preliminary Report dated December 16, 2014, which is available here:

<http://leg.wa.gov/JointCommittees/ABHS/Documents/Adult%20Behavioral%20Health%20System%20Task%20Force%20Preliminary%20Report%20Dec%202014.pdf>

<sup>2</sup> Representative Jim Moeller and Representative Paul Harris were absent during the voting. Andi Smith and Kevin Quigley were represented by their designated alternates Bob Crittenden and Carla Reyes. Recommendations were unanimous except where indicated.

<sup>3</sup> The fiscal categorization is provided by staff of the non-partisan fiscal offices of the Legislature. Due to the broad nature of these options, it is not possible to provide dollar specific fiscal estimates. Many of these options are scalable and cost impacts would vary based on the details that would be included in a more specific policy or budget proposal.

individual items requested for funding may not appear in the Governor's budget and therefore may not be supported by the executive members of the Task Force.

#### Relating to Electronic Data and Health Information Sharing

- 2) State agencies and stakeholders should work to develop common understandings of privacy laws, promulgate data sharing standards, and advocate to the federal government to amend 42 CFR to represent a more contemporary standard to allow the sharing of health information, including substance use disorder information, when it promotes the goal of providing integrated, whole-person care. **No fiscal impact.**

#### Relating to Workforce Development: Licensing, Recruitment, and Professional Development

- 3) Services and treatment opportunities cannot be expanded without a robust workforce. The Legislature should fund the State Workforce Training and Education Coordinating Board to assess workforce shortages and create an action plan to address the workforce shortages across the health care spectrum, and to meet the increased demand for services now and with the integration of behavioral health and primary care in 2020. The action plan should not only focus on behavioral health, but also access to primary care physicians across the state. The study should be prepared with consideration of the recommendations made to the Task Force, and be completed as soon as possible but no later than December 31, 2016. **Fiscal impact:** less than \$1 million for the study. **Comment:** Crittenden abstains.

#### Relating to Providing an Adequate Network of Behavioral Health Services

- 4) The state should examine where it should revise the state Medicaid plan to bring the Mental Health and Chemical Dependency Systems into alignment, and recommend appropriate funding for clinically appropriate chemical dependency services which are not covered by Medicaid, no later than July 31, 2016. **Fiscal impact:** likely less than \$1 million to develop recommendations. **Comment:** directed to Governor and state agencies.

#### Relating to Involuntary Treatment Systems

- 5) The state should enhance the involuntary treatment system for chemical dependency by creating capacity for secure detox. **Fiscal impact:** likely more than \$1 million. **Comment:** Crittenden abstains. This recommendation has implications related to impacts on jails.
- 6) Individuals in crisis should not have their care and support disrupted - regardless of whether they are incarcerated. The Task Force recommends:
  - Washington take the necessary steps to suspend, rather than terminate, an individual's Medicaid benefits while they are incarcerated. Termination of benefits creates an unnecessary disruption and can create barriers to ensuring a "warm hand-off."

- Help ensure that individuals have access to behavioral health services while incarcerated and to connect them to services when they are released by restoring amounts of non-Medicaid funding provided for jail services to 2013 levels.
- Direct the Health Care Authority and the Governor's Office to pursue an 1115 Medicaid Waiver for behavioral health services provided to individuals who are incarcerated.

**Fiscal impact:** likely more than \$1 million. **Comment:** Darneille votes no. Crittenden abstains.

### Support

#### Relating to Funding Behavioral Health Systems

- 7) State agencies should continue to redesign service reimbursement rates and treatment modalities to ensure that they support integrated care models for 2016 and continuing to full integration in 2020. **Fiscal impact:** indeterminate. **Comment:** This direction is to state agencies.
- 8) The state has an opportunity to work together with tribes to provide appropriate access to treatment in both state and tribal health settings, and make sure tribal voices are represented and recognized, as referenced in the 2013 Tribal Centric Behavioral Health report.<sup>4</sup> **Fiscal impact:** indeterminate.

#### Relating to Electronic Data and Health Information Sharing

- 9) State agencies should facilitate sharing of clinical data across provider and delivery systems and share data across state programs, including measures such as:
- Aligning data dictionaries and reporting requirements across programs and contracts;
  - Defining required data elements for behavioral health organizations and providers;
  - Building on the standards of the state Health Information Exchange system to have an integrated clinical data repository with a goal of having it provide real-time data; and
  - Creating a single release of information across systems.

**Fiscal impact:** Likely more than \$1 million. **Comment:** This direction is to state agencies. Crittenden abstains.

#### Relating to Telemedicine

- 10) The state should encourage and expand use of telepsychiatry and telepharmacy, including measures such as:
- Adopting the Interstate Medical Licensure Compact;
  - Adopting specific laws to regulate telemedicine providers;
  - Allowing payment for telemedicine visits from home;
  - Requiring payment parity between telemedicine and in-person visits;
  - Providing reimbursement for provider-to-provider consultation;
  - Conducting education campaigns in rural areas.

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<sup>4</sup> The 2013 Tribal Centric Behavioral Health Report is included in this report as Appendix F and is available here: [http://www.hca.wa.gov/documents/legislative/Tribal\\_Centric\\_Behavioral\\_Health.pdf](http://www.hca.wa.gov/documents/legislative/Tribal_Centric_Behavioral_Health.pdf)

**Fiscal impact:** indeterminate.

Relating to Peer Services/Workforce Development

11) The state should promote peer services at all levels of care in the behavioral health system through means such as:

- Professionalizing peer services;
- Increasing the scope of the use of peer services throughout the behavioral health system;
- Providing technical support to employers;
- Increasing pay rates;
- Conducting research; and
- Reexamining peer credentialing practices.

**Fiscal impact:** indeterminate. **Comment:** directed to Governor.

Relating to Providing an Adequate Network of Behavioral Health Services

12) The Governor's office should lead a process to be completed by September 2016 which includes representation from state agencies, behavioral health organizations, Medicaid managed care organizations, and early adopter regions to review capacity in the system to ensure an adequate network of providers, including resources such as inpatient beds, for behavioral health treatment needs, and measures such as:

- Expanding inpatient treatment availability for youth with substance use disorders
- Allowing partial hospitalization models for adults with behavioral health needs
- Analyzing SB 5649 reports to determine areas with inadequate ITA resources
- Creating a tiered inpatient psychiatric system
- Expanding juvenile and geriatric ITA beds
- Requiring state hospitals to immediately admit involuntary patients committed to 90 or 180 days of inpatient treatment
- Allowing extensions of involuntary holds when a certified bed or single bed certification cannot be located within maximum time limits

**Fiscal impact:** likely less than \$1 million for the process of reviewing system capacity. **Comment:** directed to Governor and state agencies.

13) The state should continue to increase access to medication assisted treatment for persons with substance use disorders near their home communities and examine the payment methodology to make sure it is supportive of increased access, and provide recommendations on future funding by September 2016. **Fiscal impact:** likely less than \$1 million. **Comment:** This references existing funding. **Note:** funding was provided in the FY 2015-17 operating budget and DSHS has recently received a federal grant to provide increased access to Medication Assisted Treatment.

14) The state should continue its application for authority to utilize Medicaid funds for residential substance use disorder treatment in facilities larger than 16 beds. This should be administered in a way that does not reduce flexible state funding for behavioral health organizations. **Fiscal impact:** more than \$1 million. **Comment:** Crittenden abstains.

### Relating to Increasing Collaboration Across Health Systems

- 15) Behavioral health organizations and tribes should encourage equitable and timely access to culturally appropriate mental health services for American Indian and Alaska Native Medicaid enrollees, including measures such as:
- Use of tribal liaisons;
  - Contracts with tribal and urban Indian mental health programs;
  - Providing culturally appropriate evidence-based and promising practices; and
  - Training providers who serve consumers to meet minimal cultural competency standards, notably American Indian and Alaska Native populations.

**Fiscal impact:** indeterminate.

- 16) The Legislature should direct state agencies to align regulations across mental health, chemical dependency, and primary care to reduce redundant audits, paperwork requirements, and administrative burdens for behavioral health providers. **Fiscal impact:** likely less than \$1 million.

**Comment:** Crittenden abstains.

### Relating to Involuntary Treatment Systems

- 17) The state should encourage enforcement of the Involuntary Treatment Act for American Indian and Alaska Native populations in a more culturally appropriate manner, including measures such as:
- Use of tribal programs to train DMHPs;
  - Contracting with tribal DMHPs;
  - Allowing tribal courts to make ITA commitments;
  - Studying the feasibility of tribal residential programs to serve as E&T or crisis triage centers to serve American Indian and Alaska Native people.

**Fiscal impact:** likely more than \$1 million. **Comment:** Crittenden abstains.

### Relating to Housing Services

- 18) There is a critical shortage of low barrier housing. Stable housing is often the key to establishing and ensuring continuity of treatment. Stable housing such as Housing First and other models should be supported. **Fiscal impact:** indeterminate.

### Relating to Health Care System Oversight

- 19) The state should create a Behavioral Health Integration Workgroup which shall provide a forum for ongoing input and oversight of health care integration activities that shall report to the Joint Select Committee on Health Care Oversight at least twice a year. **No fiscal impact. Comment:** The workgroup will include the representation of counties and tribes, among others.

- 20) The Adult Behavioral Health Systems Task Force should ask the Health Care Authority to provide a detailed roadmap for health integration, including:

- And inventory of integration activities statewide;
- A phased timeline specifying different paths towards integration;
- Plans to move contracting to biennial cycles.

**No fiscal impact.**

21) Behavioral health organizations should be encouraged to provide increased participation for the tribes to assure clear and consistent communication between the state, the behavioral health organizations, and tribes, and to develop culturally-appropriate evidence-based and promising American Indian and Alaska Native practice treatments. **No fiscal impact.**

## Appendix A

*The following document is the Final Report of the Chemical Dependency Integration Work Group, and is approved for inclusion as an appendix to the Task Force's final report. Inclusion does not imply endorsement by the Task Force, except as indicated in the body of the report. The Task Force thanks the members of the work group for their exemplary service.*

### Chemical Dependency/Mental Health Integration – Public Safety Work Group – Final Recommendations - 2015

- 1) The state should provide a comprehensive CD service package. These would include but not limited to; case management, peer services, recovery supports, and medication monitoring/management. (Please see Addendum) (Benefit package and Crosswalk for payment)
  - The state should maintain financial support for CD services that were state funded and are not funded under Medicaid expansion.
    - Residential – more than 16 beds. The state should maintain financial support for CD services provided in IMD (greater than 16 bed) facilities that are not reimbursable by Medicaid.
    - Drug testing
    - Community Education
- 2) Revise the Medicaid State Plans.
  - It continues to be the recommendation, as it has since the beginning, to bring the Mental Health and Chemical Dependency Medicaid State Plans into alignment. True integration of behavioral health services cannot occur until there is parity in the two plans. Ex: peer to peer services.
  - Do not cut much needed non-Medicaid money. These funds cover gaping holes in the system (residential treatment, Medicare, non-Medicaid eligible people and non-Medicaid services).
  - Work towards a waiver for the IMD rule (16 bed residential) for residential treatment. The current system, which does not have enough residential beds (waiting lists), is built upon facilities that are currently not eligible for Medicaid funding, because they are larger than 16 beds and struggle for financial viability.
  - Better penetration and recovery outcomes for those seeking Mental Health and Chemical Dependency services
- 3) Integrate and collapse the mental health and chemical dependency regulations, and audit procedures, to reduce administrative duplication and cost.
  - “One Contract, One set of Regulations, One Audit and One Data Set is imperative to achieve a fully integrative system of care.”
- 4) We request that the legislature work with the Attorney’s Generals office and Federal Government to update 42 CFR regulations to meet with the vision of effective integrated whole person care.
- 5) Continue with the Task Force leading to 2020.
  - The Behavioral Health Task Force presents an opportunity to monitor the progress regarding the integration of behavioral health (BH) and physical health into the Medicaid based system.

- The Task Force continues to allow the state and county representatives to hear from a multi-discipline group of stakeholders on how progress is being made, goals achieved and potential obstacles.
- 6) The legislature should pass a law, which would integrate the involuntary mental health and chemical dependency statutes.
  - 7) State should endeavor to have peer services at all levels of care in the Behavioral Health system.
  - 8) Actuarial rates should represent the actual cost of doing business, and not just be based on historic rates. The state should create (or purchase) an integrated data reporting system for MH and CD providers that combines the strengths of the existing separate data systems.

## CD Integration Workgroup

### Definition of Comprehensive CD (chemical dependency) Benefits

Each Behavioral Health Organization should ***provide rapid access to the following billable services along a continuum of care for chemically dependent clients:***

Each BHO will need to arrange for access to the full range of services but does not necessarily need to have all types of facilities within their geographic coverage area. This is similar to the network requirement for RSNs – the need to arrange for all medically necessary services does not mean all types of services will need to exist in the geographic coverage area. This is an important distinction for the actuary process because it means that every BHO will need to have included in its rates the types of services (i.e. acute detox and sub-acute detox) , even if some of those services are not located within their geographic area.

***Outreach/engagement:*** proactively seeking out individuals in need of CD treatment, encouraging them to seek treatment, and helping to connect them to care (e.g. at needle exchanges, homeless encampments, etc.)

***Pre-treatment/interim services:*** help and support for individuals who are waiting to get into treatment (e.g. waiting for detox, waiting between detox and residential). This could include having a case manager call every day to check in or having a client come in once or twice per week until they can get into treatment

***Withdrawal management:*** (formerly known as “detox”) inpatient, outpatient/ambulatory, acute, sub-acute, and medication assisted

***Outpatient treatment:***

***Intensive outpatient treatment (IOP):***

***Residential treatment:*** short and long term, including care for specialty populations such as pregnant and parenting women (PPW) and ethnic minority communities, medication assisted, and co-occurring

***Integrated crisis response services:*** integrated mental health/chemical dependency outreach and detention services for individuals in crisis

***Case management/care transitions (care coordinators/navigators):*** for patients in all levels of care, including discharge planning from hospitals and jails, in order to safely transition and not “drop off” in between levels or types of care

***Peer services:*** peer support specialists are central to the recovery model and should be utilized along the entire continuum of care

***Recovery supports:*** including support with access to housing (ATR likely going away), transportation, job training (supported employment), and childcare

It is imperative that this continuum of services is not condensed or diminished as a result of the transition to BHOs. It is because of the broad range of services (e.g. medication assisted options, programs for

individuals involved in the criminal justice system, pregnant and parenting women programs) that our clients have the positive outcomes that they do today.

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,</p>

			investigation activities, assessment activities and legal proceedings.
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	<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> </ul>		Although, in some counties, there is not access to these

be included in the Medicaid benefit package.)	<ul style="list-style-type: none"> <li>• 566.43 Sobering Services</li> <li>• 566.44 Involuntary Commitment</li> <li>• 566.45 Sub-Acute Detoxification Services</li> </ul>		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>	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><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</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> </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>	Medicaid does not pay for all of the services that State – GIA does – asking to include the same level in the benefit package.

<p>under the State – GIA dollars.</p>	<ul style="list-style-type: none"> <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>		<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>
<p><b>Residential Treatment (Short and Long Term)</b></p>	<p><b>566.8X Residential Treatment and Group Care Enhancement Services</b></p> <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>	<p>Pays for 16 beds or under facilities</p>	<p>566.81-83 refer <b>ONLY</b> to the CJTA (criminal justice treatment act) funds.</p> <p>State GIA or Block Grant are used to pay for larger agencies.</p>

## **Chemical Dependency Integration Work Group Participants**

Mindy Greenwood (co-chair)  
CD Program Manager  
Cascade Mental Health/Community Allied Behavioral Health  
Chehalis, WA

Brad Finegood, MA, LMHC (co-chair)  
Assistant Division Director, Prevention and Treatment Coordinator  
Mental Health, Chemical Abuse and Dependency Services Division  
King County, Department of Community and Human Services

Kevin Black (advisory)  
Senior Counsel, WA State Senate

Carlos Carreon  
Cowlitz County Health and Human Services

Beth Dannhardt  
Triumph Treatment Services

Lauren Davis  
Washington Recovery Alliance  
King County Alcoholism and Substance Abuse Administrative Board  
King County Mental Health Advisory Board

Stacey Devenney  
Chief Clinical Officer  
Kitsap Mental Health Services  
Bremerton, WA 98311

Carl Erickson  
Cowlitz County Health and Human Services

Angela Grout  
Seadrunar/Seadrunar Recycling

Sheri Healey  
Executive Director  
Seadrunar/Seadrunar Recycling

Peggy Papsdorf  
Policy Analyst  
Pioneer Human Services

Craig Phillips  
President and CEO, ABHS

Melissa Laws  
Prosperity  
Tacoma, WA

Gregory Robinson  
Senior Policy Analyst  
Washington Council for Behavioral Health

Ken Stark  
Community Partner

Keri Waterland  
Assistant Secretary, Department of Corrections

Dawn Williams  
Department of Corrections

Sarah Hockett  
Crisis/DMHP Manager  
Cascade Mental Health

## Appendix B

*The following document is the Final Report of the Full Integration/Early Adopter Work Group, and is approved for inclusion as an appendix to the Task Force's final report. Inclusion does not imply endorsement by the Task Force, except as indicated in the body of the report. The Task Force thanks the members of the work group for their exemplary service.*

Adult Behavioral Health Task Force  
Recommendations from the Full Integration/Early Adopter Workgroup  
November 23, 2015

1. Executive agencies should build service reimbursement rates that support integrated care models.
  - Agencies should be directed to identify treatment modalities that support integrated care and to amend regulations and state plans to integrate those modalities. Where fee for service continues to exist rates should be developed for these new modalities
  - Agencies should be directed to review current modalities and rates for appropriateness and adequacy in integrated settings.
2. The legislature, agencies, purchasers, and providers should actively pursue statewide policies and funding to support the workforce development activities.
  - While there are issues with reserves in some regions, cutting rates to the bottom of the rate band has serious implications for service delivery and in particular the ability to attract and retain workforce. If the legislature has concerns about rates, it should address the reserves directly and leave rates in place to support adequate compensation for critically needed employees and the ability to recruit and grow capacity.
  - Increase loan repayment slots for behavioral health professionals.
  - Appropriate start-up funds for Washington State higher education institutions to increase the number of slots for professional education in behavioral health including therapists, psychiatric nurses, chemical dependency professionals and psychiatric prescribers
  - Direct agencies to review regulations to ensure that behavioral health staff are allowed to practice at the top of their licensure
  - Explore increased opportunities and roles for interns.
  - Direct agencies to develop alternative tracks for licensure as a Chemical Dependency Professional (CDP). Develop and/or create limited certificates to advance substance abuse and/or mental health staff.
3. DSHS and HCA should continue to share procurement documents and draft contracts developed for early adopter and later regions with the Early Adopter/Full Integration Work Group for comment before they are released. This has been a very helpful and positive process and should be retained.
4. DSHS and HCA should lead a process to align regulations across CD/MH/primary care in order to reduce administrative burdens.
  - To the workgroup's knowledge this has not been addressed or has only occurred internally.
  - We recommend a narrow but robust stakeholder process to look for clear conflicts in regulations that limit the potential for success integrated environments e.g., behavioral health/primary care, substance use disorder and mental health treatment.

- Behavioral health facility licensure should be simplified through true adoption of deeming for agencies accredited by recognized accreditors, reduction in complexity and duplication (e.g., licensing large organizations as multiple smaller sites). The legislature should direct this activity through setting clear principles and requirements.
5. State agencies should develop a data system/data sharing plan and funding mechanism to allow for real time data sharing.
    - State agencies should, to the extent possible within federal rules, align data dictionaries and reporting requirements across programs and contracts in order to relieve provider administrative burden and to increase the potential for collection of meaningful outcomes
  6. There is a gap between the end of the task force and the current full implementation date (2020). The workgroup believes:
    - There is a need for a forum for on-going into or oversight of the activities leading to full integration
    - There is great value in the cross-sector interaction present in the workgroup to provide input to plans and to monitor/support the results as those plans are implemented. There is interest in continuing the workgroup for those purposes.
  7. Inadequate rates are a major challenge to the system
    - As noted above the drop in rates in the past session and the planned drop going forward greatly impact recruitment and retention.
    - MCO rates in the Apple Health program currently impair the ability to develop adequate networks and to provide behavioral health benefits to members
  8. We recommend that the Task Force asks the HCA to provide a detailed roadmap that includes:
    - An inventory of integration activities occurring statewide
    - Plans to move contracting to biennial cycles instead of the current off cycle plan
    - A phased timeline that acknowledges that:
      - regions might lie to move to full integration later than the present early adopter timeline but sooner than the 2020 date
      - Regions might want to move to full integration in phased steps rather than all at once
      - Assesses the readiness of regions to meet the 2020 date and provides recommendations for new dates if there are regions that cannot meet that timeline.
      - Outlines models that may be possible for those regions that wish to proceed earlier or in a more stepped manner

Full Integration/Early Adopter Work Group Roster

Name	Organization
Rick Weaver	Central Washington Comprehensive Mental Health (Co-Chair)
Joe Roszak	Kitsap Mental Health Services (Co-Chair)

Kevin Black	Legislative Staff (Non-voting, advisory)
Julie Youngblood	Coordinated Care
Victoria Cates	Coordinated Care
Vanessa Gaston	Clark County
Alice Lind	HCA
Susan McLaughlin	King County
Annette Klinefelter	Daybreak
Molly Firth	CHPW
Jenny Hamilton	HCA
Julie Lindberg	Molina Healthcare
Christine Barada	Spokane County
Marc Bollinger	SWBH
Kirby Richards	Skamania County
Alan Melnick	Clark County
Cheri Dolezal	Optum
Ann Christian	Washington Community Mental Health Council
Erin Hafer	CHPW
Craig Pridemore	Columbia River Mental Health Services
Virginia Eliason	HCA
Isabel Jones	HCA
Bea Dixon	Optum
Pat Knox	Recovery Center of King County
Chris Blake	Legislative Staff (Non-voting, advisory)
Karen Spoelman	King County
Sydney Forrester	Legislative Staff (Non-voting, advisory)
Melena Thompson	DSHS-DBHR
Stacey Folsom	Legislative Staff (Non-voting, advisory)
Chris Donnar	
Dennis Martin	HCA
Susie McDaniel	Spokane County
Anders Edgerton	Kitsap County
Abby Murphy	Washington Counties
Maryanne Lindeblad	HCA
Mary O'Brien	Yakima Valley Farmworkers Clinic
Luke Wickham	Legislative Staff (Non-voting, advisory)
Andy Toulon	Legislative Staff (Non-voting, advisory)
Laurie Lippold	
Nick Federici	
Karen Lee	Columbia United Providers
Glen Wachter	Columbia United Providers
Nathan Johnson	HCA
Melissa Johnson	
Rhonda Donkin	DSHS
Carlos Carreon	Cowlitz County
S Prasad	WACMHC
Matt Canedy	Amerigroup
Jane Beyer	DSHS

Travis Sugarman	Legislative Staff (Non-voting, advisory)
Lindsey Grad	SEIU Healthcare 1199 NW
Chris Imhoff	DSHS
Lonnie Johns Brown	
Joe Valentine	NSMHA
Doug Porter	Pierce County
Kristine Lee	Amerigroup
Dale Jarvis	DJ Consult
Connie Mom Ching	Columbia United Providers
Wil Jackson	DSHS

## Appendix C

*The following policy recommendations were submitted to the Task Force by Vanessa Gaston on behalf of the Early Adopter Region of Southwest Washington Behavioral Health. They are approved for inclusion as an appendix to the Task Force's final report. Inclusion does not imply endorsement by the Task Force, except as indicated in the body of the report.*

# Recommendations to the Legislative Adult Behavioral Health Task Force

By SWWA Early Adopter Region

Clark County, Skamania County, SWBH RSN and Provider Network

### **Workforce Issues:**

1. **Issue:**

Shortage of behavioral health professionals and there's high turnover – Chemical Dependency Professionals (CDPs), Mental Health professionals, Psychiatrists non-profits compete with private sector which pays more. So community based non-profit providers want to make sure rates are adequate to pay a livable wage.

**Recommendations:**

- Providers recommend expanding Telemedicine especially tele-psychiatry.
- Continue to allow for a variety of behavioral health professionals to be paid for such as mental health peers and bachelor level case managers

2. **Issue:**

Ongoing issues with the delays in Department of Health (DOH) licensure process impacts all healthcare providers. DOH allows a 60 day grace period for clinicians to work while licensure process is being completed. However, process takes longer than 60 days.

**Recommendation:**

- Providers are recommending seeking a waiver and agreements with neighboring states to allow of licensure reciprocity or work to streamline the process and remove barriers to delays. Consider accepting other states FBI finger print results.

3. **Issue:**

DOH criteria for the only credential that recognize CDP make it difficult to have highly trained and educated professionals be trained internally by CDPs to obtain the necessary credential. DOH requires the person to go back to Community College and get 30-45 credits in Chemical

Dependency (CD) counseling even if they have a masters in counseling and years of experience in doing CD work.

Recommendation:

- Reduce the number of required credits needed for CD Counseling if a person is a Masters Social Worker (MSW), Licensed Professional Counselor (LPC) or Licensed Marriage & Family Therapist (LMFT) and receive specific CD training. Also, consider a reciprocity agreement with neighboring states.

4. Issue:

Process for mental health professionals to be dual licensed as a CDP is cumbersome and expensive.

Recommendation:

Create a dual license with one renewal costs with a single line of continuing education requirement. Encourage Behavioral Health CEU track.

**Medicaid Program Issues:**

1. Issue:

When a person on Medicaid enters an institution for more than 30 days the person's Medicaid is terminated. The person has to reapply for Medicaid and select or be assigned to a managed care organization when he/she leaves the institution which can cause delay in getting access to care.

Recommendation:

- Seek a waiver to allow for the person's status to be suspended instead of terminated if in an institution less than 6 months. When the person leaves the institution it allows for him/her to move from suspended status back to open without having to reapply for Medicaid all over again. Research New York State's Waiver process.

2. Issue:

State cannot use Medicaid to pay for CD residential treatment in a facility that has more than 16 beds instead has to use state only funds. There is a huge shortage of CD residential beds in Washington State now. Washington State requested and received an IMD waiver for mental health.

Recommendation:

- Request an IMD waiver for CD residential treatment under the 1115 Waiver process.

**Vulnerable Population with High Needs:**

Issue: People with chronic health disorders have not had adequate and coordinated care for their complex health and social needs. This situation results in individuals with multiple needs and issues including self-medication (addiction disorders), crime, homelessness, lack of jobs, and few opportunities for healthy food and exercise opportunities.

Recommendations:

- Invest in programs that address prevention and the social determinants of health including providing affordable housing, access to education/training, job placement, safe communities, increased access to health foods thru grocery stores and farmer’s markets.
- Invest in care coordination / care navigation – across systems including medical, behavioral health, housing, workforce development, law enforcement, and public health.

**RCW and WAC Changes - System documentation requirements:**

Issue: Currently, RCWs and WACs for mental health, chemical dependency, and medical care contain different requirements, different standards, and separate billing systems. Time spent by practitioners on meeting documentation standards for these different systems can leave little time for actual treatment and problem solving.

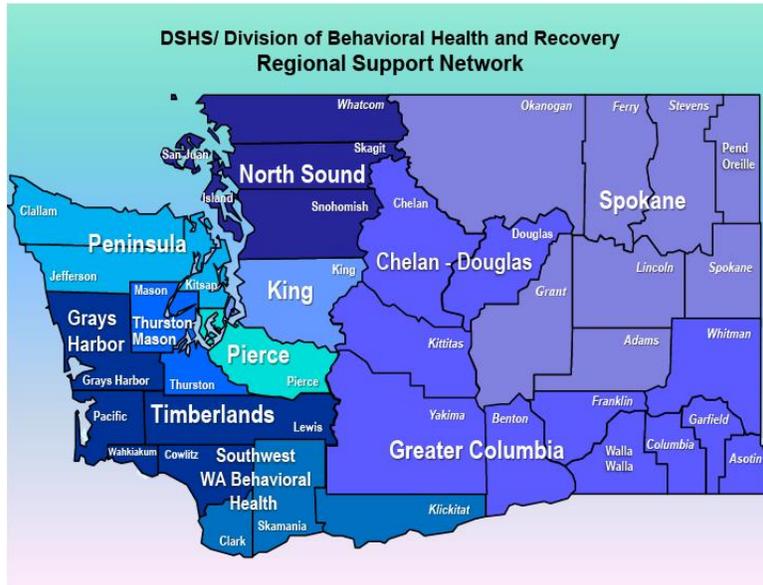
Recommendations:

- Align RCWs and WACs across systems of behavioral health and between behavioral health and medical care.
- Require health plans managing Medicaid contracts for Early Adopter to align documentation requirements across systems, regardless of patient presentation, diagnosis, or identified need.

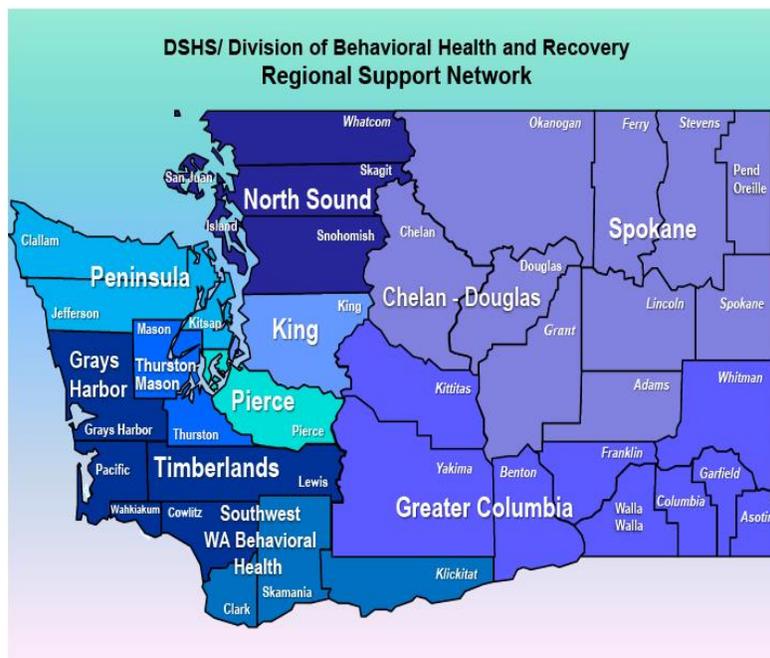
## Appendix D

The following alternative regional support area map recommendations were submitted by the Washington State Association of Counties (WSAC) and approved by the Task Force. See Section V in the body of the report for more information.

WSAC Proposed Map #1 (CDRSN merge with GCRSN)



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



## Appendix E

*The following working document contains policy recommendations submitted to the Task Force during 2015, with source attribution. This working document was used as a basis for discussion of the final recommendations presented in section VI of the report.*

### 2015 Proposed Policy/Reform Recommendations With Source Attribution

#### Relating to Funding Behavioral Health Systems

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
1.	The Legislature should increase Medicaid and non-Medicaid funding to a level that covers the full cost of providing behavioral health services, and fully funds needs such as technology, infrastructure, outreach, contingency reserves, and workforce.	Actuarial rates should represent the actual cost of doing business, and not just be based on historic rates. The state should create (or purchase) an integrated data reporting system for MH and CD providers that combines the strengths of the existing separate data systems.	Chemical Dependency Integration/Public Safety Work Group Recommendation #8
		Inadequate rates are a major challenge to the system. The drop in rates in the past session and the planned drop going forward greatly impact recruitment and retention. MCO rates in the Apple Health program currently impair the ability to develop adequate networks and to provide behavioral health benefits to members	Full Integration/Early Adopter Work Group recommendation
		While there are issues with reserves in some regions, cutting rates to the bottom of the rate band has serious implications for service delivery and in particular the ability to attract and retain workforce. If the legislature has concerns about rates, it should address the reserves directly and leave rates in place to support adequate compensation for critically needed employees and the ability to recruit and grow capacity.	Full Integration/Early Adopter Work Group recommendation
		The state must provide adequate funding to support the infrastructure and technology needed to integrate of substance use disorder treatment with mental health in managed care.	Jim Vollendroff, Director, King County Mental Health, Chemicals Abuse & Dependency Services Division
		The state should adjust substance use disorder rates upward to cover the actual cost of services, in order to avoid the loss of providers, especially in rural areas.	Wes McCart, Stevens County Commissioner

	<p>RSNs/BHOs must structure contracts with providers to provide enough funding support to allow providers to build up an operating reserve, to plan for contingencies, keep up with technology, provide funds to support outreach activities in the community, and to provide more competitive salaries so we can hire the staff required to expand services.</p>	<p>Craig Pridemore, CEO, Columbia River Mental Health Services</p>
	<p>Integrated health care contracts must be administered in such a way as to allow substance use disorder providers who provide necessary mental health medications or treatments to patients from around the state to be reimbursed for this care without imposing costly administrative burdens (providers are currently required to negotiate individual contracts with 11 RSNs).</p>	<p>Annette Klinefelter, Executive Director Daybreak Youth Services</p>
	<p>Recognize internships as an encounterable event for productivity.</p>	<p>Joe Roszak, Early Adopter/Full Integration Work Group</p>
	<p>Federal funds should be used to support innovative, recovery-based ideas within peer organizations.</p>	<p>Brad Berry, Executive Director, Consumer Voices are Born</p>
	<p>The state should address financial barriers affecting the stability of the work force and ensure that recruitment and retention strategies address financial considerations, including (1) increasing reimbursement rates to allow providers to hire and retain a competent workforce; (2) provide competitive salaries; (3) offer broader access to student loan repayment for providers in shortage areas; and (4) provide payment for new technologies and evolving practices.</p>	<p>Asst. Prof. Anna Ratzliff, UW Dept of Psych and Behavioral Health Sciences, SB 5732 Workforce Development Workgroup</p>
	<p>Rates need to be set at a level that allows providers to pay salaries that support recruitment and retention.</p>	<p>Ann Christian, CEO, Washington Community Mental Health Council</p>
	<p>Medicaid rates need to be evaluated because of their impact on the ability to recruit the workforce.</p>	<p>Chelene Whiteaker, Policy Director, Washington State Hospital Association</p>

	Substance abuse treatment services need to be paid in parity with mental health services.	Dennis Neal, CEO, Northwest Resources
	Restore Medicaid rate cuts and raise the rate band.	Joe Roszak, Early Adopter/Full Integration Work Group
	Telemedicine laws should be expanded to pay for telemedicine visits when they are in their home.	Cara Towle, RN, MSN, Director for Telehealth Services, University of Washington
	Recovery coaching should be included as a reimbursable service for individual mentoring and group services through Medicaid, just as peer services for mental health are reimbursable.	Ruby Takushi, Director of Programs, Recovery Cafe
	There should be Medicaid funding for peer services in the area of chemical dependency.	Ann Rider, Executive Director, Capital Recovery Center
	The Medicaid benefit package only pays for chemical dependency assessments and treatments, but should also include other services like recovery supports, case management, care transitions, and outreach and engagement.	Mindy Greenwood, Chemical Integration Work Group
	State agencies should align a Medicaid state plan for both chemical dependency and mental health so that chemical dependency providers can bill for the types of services that mental health can bill for.	Mindy Greenwood, Chemical Integration Work Group
	The state should maintain the grant and aid programs to help with additional services if they cannot be included in the Medicaid benefit package and the state needs to include funds to use for IMD beds.	Mindy Greenwood, Chemical Integration Work Group
	Behavioral health organization contracts for future procurement of behavioral health services must assure that the contracts can adequately provide for caseloads and recruitment and retention of qualified staff in both chemical dependency and mental health.	Lindsey Grad, SEIU 775

		The state should restore cut made to the behavioral health jail proviso made in 2014.	Rick Weaver, CEO, Comprehensive Mental Health
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Item	Policy/Reform Recommendation	Source Recommendation	Proponent
2.	State agencies should redesign service reimbursement rates (where fee for services continues to exist) and treatment modalities to ensure that they support integrated care models.	<p>Executive agencies should build service reimbursement rates that support integrated care models.</p> <ul style="list-style-type: none"> <li>Agencies should be directed to identify treatment modalities that support integrated care and to amend regulations and state plans to integrate those modalities. Where fee for service continues to exist rates should be developed for these new modalities</li> <li>Agencies should be directed to review current modalities and rates for appropriateness and adequacy in integrated settings.</li> </ul>	Full Integration/Early Adopter Work Group recommendation

Item	Policy/Reform Recommendation	Source Recommendation	Proponent
3.	<p>The state should provide funding to:</p> <ul style="list-style-type: none"> <li>Continue to reimburse tribal behavioral health programs at the Indian Health Services encounter rate;</li> <li>Develop payment policies for persons with co-occurring disorders;</li> <li>Fund tribal programs to provide chemical dependency to services to be provided to non-native people.</li> </ul>	The state should continue to reimburse tribal mental health and chemical dependency programs at the Indian Health Services encounter rate, have payment policies for persons with co-occurring disorders, and fund tribal programs for chemical dependency to services to be provided to non-native people.	Tribal Centric Behavioral Health Report, November 2013

Relating to Electronic Data and Health Information Sharing

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
4.	<p>State agencies should facilitate sharing of clinical data across provider and delivery systems and share data across state programs, including measures such as:</p> <ul style="list-style-type: none"> <li>• Creating a single release of information across systems;</li> <li>• Establishing a real time clinical data repository</li> <li>• Defining required data elements for BHOs and providers</li> <li>• Align data dictionaries and reporting requirements across programs and contracts</li> </ul>	<p>The state should create (or purchase) an integrated data reporting system for MH and CD providers that combines the strengths of the existing separate data systems.</p>	<p>Chemical Dependency Integration/Public Safety Work Group recommendation</p>
		<p>State agencies should develop a data system/data sharing plan and funding mechanism to allow for real time data sharing.</p>	<p>Full Integration/Early Adopter Work Group recommendation</p>
		<p>State agencies should, to the extent possible within federal rules, align data dictionaries and reporting requirements across programs and contracts in order to relieve provider administrative burden and to increase the potential for collection of meaningful outcomes</p>	<p>Full Integration/Early Adopter Work Group recommendation</p>
		<p>The state should define required data elements at the so that behavioral health organizations and providers can begin system development.</p>	<p>Jim Vollendroff, Director, King County Mental Health, Chemicals Abuse &amp; Dependency Services Division</p>
		<p>The state should support electronic information sharing that would support care coordination.</p>	<p>Cammy Hart-Anderson, Division Manager, Snohomish County Human Services</p>
		<p>Agencies need to continue to find better ways to use data across different state programs through integrated data systems.</p>	<p>Adam Aaseby, Chief Information Officer, Health Care Authority</p>
		<p>There should be a clinical data repository to allow providers to see clinical data across provider systems and across delivery systems in real time.</p>	<p>Adam Aaseby, Chief Information Officer, Health Care Authority</p>
		<p>The state should create and maintain a real-time, integrated registry database.</p>	<p>Stacey Devenney, Chief Clinical Officer, Kitsap Mental Health Services</p>

		A single health record release with common language should be created for use across all health care systems, including primary care and behavioral health.	Stacey Devenney, Chief Clinical Officer, Kitsap Mental Health Services
		A clinical data registry should be developed to share patient health information across health care settings.	Ken Taylor, Chief Executive Officer, Valley Cities Counseling and Consultation

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
5.	State agencies and stakeholders should work to develop common understandings of privacy laws, promulgate data sharing standards, and advocate to the federal government for more contemporary standards to allow the sharing of health information, including substance use disorder information, when it promotes the goal of providing integrated, whole-person care.	The Legislature should work with the Attorney's Generals office and Federal Government to update 42 CFR regulations to meet with the vision of effective integrated whole person care.	Chemical Dependency Integration/Public Safety Work Group Recommendation #4
		The Interagency Privacy Workgroup should continue its efforts to develop a common understanding of the meaning of various privacy laws and data sharing standards, and open the forum to stakeholders from the private sector.	Adam Aaseby, Chief Information Officer, Health Care Authority
		Washington should collaborate with other states and professionals organizations to advocate for more adoption of contemporary federal privacy standards under 42 C.F.R. which protect privacy while allowing health care providers to share substance use history information to provide integrated, informed whole person care.	Stacey Devenney, Chief Clinical Officer, Kitsap Mental Health Services
		The Attorney General's Office and agencies should update interpretations of federal privacy regulations under 42 C.F.R. to meet the vision of effective, integrated, whole person care.	Stacey Devenney, Chief Clinical Officer, Kitsap Mental Health Services
		The state should work with consumer health care advocacy groups to promote the idea that substance misuse and abuse is a disease for which treatment	Stacey Devenney, Chief Clinical Officer, Kitsap Mental Health Services

		works and to reduce stigma, to increase support for giving health care providers access to substance abuse treatment records.	
		Integrated health records through a good health information exchange are important and will drive a much better coordination of care.	Doug Bowes, CEO, United Health Care Community Plan
		We have benefitted from an integrated health record, without carve outs, that allows our clinicians to see every service the patient has received.	Karen Gregory, Behavioral Health Director, Amerigroup Washington

Relating to Workforce Development: Licensing, Recruitment, Professional Development, and Telemedicine

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
6.	<p>The state should restructure professional licensing and certification rules and practices to make them more flexible in order to support the development of the behavioral health workforce, including measures such as:</p> <ul style="list-style-type: none"> <li>• Creating a fast track process for dual certification in mental health and substance use disorders</li> <li>• Reduce the number of required credits to obtain a chemical dependency professional certification for those who hold other professional licenses</li> </ul>	<p>The Legislature should direct agencies to develop alternative tracks for licensure as a Chemical Dependency Professional (CDP). Develop and/or create limited certificates to advance substance abuse and/or mental health staff. Explore increased opportunities and roles for interns.</p>	Full Integration/Early Adopter Work Group recommendation
		<p>Providers are recommending seeking a waiver and agreements with neighboring states to allow of licensure reciprocity or work to streamline the process and remove barriers to delays. Consider accepting other states FBI finger print results.</p>	Early Adopter Region recommendations
		<p>In order to make it easier for highly trained and educated professionals to be trained internally to obtain a CDP credential, reduce the number of required credits needed for CD Counseling if a person is a Masters</p>	Early Adopter Region recommendations

<ul style="list-style-type: none"> <li>• Creating more options to secure supervised hours</li> <li>• Licensing instead of certifying CDPs</li> <li>• Addressing accreditation across agencies</li> <li>• Pursuing licensing reciprocity with border states</li> <li>• Allow licensing reciprocity from other states or streamline licensing delays.</li> <li>• Consider accepting other states' FBI fingerprint background check results</li> </ul>	<p>Social Worker (MSW), Licensed Professional Counselor (LPC) or Licensed Marriage &amp; Family Therapist (LMFT) and receive specific CD training. Also, consider a reciprocity agreement with neighboring states.</p>	
	<p>To ease the process for mental health professionals to become dually licensed as a CDP, create a dual license with one renewal cost with a single line of continuing education requirements. Encourage Behavioral Health CEU track.</p>	<p>Early Adopter Region recommendations</p>
	<p>Consider developing fast-track options to complete a course within a weeklong period as an alternative to going to a traditional college and allowing Masters-level mental health professionals to become dually-certified in chemical dependency and for people to enter the chemical dependency field.</p>	<p>Loretta Stover, County Coordinator for Chemical Dependency for Chelan and Douglas Counties</p>
	<p>There needs to be ongoing skill support through certificate programs so that those providers who already have a health care credential can add a specialty (such as allowing a mental health professional to add a chemical dependency expertise in a more efficient way than going back through the entire chemical dependency professional credentialing process).</p>	<p>Ann Christian, CEO, Washington Community Mental Health Council</p>
	<p>There should be flexible options for chemical dependency professionals to secure supervised hours.</p>	<p>Ann Christian, CEO, Washington Community Mental Health Council</p>
	<p>Chemical dependency professionals should be able to become "licensed" chemical professionals as opposed to "certified" chemical dependency professionals to allow for reimbursement from managed care companies.</p>	<p>Dennis Neal, CEO, Northwest Resources</p>

		Facilitate licensure equity for chemical dependency and mental health under behavioral health by creating limited certificates to advance substance abuse and mental health staff, such as establishing a parallel to the agency-affiliated counselor status for the chemical dependency field.	Joe Roszak, Early Adopter/Full Integration Work Group
		Develop a universal definition of "deeming" for agencies and apply this concept consistently across agencies so that being accredited with one entity has the same value across all agencies in terms of relief from audits and inspections.	Joe Roszak, Early Adopter/Full Integration Work Group
		There needs to be a method for licensing reciprocity with border states to be able to hire providers more quickly.	Vanessa Gaston, Director, Clark County Community Services
		There should be a single dual license with one renewal fee and a single line of continuing education requirements for those trained in both substance use disorders and mental health conditions.	Vanessa Gaston, Director, Clark County Community Services
		Finding a way to clearly license people across the entire realm of recovery would be a benefit to the whole state, especially in areas where clinics and agencies are co-locating health care providers.	Brad Berry, Executive Director, Consumer Voices are Born
		There needs to be a fast-track to get a chemical dependency profession to become a Masters-level mental health professional.	Dennis Neal, CEO, Northwest Resources

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
7.	<p>State regulations should be revised to allow behavioral health providers to have greater flexibility to meet workforce needs, including measures such as:</p> <ul style="list-style-type: none"> <li>• Giving providers more say in scope of practice</li> <li>• Allowing practitioners to work at the top of their credential</li> <li>• Requiring contracts with licensed providers, not individuals</li> <li>• Allowing payment for a variety of behavioral health professionals</li> </ul>	<p>The Legislature should direct agencies to review regulations to ensure that behavioral health staff are allowed to practice at the top of their licensure</p>	<p>Full Integration/Early Adopter Work Group recommendation</p>
		<p>State agencies should explore amending regulation to increase opportunities and roles for interns.</p>	<p>Full Integration/Early Adopter Work Group recommendation</p>
		<p>State laws and practices should be amended so that providers have more say in scope of practice issues to allow practitioners to work at the top of their credential and provide services efficiently.</p>	<p>Craig Pridemore, CEO, Columbia River Mental Health Services</p>
		<p>Provide incentives to providers to render services at the top of their licensure (e.g., primary care provider managing psychotropic medication with consultative support, medical assistants performing blood draws).</p>	<p>Joe Roszak, Early Adopter/Full Integration Work Group</p>
		<p>There should be a review of agency rules regulating behavioral health organizations that considers the level of credentialing required for certain tasks so that some activities may be performed by professionals with a lesser level of credentialing and training.</p>	<p>Bea Dixon, Executive Director, Pierce Regional Support Network</p>
		<p>Contract with the agency rather than the individual for licensure and certification.</p>	<p>Joe Roszak, Early Adopter/Full Integration Work Group</p>
		<p>Continue to allow for a variety of behavioral health professionals to be paid for such as mental health peers and bachelor level case managers</p>	<p>Early Adopter Region recommendation</p>

		Managed care organizations and health plans must be required to contract with licensed behavioral health organizations, not just licensed individual clinicians.	Ann Christian, CEO, Washington Community Mental Health Council
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Item	Policy/Reform Recommendation	Source Recommendations	Proponent
8.	<p>The state should lead and facilitate efforts to increase size of the behavioral health workforce, including measures such as:</p> <ul style="list-style-type: none"> <li>Working directly with educational institutions to increase slots for professional education in behavioral health</li> <li>Providing more loan forgiveness programs</li> <li>Increasing use of mid-level providers such as psychiatric ARNPs</li> <li>Allowing certified psychologists to prescribe some psychiatric medications</li> <li>Creating a psychiatry specialty credential</li> <li>Establishing a state institute for training in integrated care and practice transformation</li> <li>Expanding residency programs</li> <li>A behavioral health running start program</li> <li>Collecting data to evaluate the size of the workforce</li> </ul>	The Legislature should appropriate start-up funds for Washington State higher education institutions to increase the number of slots for professional education in behavioral health including therapists, psychiatric nurses, chemical dependency professionals and psychiatric prescribers.	Full Integration/Early Adopter Work Group recommendation
		The state should increase loan repayment slots for behavioral health professionals.	Full Integration/Early Adopter Work Group recommendation
		Increase the use of mid-level providers, i.e. psychiatric ARNPs, and use tools like education and loan forgiveness to increase the work force.	Cassie Sauer, Senior Vice President, Advocacy and Government Affairs, Washington State Hospital Association.
		The state should create a certification program to allow psychologists to prescribe some psychiatric medications	Cassie Sauer, Senior Vice President, Advocacy and Government Affairs, Washington State Hospital Association.
		There should be an assessment of ways to expand the use of the existing workforce, such as sponsoring a pilot project to train and certify psychologists to prescribe psychiatric medications.	Chelene Whiteaker, Policy Director, Washington State Hospital Association
		The state should explore having a psychiatry specialty credential for physician assistants.	Ann Christian, CEO, Washington Community Mental Health Council
		There needs to be more loan repayment programs to support	Ann Christian, CEO, Washington

		behavioral health professionals working in behavioral health settings.	Community Mental Health Council
		The workforce can be increased through increased funding for training programs and expanded residency programs.	Chelene Whiteaker, Policy Director, Washington State Hospital Association
		Establish more student loan reimbursement incentives for behavioral health professionals.	Joe Roszak, Early Adopter/Full Integration Work Group
		Expand pathways to existing credentials, such as a behavioral health version of the Running Start program.	Joe Roszak, Early Adopter/Full Integration Work Group
		Conduct a scientific survey of both employers and worker to provide comprehensive data that offers a more accurate picture of the behavioral health care workforce.	Eleni Papadakis, Executive Director of the Workforce Training and Education Coordinating Board
		There needs to be better data collection to evaluate shortage of providers in the mental health system.	Chelene Whiteaker, Policy Director, Washington State Hospital Association

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
9.	The state, BHOs, and early adopter regions should support professional development for behavioral health workers, including skills development, training, support for evidence-based approaches, and practice improvements. Improved training is need in colleges, universities, and within the existing workforce.	There should be ongoing training and practice improvement with the existing workforce.	Ann Christian, CEO, Washington Community Mental Health Council
		The state should support professional development of a statewide expanded behavioral health workforce to implement consistent treatment models and evidence-based practices, including (1) shifting toward recovery and resilience principles; (2) promoting training that has follow up clinical supervision to make sure that people are prepared to deliver new practices; (3) invest in professional development to promote integrated, team-based practice skills; (4) work with professional schools to train in evidence-	Asst. Prof. Anna Ratzliff, UW Dept of Psych and Behavioral Health Sciences, SB 5732 Workforce Development Workgroup

		based practices and telehealth; (5) expanding the use of tele-behavioral health through support of training, payment, administration, and technology; and (6) targeting training for other professions who work with those with behavioral health needs.	
		Behavioral health organizations and regional service networks need to educate providers on their integration efforts around specialty programs and benefit packages as well as what they are doing to learn about the ASAM criteria.	Mindy Greenwood, Chemical Integration Work Group
		Provide training and support practice change to promote integrated behavioral health care and team-based approaches, including (1) providing training in evidence-based practices and other priority methodologies; (2) providing training to support geographically and culturally disparate groups; (3) allowing providers to practice to the top of their licenses; (4) funding the incorporation of evidence-based practices and integrated care into the core curriculum of training programs; (5) establishing a state institute for training in integrated care and practice transformation; and (6) targeting training for numerous professions that are involved in direct care.	Asst. Prof. Anna Ratzliff, UW Dept of Psych and Behavioral Health Sciences, SB 5732 Workforce Development Workgroup
		Higher education degree programs need to update their curricula in a way that focuses on whole person health care and that teaches evidence-based medicine.	Ann Christian, CEO, Washington Community Mental Health Council
		We use extensive training programs in integrated care management and utilization management to help unify care.	Karen Gregory, Behavioral Health Director, Amerigroup Washington

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
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10.	<p>The state should encourage and expand use of telepsychiatry and telepharmacy, including measures such as:</p> <ul style="list-style-type: none"> <li>• Adopting the Interstate Medical Licensure Compact</li> <li>• Adopting specific laws to regulate telemedicine providers</li> <li>• Allowing payment for telemedicine visits from home</li> <li>• Requiring payment parity between telemedicine and in-person visits</li> <li>• Providing reimbursement for provider-to-provider consultation</li> <li>• Conducting education campaigns in rural areas</li> <li>• Mandating malpractice liability coverage for telepsychiatry providers</li> </ul>	Providers recommend expanding Telemedicine especially tele-psychiatry.	Early Adopter Region Recommendation
		Expand the use of telepsychiatry and telepharmacy	Cassie Sauer, Senior Vice President, Advocacy and Government Affairs, Washington State Hospital Association.
		The Interstate Medical Licensure Compact should be adopted to provide an expedited process for becoming licensed in other states so that providers may perform telepsychiatry services more easily across state lines.	Cara Towle, RN, MSN, Director for Telehealth Services, University of Washington
		Other states have adopted specific laws to regulate providers who engage in telemedicine.	Dr. Arpan Waghray, Medical Director of Behavioral Medicine, Swedish Health Services
		Technology solutions need to be explored through telepsychiatry and web-based tools.	Ann Christian, CEO, Washington Community Mental Health Council
		Telemedicine laws should require payment parity with in-person visits	Cara Towle, RN, MSN, Director for Telehealth Services, University of Washington
		Conduct education campaigns for patients in rural areas to make patients feel more comfortable with using telepsychiatry.	Dr. Arpan Waghray, Medical Director of Behavioral Medicine, Swedish Health Services
		Require carriers to provide malpractice liability coverage for practitioners performing telepsychiatry for a specified amount, to ease the concerns of providers.	Dr. Arpan Waghray, Medical Director of Behavioral Medicine, Swedish Health Services
		Telemedicine laws should provide reimbursement for provider-to-provider consultation, so that psychiatric experts may consult clinicians under a collaborative care model.	Cara Towle, RN, MSN, Director for Telehealth Services, University of Washington

		Telehealth should be supported to extend the reach of providers to rural areas.	Doug Bowes, CEO, United Health Care Community Plan
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Relating to Peer Services

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
11.	<p>The state should promote peer services at all levels of care in the behavioral health system through means such as:</p> <ul style="list-style-type: none"> <li>• Professionalizing peer services;</li> <li>• Increasing the scope of the use of peer services throughout the behavioral health system;</li> <li>• Providing technical support to employers;</li> <li>• Increasing pay rates;</li> <li>• Conducting research; and</li> <li>• Reexamining peer credentialing practices.</li> </ul>	The state should endeavor to have peer services at all levels of care in the Behavioral Health system.	Chemical Dependency Integration/Public Safety Work Group Recommendation #7
		There should be a certificate for those who pass the credentialing exam to become a peer so the service will become professionalized through recognized standards and continuing education.	Beth Hammonds, Regional Director, Recovery Innovations, Inc.
		The state should assist agencies and providers in structuring jobs, defining the role of peers, supervising peers, and billing for peer services through funding for agencies that wish to use peer services.	Jennifer Bliss, Peer Support Program Manager, DSHS
		The state should recognize recovery coaches for those with substance use disorders in the same way that it recognizes peer support specialists for mental health conditions.	Ruby Takushi, Director of Programs, Recovery Cafe
		The recovery coach concept should be included in any system of care that uses peer support.	Ruby Takushi, Director of Programs, Recovery Cafe
		Peer-to-peer programs similar to those used in drug courts and should be used in jails as well.	Brad Berry, Executive Director, Consumer Voices are Born
		There should be support for providers for training on how to supervise peers.	Ann Rider, Executive Director, Capital Recovery Center

		The Department of Social and Health Services should review its list of people disqualified from serving as a provider which may unnecessarily prevent people from becoming peer support professionals.	Jennifer Bliss, Peer Support Program Manager, DSHS
		The state should review better ways to address the pay, credentialing, and education for peers.	Beth Hammonds, Regional Director, Recovery Innovations, Inc.
		The state should expand the number of peer support programs.	Ann Rider, Executive Director, Capital Recovery Center
		Recovery coaching should be included as a reimbursable service for individual mentoring and group services through Medicaid, just as peer services for mental health are reimbursable.	Ruby Takushi, Director of Programs, Recovery Cafe
		Agencies that bill for recovery coaches should be allowed to bill Medicaid for the training, supervision, and ongoing support.	Ruby Takushi, Director of Programs, Recovery Cafe
		There needs to be more research into the evidence behind peer support services.	Jennifer Bliss, Peer Support Program Manager, DSHS

Relating to Providing an Adequate Network of Behavioral Health Services

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
12.	The state should revise the Medicaid plan to provide a comprehensive chemical dependency service package which aligns with benefits provided for mental health,	The state should provide a comprehensive CD service package. These would include but not limited to; case management, peer services, recovery supports, and medication monitoring/management.	Chemical Dependency Integration/Public Safety Work Group Recommendation #1

	and provide sufficient funding for essential chemical dependency services which are not covered by Medicaid.	The state should maintain financial support for chemical dependency services that were state funded and are not funded under Medicaid expansion, including 1) Residential services in facilities with more than 16 beds that are not reimbursed by Medicaid; 2) Drug testing, including urinalysis; and 3) Community Education	Chemical Dependency Integration/Public Safety Work Group Recommendation #1
		Bring the Mental Health and Chemical Dependency Medicaid State Plans into alignment. True integration of behavioral health services cannot occur until there is parity in the two plans. Example: support and reimbursement for peer to peer services.	Chemical Dependency Integration/Public Safety Work Group Recommendation #2
		Do not cut much needed non-Medicaid money. These funds cover gaping holes in the system.	Chemical Dependency Integration/Public Safety Work Group Recommendation #2
		Full support for the chemical dependency program will drive better penetration and recovery outcomes for those seeking mental health and chemical dependency services	Chemical Dependency Integration/Public Safety Work Group Recommendation #2

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
13.	<p>The state, BHOs, and early adopter regions should act to ensure an adequate network of providers, including inpatient beds, for behavioral health treatment needs, including measures such as:</p> <ul style="list-style-type: none"> <li>Expanding inpatient treatment availability for youth with substance use disorders</li> <li>Allowing partial hospitalization models</li> </ul>	The state, early adopter regions, and BHOs must drastically expand availability of inpatient treatment beds for youth with substance use disorders. There must be provisions for BHOs/early adopter regions to ensure network adequacy.	Annette Klinefelter, Executive Director Daybreak Youth Services
		DSHS/HCA should develop coverage (billing codes) to allow for a partial hospitalization model for adults who can receive intensive hospital-based behavioral health services during the	Cassie Sauer, Senior Vice President, Advocacy and Government Affairs, Washington State Hospital Association.

<p>for adults with behavioral health needs</p> <ul style="list-style-type: none"> <li>Analyzing SB 5649 reports to determine areas with inadequate ITA resources</li> <li>Creating a tiered inpatient psychiatric system</li> <li>Expanding juvenile and geriatric ITA beds</li> <li>Requiring state hospitals to immediately admit involuntary patients committed to 90 or 180 days of inpatient treatment</li> <li>Allowing extensions of involuntary holds when a certified bed or single bed certification cannot be located within maximum time limits</li> </ul>	<p>day but go home at night (in use for children).</p>	
	<p>The Legislature should look at SB 5649 reports showing where single bed certifications are used and where patients who meet detention criteria are turned away without detention to plan allocation of future ITA resources.</p>	<p>Cassie Sauer, Senior Vice President, Advocacy and Government Affairs, Washington State Hospital Association.</p>
	<p>The state should create an electronic system to display ITA bed openings statewide.</p>	<p>Cassie Sauer, Senior Vice President, Advocacy and Government Affairs, Washington State Hospital Association.</p>
	<p>The state should create a tiered inpatient psychiatric system for providers who want to treat patients with moderate psychiatric needs (without meeting standards targeted towards the highest acuity patients)</p>	<p>Cassie Sauer, Senior Vice President, Advocacy and Government Affairs, Washington State Hospital Association.</p>
	<p>The state should increase the availability of ITA beds for juvenile and geriatric patients</p>	<p>Carola Schmid, Designated Mental Health Professional (DMHP), Snohomish County Human Services</p>
	<p>The Legislature should amend state law to allow a 4-6 hour extension of an involuntary detention hold without a single bed certification when a designated mental health professional cannot locate a certified bed or single bed certification placement within the time available.</p>	<p>Ian Harrell, Director, Behavioral Health and Recovery</p>
	<p>State hospitals should support the community ITA system by: 1) Immediately admitting patients on 90-day commitment orders which will free up local beds for detention; and 2) Serving as evaluation and treatment centers of last resort when there are no certified beds or facilities able to attest to a single bed</p>	<p>Carola Schmid, Designated Mental Health Professional (DMHP), Snohomish County Human Services; Ian Harrell, DMHP, Behavioral Health and Recovery</p>

		certification can be found to meet detention needs	(Thurston, Mason & Grays Harbor)
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Item	Policy/Reform Recommendation	Source Recommendation	Proponent
14.	The state should increase access to medication assisted treatment for persons with substance use disorders near their home communities and reduce the need for medical transit services.	Providers must have real-time access to medication management to address opiate overdose issues, specifically data related to patients using community paratransit services to go to a suboxone doctor or methadone maintenance outside of the client's county.	Mindy Greenwood, Chemical Integration Work Group

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
15.	The state should apply for a Medicaid waiver to allow residential substance use disorder treatment in facilities larger than 16 beds.	Request an IMD waiver for CD residential treatment under the 1115 Waiver process. There is a huge shortage of CD residential beds in Washington State now. Washington State requested and received an IMD waiver for mental health.	Early Adopter Region recommendation
		Work towards a waiver for the IMD rule for chemical dependency residential treatment. The current system, which does not have enough residential beds (waiting lists), is built upon facilities that are currently not eligible for Medicaid funding, because they are larger than 16 beds and struggle for financial viability.	Chemical Dependency Integration/Public Safety Work Group Recommendation #2

Relating to Increasing Collaboration Across Health Systems

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
16.	The state, BHOs, and early adopter regions should support new practice models that increase collaboration between diverse and unconventional practice settings such as primary care, behavioral health	There needs to be support for activities that can be done in the community, such as peer support and family and community health workers.	Jürgen Unützer, AIMS Center, University of Washington
		Invest in programs that address prevention and the social determinants of health including providing affordable housing, access to education/training, job placement,	Early Adopter Region recommendation

<p>care, pharmacists, care coordinators, schools, jails, and a patient's family and community supports.</p>	<p>safe communities, increased access to health foods thru grocery stores and farmer's markets.</p>	
	<p>Invest in care coordination/care navigation – across systems including medical, behavioral health, housing, workforce development, law enforcement, and public health.</p>	<p>Early Adopter Region recommendation</p>
	<p>There should be increased use of consultation models, such as having primary care providers consulting with behavioral health providers.</p>	<p>Ann Christian, CEO, Washington Community Mental Health Council</p>
	<p>There is a need for practicing differently, including (1) allowing pharmacists to follow up with patients who have unfilled mental health medications; (2) utilizing care coordinators within primary care settings to advance mental health care; and (3) reviewing rules to make sure that they are not outdated and creating barriers to licensure.</p>	<p>Chelene Whiteaker, Policy Director, Washington State Hospital Association</p>
	<p>The state should consider different ways to reimburse integrated care and care coordination that might be different from reimbursement for a specific encounter with a patient, such as the way that the Centers for Medicaid and Medicare Services are introducing codes to reimburse for provider-to-provider consultation and other care management services.</p>	<p>Marc Avery, MD, University of Washington Department of Psychiatry and Behavioral Sciences</p>
	<p>The state agencies should put together a crosswalk for the Task Force and the providers to show the differences in Medicaid payments for mental health and chemical dependency.</p>	<p>Mindy Greenwood, Chemical Integration Work Group</p>
	<p>Funding needs to go toward prevention and early intervention before it gets to the point of needing more costly services.</p>	<p>Cassandra Ando, Public Policy Chair, National Alliance on Mental Illness - WA</p>
	<p>In addition to supporting the traditional specialty behavioral health services, such as hospitals and community mental health</p>	<p>Jürgen Unützer, AIMS Center,</p>

		centers, there needs to be workforce support for other kinds of health care settings, such as primary care clinics, school-based settings, and jails, and provide better consultation to them so that patients do not get so sick that they require inpatient care.	University of Washington
		A best practice is to embed behavioral care workers in primary care offices to do screenings and take referrals.	Karen Gregory, Behavioral Health Director, Amerigroup Washington
		Holding lots of stakeholder meetings and providing education and technical support to providers has proven to be very important to maintaining an integrated provider network.	Karen Gregory, Behavioral Health Director, Amerigroup Washington
		The state should mandate coordination between BHOs and MCOs.	Julie Youngblood, Manager of Case Management for Behavioral Health, Coordinated Care

Item	Policy/Reform Recommendation	Source Recommendation	Proponent
17.	<p>Behavioral Health Organizations must improve their ability to provide equitable and timely access to culturally appropriate mental health services for American Indian and Alaska Native Medicaid enrollees, including measures such as:</p> <ul style="list-style-type: none"> <li>• Use of tribal liaisons;</li> <li>• Contracts with tribal and urban Indian mental health programs;</li> <li>• Providing culturally appropriate evidence-based and promising practices; and</li> <li>• Requiring providers who serve AI/AN consumers to meet minimal cultural</li> </ul>	Behavioral health organizations must improve their ability to provide equitable and timely access to culturally appropriate mental health services for American Indian and Alaska Native Medicaid enrollees through the use of tribal liaisons, contracts with tribal and urban Indian mental health programs, providing culturally appropriate evidence-based and promising AI/AN practice treatments, and requiring providers who serve AI/AN consumers to meet minimal cultural competency standards.	Tribal Centric Behavioral Health Report, November 2013

	competency standards.		
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Relating to Reducing Regulatory Burdens on Providers

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
18.	The Legislature should direct state agencies to align regulations across mental health, chemical dependency, and primary care to reduce redundant audits, paperwork requirements, and administrative burdens for behavioral health providers.	DSHS and HCA should lead a process to align regulations across CD/MH/primary care in order to reduce administrative burdens. We recommend a narrow but robust stakeholder process to look for clear conflicts in regulations that limit the potential for success integrated environments e.g., behavioral health/primary care, substance use disorder and mental health treatment.	Full Integration/Early Adopter Work Group recommendation
		Behavioral health facility licensure should be simplified through true adoption of deeming for agencies accredited by recognized accreditors, reduction in complexity and duplication (e.g., licensing large organizations as multiple smaller sites). The legislature should direct this activity through setting clear principles and requirements.	Full Integration/Early Adopter Work Group recommendation
		Integrate and collapse the mental health and chemical dependency regulations, and audit procedures, to reduce administrative duplication and cost. "One Contract, One set of Regulations, One Audit and One Data Set is imperative to achieve a fully integrative system of care."	Chemical Dependency Integration/Public Safety Work Group Recommendation #3
		Align RCWs and WACs across systems of behavioral health and between behavioral health and medical care. Currently, RCWs and WACs for mental health, chemical dependency, and medical care contain different requirements, different standards, and separate billing systems. Time spent by	Early Adopter Region recommendation

		practitioners on meeting documentation standards for these different systems can leave little time for actual treatment and problem solving.	
		Explore lean proposals such as One Contract/One Audit/One Data Set to reduce redundant audits and unnecessary paperwork shuffles that detract from productivity.	Joe Roszak, Early Adopter/Full Integration Work Group

Relating to Involuntary Treatment Systems

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
19.	The state should integrate the involuntary treatment systems for chemical dependency and mental health and provide sufficient capacity for secure detox	The Legislature should integrate the involuntary treatment systems for mental health and chemical dependency.	Chemical Dependency Integration/Public Safety Work Group Recommendation #6
		The state should have a chemical dependency involuntary treatment system which is equivalent to current mental health involuntary treatment system. We need funding to develop secure detox programs.	Cammy Hart-Anderson, Division Manager, Snohomish County Human Services
		It is important to have a single crisis system, like in Illinois. Crisis response teams and crisis line services operated by independent behavioral health agencies can partner with health plans to share information.	Julie Lindberg, Molina Healthcare of Washington

Item	Policy/Reform Recommendation	Source Recommendation	Proponent
20.	The state should require enforcement of the Involuntary Treatment Act for AI/AN populations in a more culturally appropriate manner, including measures such as: <ul style="list-style-type: none"> <li>• Use of tribal programs to train DMHPs;</li> </ul>	The Involuntary Treatment Act (ITA) should be enforced in a more culturally appropriate way through the use of tribal programs to train Designated Mental Health Professionals (DMHP), contracting with tribal DMHPs, allowing tribal courts to make ITA commitments, and conducting a feasibility study of	Tribal Centric Behavioral Health Report, November 2013

	<ul style="list-style-type: none"> <li>Contracting with tribal DMHPs;</li> <li>Allowing tribal courts to make ITA commitments;</li> <li>Studying the feasibility of tribal residential programs to serve as E&amp;T or crisis triage centers to serve AI/AN people.</li> </ul>	establishing tribal residential programs to service as E&T or crisis triage centers to serve AI/AN people.	
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Relating to Housing Services

Item	Policy/Reform Recommendation	Source Recommendation	Proponent
21.	The system should provide more low-barrier and supportive housing	The system should provide for more low-barrier housing.	Cammy Hart-Anderson, Division Manager, Snohomish County Human Services

Relating to Behavioral Health in Jails, Work Release, and Prison

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
22.	The state should suspend Medicaid benefits, rather than terminate them, for persons in jail or prison custody in some circumstances.	The state should move to allow suspension of Medicaid during periods of incarceration. The federal government does not require termination of benefits during incarceration. If benefits were suspended, the person could immediately begin receiving Medicaid benefits upon release, taking enrollment difficulties off the table.	Elisabeth Smith, Northwest Health Law Advocates
		The state should seek a waiver to allow for a person's Medicaid status to be suspended instead of terminated if in an institution less than 6 months. When the person leaves the institution it allows for him/her to move from suspended status back to open without having to reapply for Medicaid all over again. Research New York State's waiver process.	Early Adopter Region recommendation
		The state should suspend Medicaid benefits, rather than terminate them, for persons in custody.	Rick Weaver, CEO, Comprehensive Mental Health

		It is a significant barrier to jail transition services when a jail or prison inmate is not enrolled in Medicaid during incarceration, and therefore is not assigned to an MCO until after release. Outreach is doable, but you have to know who your people are.	Julie Lindberg, Molina Healthcare of Washington
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Item	Policy/Reform Recommendation	Source Recommendations	Proponent
23.	The state, BHOs, and early adopter regions should arrange for inmates and offenders without health coverage to apply for and enroll in health coverage before exiting jail or prison, and remove existing barriers to enrollment. Once the inmates or offenders are enrolled, health providers should collaborate with jail and prison systems to conduct outreach and transition planning for inmates and offenders with behavioral health disorders before the person is released from custody.	Personnel at city, county, or state correctional facilities should take advantage of the opportunity to receive staff training and be certified at the institutional level to assist inmates in making applications for medical services upon release from custody. Training and support is available through the Health Care Authority.	Mark Westenhaver, Health Care Authority
		DOC experiences challenges enrolling offenders with family members in health care before release because it doesn't have access to family information (so only enrolls offenders who are "single," while providing information to all offenders). The design of the Health Benefit Exchange system is challenging because it requires an address for enrollment.	Ronna Cole, Department of Corrections
		Offenders eligible for Medicaid in work release should be able to enroll in Medicaid. Federal rules are interpreted to prohibit this because the offenders sleep in a correctional facility while attending work, education, and/or treatment outside the facility during the day. Many city and county jails also have work release facilities with similar concerns.	Ronna Cole, Department of Corrections
		Medical providers should collaborate with jail and prison systems to engage in transition planning for persons in custody.	Cammy Hart-Anderson, Division Manager,

			Snohomish County Human Services
		When establishing a network, the health plan should develop partnerships with counties and collaborate with existing human services systems. Wherever possible, contract with the existing behavioral health provider system. This minimizes disruption in care.	Julie Lindberg, Molina Healthcare of Washington

Item	Policy/Reform Recommendation	Source Recommendation	Proponent
24.	Procedures should be established to divert persons with behavioral health disorders who create disturbances away from jails into appropriate treatment programs.	Local governments should address the tendency to use jail systems as a "dumping ground" for individuals with behavioral health disorders who cause problems, rather than steering those individuals to the outside resources available to give them the help they need. Embedding social workers within police agencies has been helpful in Snohomish County.	Anthony Aston, Snohomish County Corrections

Relating to Health Care System Management

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
25.	The state should unify health care management under a single entity without "carving out" health programs, and require the responsible entity to provide fully integrated services at the clinical level.	One entity should manage the whole health benefit without carving out programs and creating silos. Coordination by health homes works well.	Doug Bowes, CEO, United Health Care Community Plan
		Contract design should speak to how the services are integrated. Instead of having subcontracts that create silos, make sure all providers have to sit in the same place and have case managers and care managers who talk to each other, creating integration at the clinical level.	Doug Bowes, CEO, United Health Care Community Plan
		We use coordinated member-centric outreach, from workers who are cross	Julie Youngblood, Manager of Case

		trained, to provide one touch services. Best practices are taught to all staff. Each program must be adapted to local needs.	Management for Behavioral Health, Coordinated Care
		Never carve out behavioral health services, or else you will create silos. Specialty BH providers should do the work, but they must be integrated with the treatment team, so that internal silos are not created.	Julie Lindberg, Molina Healthcare of Washington
		Require health plans managing Medicaid contracts for Early Adopter to align documentation requirements across systems, regardless of patient presentation, diagnosis, or identified need.	Early Adopter Region recommendation

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
26.	Health networks should deploy special programs to engage clients who are hard to serve and to target the highest utilizers of health and public welfare systems who drive the highest costs.	We have found success using a tiered approach driven by risk data that incorporates a High Intensity Team that focuses extra efforts on high cost, high utilizing patients that seem to fall through the gaps.	Karen Gregory, Behavioral Health Director, Amerigroup Washington
		Care can be extended to difficult to serve populations through many techniques: field-based case management, feet on the street, curbside doctors, care coordination, working closely with families and caregivers, making use of peers.	Karen Gregory, Behavioral Health Director, Amerigroup Washington

Relating to Health Care System Oversight

Item	Policy/Reform Recommendation	Source Recommendations	Proponent
27.	The Legislature should continue the Adult Behavioral Health Task Force until 2020 to provide a forum for ongoing input or oversight of health care integration activities.	The Behavioral Health Task Force presents an opportunity to monitor the progress regarding the integration of behavioral health and physical health into the Medicaid based system. The Task Force continues to allow the state and county representatives to hear from a multi-discipline group of stakeholders on	Chemical Dependency Integration/Public Safety Work Group Recommendation #5

		how progress is being made, goals achieved and potential obstacles.	
		There is a gap between the end of the task force and the current full implementation date (2020). The workgroup believes there is a need for a forum for on-going into or oversight of the activities leading to full integration and there is great value in the cross-sector interaction present in the workgroup to provide input to plans and to monitor/support the results as those plans are implemented. There is interest in continuing the workgroup for those purposes.	Full Integration/Early Adopter Work Group Recommendation
		DSHS and HCA should continue to share procurement documents and draft contracts developed for early adopter and later regions with the Early Adopter/Full Integration Work Group for comment before they are released. This has been a very helpful and positive process and should be retained.	Full Integration/Early Adopter Work Group recommendation

Item	Policy/Reform Recommendation	Source Recommendation	Proponent
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28.	<p>The ABHS Task Force should ask HCA to provide a detailed roadmap for health integration, including:</p> <ul style="list-style-type: none"> <li>• And inventory of integration activities statewide;</li> <li>• A phased timeline specifying different paths towards integration;</li> <li>• Plans to move contracting to biennial cycles.</li> </ul>	<p>We recommend that the Task Force asks the HCA to provide a detailed roadmap that includes:</p> <ul style="list-style-type: none"> <li>• An inventory of integration activities occurring statewide</li> <li>• Plans to move contracting to biennial cycles instead of the current off cycle plan</li> <li>• A phased timeline that acknowledges that: <ul style="list-style-type: none"> <li>○ Regions might like to move to full integration later than the present early adopter timeline but sooner than the 2020 date</li> <li>○ Regions might want to move to full integration in phased steps rather than all at once</li> <li>○ Assesses the readiness of regions to meet the 2020 date and provides recommendations for new dates if there are regions that cannot meet that timeline.</li> <li>○ Outlines models that may be possible for those regions that wish to proceed earlier or in a more stepped manner</li> </ul> </li> </ul>	Full Integration/Early Adopter Work Group recommendation
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Item	Policy/Reform Recommendation	Source Recommendation	Proponent
29.	State agencies should establish an ongoing workgroup to assure clear and consistent communication between the state and tribes and to develop culturally-appropriate evidence-based and promising AI/AN practice treatments.	State agencies should establish an ongoing workgroup to assure clear and consistent communication between the state and tribes and to develop culturally-appropriate evidence-based and promising AI/AN practice treatments.	Tribal Centric Behavioral Health Report, November 2013

**Appendix F**

*On December 11, 2015, the Task Force voted to include the Tribal Centric Behavioral Health Report, dated November 30, 2013, as an appendix to its final report.*

**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**

# 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

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).

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%
<b>NOTE:</b> MH outpatient services do not include mental health drugs or medication management.			
<b>NOTE:</b> 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.

**Workgroup Members**

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## Appendix G

The following CD/MH Integration policy recommendations were submitted to the Task Force by the Public Safety Work Group. They are approved for inclusion as an appendix to the Task Force's final report. Inclusion does not imply endorsement by the Task Force, except as indicated in the body of the report.

- 9) The state should provide a comprehensive CD service package. These would include but not limited to; case management, peer services, recovery supports, and medication monitoring/management. (Please see Addendum) (Benefit package and Crosswalk for payment)
  - The state should maintain financial support for CD services that were state funded and are not funded under Medicaid expansion.
    - Residential – more than 16 beds. The state should maintain financial support for CD services provided in IMD (greater than 16 bed) facilities that are not reimbursable by Medicaid.
    - Drug testing
    - Community Education
- 10) Revise the Medicaid State Plans.
  - It continues to be the recommendation, as it has since the beginning, to bring the Mental Health and Chemical Dependency Medicaid State Plans into alignment. True integration of behavioral health services cannot occur until there is parity in the two plans. Ex: peer to peer services.
  - Do not cut much needed non-Medicaid money. These funds cover gaping holes in the system (residential treatment, Medicare, non-Medicaid eligible people and non-Medicaid services).
  - Work towards a waiver for the IMD rule (16 bed residential) for residential treatment. The current system, which does not have enough residential beds (waiting lists), is built upon facilities that are currently not eligible for Medicaid funding, because they are larger than 16 beds and struggle for financial viability.
  - Better penetration and recovery outcomes for those seeking Mental Health and Chemical Dependency services
- 11) Integrate and collapse the mental health and chemical dependency regulations, and audit procedures, to reduce administrative duplication and cost.
  - “One Contract, One set of Regulations, One Audit and One Data Set is imperative to achieve a fully integrative system of care.”

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- 12) We request that the legislature work with the Attorney's Generals office and Federal Government to update 42 CFR regulations to meet with the vision of effective integrated whole person care.
- 13) Continue with the Task Force leading to 2020.
  - The Behavioral Health Task Force presents an opportunity to monitor the progress regarding the integration of behavioral health (BH) and physical health into the Medicaid based system.
  - The Task Force continues to allow the state and county representatives to hear from a multi-discipline group of stakeholders on how progress is being made, goals achieved and potential obstacles.
- 14) The legislature should pass a law, which would integrate the involuntary mental health and chemical dependency statutes.
- 15) State should endeavor to have peer services at all levels of care in the Behavioral Health system.
- 16) Actuarial rates should represent the actual cost of doing business, and not just be based on historic rates. The state should create (or purchase) an integrated data reporting system for MH and CD providers that combines the strengths of the existing separate data systems.