Proposed Final Report:

2018 Tax Preference Performance Reviews

Government-Funded Behavioral Health Services

Legislative Auditor's Conclusion:

The preference increases the amount of funding available directly for behavioral health treatment. With recent changes in the state's management of Medicaid, more providers are likely to use the preference before it expires in 2020.

December 2018

B&O tax deduction for government-funded behavioral health care

The preference allows two types of entities to deduct the amount of government funding spent on behavioral health services:

1. **Health or social welfare organizations**--nonprofits that provide mental health and chemical dependency services to patients (i.e. behavioral health) can deduct the amount of government funding they receive.
2. **Behavioral Health Organizations (BHOs)**--regional health care entities that contract with providers for government-funded behavioral health services can deduct the amount they pay to health or social welfare organizations.

The preference is scheduled to expire January 1, 2020.

Estimated Biennial Beneficiary Savings

$10.9 Million

Tax Type
B&O Tax
RCW 82.04.4277
Applicable Statutes

Inferred public policy objectives met

The Legislature did not state a public policy objective when it passed this preference in 2011. JLARC staff infer two public policy objectives based on testimony to the Legislature when the legislation was passed.

Objectives (inferred)	Results
Increase the amount of funding available for behavioral health services.	**Met.** The preference reduces the amount of tax collected on government-funded behavioral health services so that more money goes directly to treatment.
Provide similar tax treatment for all entities that receive government funding for behavioral health services.	**Met**. The preference allows privately run BHOs to deduct from B&O taxes the amount of government funding they spend on behavioral health services. It also allows health or social welfare organizations to deduct from B&O taxes the amount of government funding they receive from privately run entities.

Changes in Washington's management of Medicaid funding will affect how health care providers are taxed

The state is currently in the process of integrating Medicaid-funding of behavioral health services with physical health services. This will change how health care entities and providers are taxed. As a result, more providers -- in Pierce County and other parts of the state -- are likely to use the preference until it expires in 2020.

When the preference expires, more government funding for behavioral health services will be taxed, so less money may go directly to behavioral health service treatment.

Recommendations

Legislative Auditor's Recommendation: Determine whether to continue (policy decision)

The Legislature should determine whether to continue the preference. If the Legislature wants to continue the tax deduction for government-funded behavioral health care, it will need to take action. Otherwise, behavioral health will be treated the same as physical health services and providers will pay B&O taxes beginning in 2020.

More information is available on the Recommendations Tab.

Commissioners' Recommendation

The Commission endorses the Legislative Auditor's recommendation with comment. The preference should be continued because it supports mental health services that can prevent more serious and costly health issues.

REVIEW DETAILS

1. Government funding for behavioral health

Preference is for two types of entities involved in government-funded behavioral health services

What is behavioral health and who pays for it?

Behavioral health services are treatments for mental health and substance use disorders. These include 24-hour crisis services, residential treatment services, in-patient and out-patient services, group treatment, and medication management and monitoring.

About 85 percent of government funding for behavioral health care in Washington State is from Medicaid. This is a health program paid for by the state and federal government, and is available to those who meet income and other eligibility requirements.

The remaining 15 percent of government funding pays for behavioral health services that are not covered by Medicaid. These include crisis hotlines and services provided while people are in jail, which are available for both Medicaid and non-Medicaid patients.

Behavioral Health Organizations (BHOs) subcontract with providers who treat patients

In most regions, Washington currently distributes state and federal funding for behavioral health services through Behavioral Health Organizations (BHOs). These entities are located in designated geographic areas around the state to manage funding for mental health and substance use treatment.

The state provides each BHO a fixed amount of public money and the BHOs must provide access to the following:

- A full-range of behavioral health services for all Medicaid-eligible individuals.
- Crisis services for any person, regardless of whether they are eligible for Medicaid.
- Additional services to non-Medicaid eligible individuals if other funding, such as federal grants or local revenue, is available.

Health or social welfare organizations provide behavioral health services

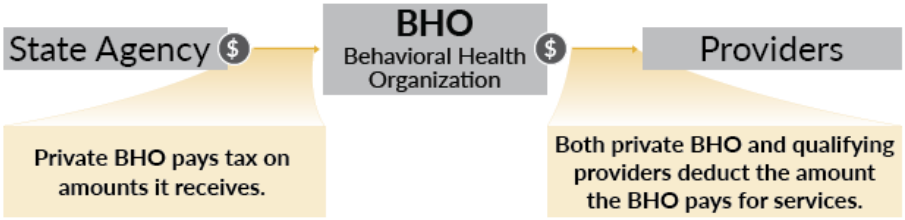
BHOs subcontract with mental health and substance use disorder treatment providers in their local areas to provide these services. These include health or social welfare organizations.

Statute defines a health or social welfare organization as either a nonprofit entity with eight or more board members who are not paid employees, or a corporation sole. The organization must provide specific health or social welfare services, such as:

- Mental health, drug, and alcohol counseling and treatment
- Family counseling
- Health care services
- Day care for children
- Employment development
- Legal services for the indigent

These organizations must follow other legal requirements in addition to providing certain services.

Exhibit 1.1: Preference applies to money flowing through BHO to health or social welfare organizations



Source: JLARC staff analysis of RCW 82.04.4277.

REVIEW DETAILS

2. Preference meets objectives

Preference enacted to increase the amount of funding available directly for behavioral health treatment, and provide consistent tax treatment to those receiving government funds

B&O tax preference for entities involved with government-funded behavioral health services

This preference provides a business & occupation (B&O) tax deduction for government-funded behavioral health services (i.e., mental health or chemical dependency services) that are provided by a health or social welfare organization.

Two different types of entities may claim the deduction:

1. A Behavioral Health Organization (BHO) may deduct the amount it pays to the health or social welfare organization for providing behavioral health services to patients.
2. The health or social welfare organization may deduct the amount it receives for providing the services.

Two inferred objectives met

The Legislature did not state a public policy objective when it passed this preference in 2011.

JLARC staff infer two public policy objectives based on testimony to the Legislature when the legislation was passed.

Inferred objective met: Preference provides similar tax treatment for all BHOs and providers of government-funded behavioral health services

Before 2008, all BHOs were government entities and were not subject to B&O tax. In 2008, Pierce County stopped serving as the BHO for its region and DSHS selected a private, for-profit entity to take its place. Unlike the governmental BHOs, this entity (Optum Pierce) and its contracted providers were subject to B&O tax.

With the preference, privately run BHOs are able to deduct some of their expenses and are taxed similarly to government-run BHOs, which do not pay tax.

Further, all health or social welfare organizations may deduct B&O taxes for the amount of government funding they receive for behavioral health services, regardless of whether the money comes from a government or private entity. Prior to this preference, only health and social welfare organizations that received money directly from a government entity (RCW 82.04.4297) could deduct B&O taxes.

This results in similar tax treatment for any entity that distributes or receives government-funding for behavioral health.

Inferred objective met: Preference increases the amount of government funding available directly for behavioral health treatment by reducing the tax

As of May 2018, Optum Pierce was the only privately-run BHO in Washington, and the only BHO that claimed the deduction. Health or social welfare entities that receive government funding from Optum Pierce can claim the deduction as well. The deduction reduces B&O tax thereby increasing the amount of government funding available for patient services.

Circumstances are unique to Washington's tax structure

The objectives for this preference are unique to Washington and the B&O tax. In states with an income tax, nonprofit providers are generally exempt from paying income tax. Further, when entities receive funding that they distribute to others, that funding is typically not considered income.

REVIEW DETAILS

3. Changes in Medicaid management impact taxes

Recent changes in Washington's management of Medicaid funding will affect how entities are taxed

Until 2016, Washington financed and delivered its Medicaid-funded behavioral health services separately from its physical health services. Now the state is in the process of integrating both behavioral and physical health. Under the new model, all Medicaid funding will be distributed from the Health Care Authority to privately run Managed Care Organizations (MCOs) for both physical and behavioral health services. About 85 percent of government funding for behavioral health comes from Medicaid.

New entities will manage government funding for behavioral health

Before integration, government funding for physical and behavioral health care was managed separately by the following types of entities:

- MCOs managed Medicaid funding for **physical health** services. These entities are privately run for-profit and nonprofit organizations.
- Behavioral Health Organizations (BHOs) managed Medicaid and non-Medicaid funding for **behavioral health** services. They contracted with local providers to deliver services to patients.

After integration is completed, Medicaid funding for physical and behavioral health will be managed together:

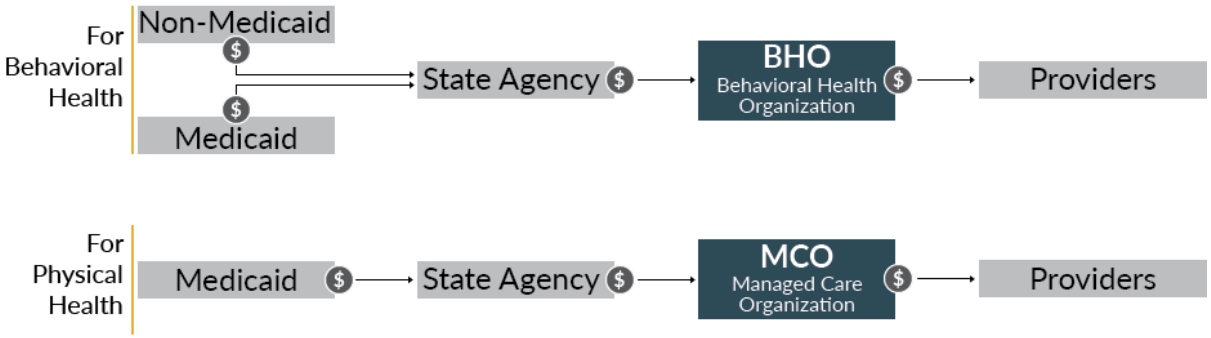
- **MCOs** will be responsible for managing **Medicaid funding for physical and behavioral health**. They will contract with local providers to deliver services to patients.
- **Behavioral Health-Administrative Service Organizations (BH-ASOs)** will manage **non-Medicaid funding for behavioral health services** instead of BHOs. These services are available to all individuals, regardless of insurance status or income level. They include crisis hotlines and services provided while people are in jail.

Integration will impact how health care entities and providers are taxed

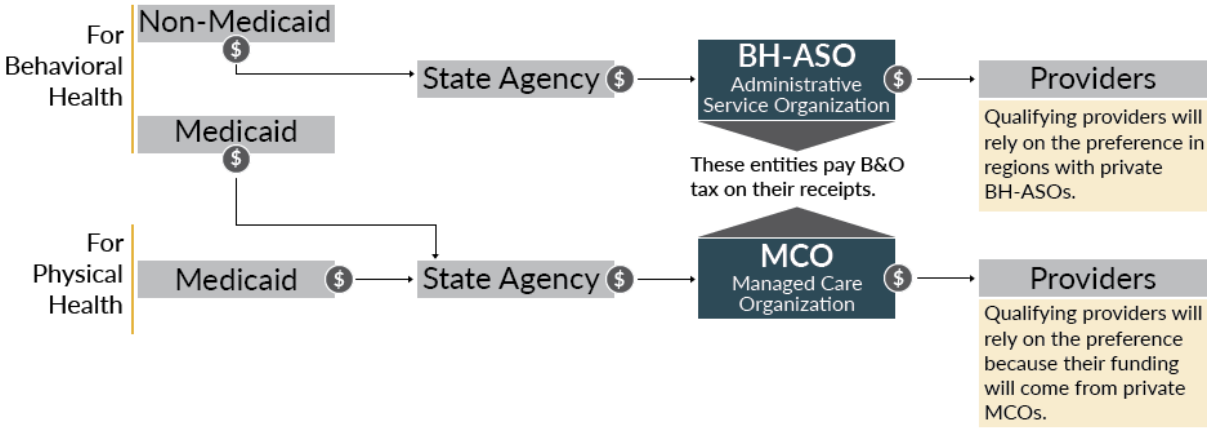
This tax preference currently applies to BHOs and health or social welfare organizations that provide behavioral health services. The integration of behavioral and physical health management will change how health care entities are taxed.

- **MCOs** are responsible for managing Medicaid funding for health care services. They are not eligible for this preference because they do not meet the current definition of a BHO. Unless they qualify for other tax preferences, MCOs must pay B&O tax on the funding they receive for behavioral health services.
- **BH-ASOs** are a new type of entity not included in the current definition of a BHO. These organizations owe tax on the funding they receive unless they are government entities and already tax-exempt, or they qualify for other preferences.
- **Health or social welfare organizations** that receive money from MCOs or BH-ASOs continue to be eligible for this preference. More of these providers are likely to claim the preference because more of them will receive money from privately run entities (MCOs or BH-ASOs).

Exhibit 3.1: Integration will change how government funding for behavioral health is managed



Before integration, BHOs distribute Medicaid and Non-Medicaid Funding for Behavioral Health.



After integration, funding will flow through for-profit MCOs and BH-ASOs, which may be for-profit or government entities.

Medicaid funding for physical health is taxed

Entities that manage or receive Medicaid funding for physical health services must pay B&O tax on the money they receive. Other deductions exist for some specific types of providers, such as public and nonprofit hospitals and community health centers, but there is no general deduction for physical health care services.

REVIEW DETAILS

4. Number of beneficiaries will likely increase

More providers likely to use the preference as the state integrates Medicaid-funded behavioral and physical health care

Direct beneficiaries include one BHO and health or social welfare organizations

The preference is available to Behavioral Health Organizations (BHOs) and to health or social welfare organizations providing behavioral health services to patients. The direct beneficiaries are:

BHOs that receive government funds for behavioral health:

- As of May 2018, Optum Pierce in Pierce County is the only privately run BHO in Washington, and the only one that claimed the deduction.

- The other seven BHOs are government entities and do not owe income tax under existing law.

Health or social welfare organizations that provide behavioral health services:

- Providers that receive government money from Optum Pierce would pay tax without this preference.
- Providers in the North Central and Southwest regions have already transitioned to an integrated managed care system and would pay tax without this preference. As more regions integrate, more providers are likely to claim the preference when they receive funding from privately-run Managed Care Organizations (MCOs) or Behavioral Health-Administrative Service Organizations (BH-ASOs).
- Providers that receive payments directly from a government-run entity are already eligible to deduct B&O tax under existing law (see RCW 82.04.4297).

JLARC staff estimate beneficiaries saved $3.6 million in 2018

JLARC staff estimate $3.6 million in beneficiary savings in fiscal year 2018 and $10.9 million in the 2017-19 biennium. This estimate is based on data available in Pierce County. It assumes the same proportion of funding goes to qualified providers in each region. It also assumes every qualified provider claims the deduction. The estimate may include providers who are eligible for other deductions on the same income, such as the deduction for hospitals and community health centers (see RCW 82.04.4311).

Exhibit 4.1 Estimated Beneficiary Savings

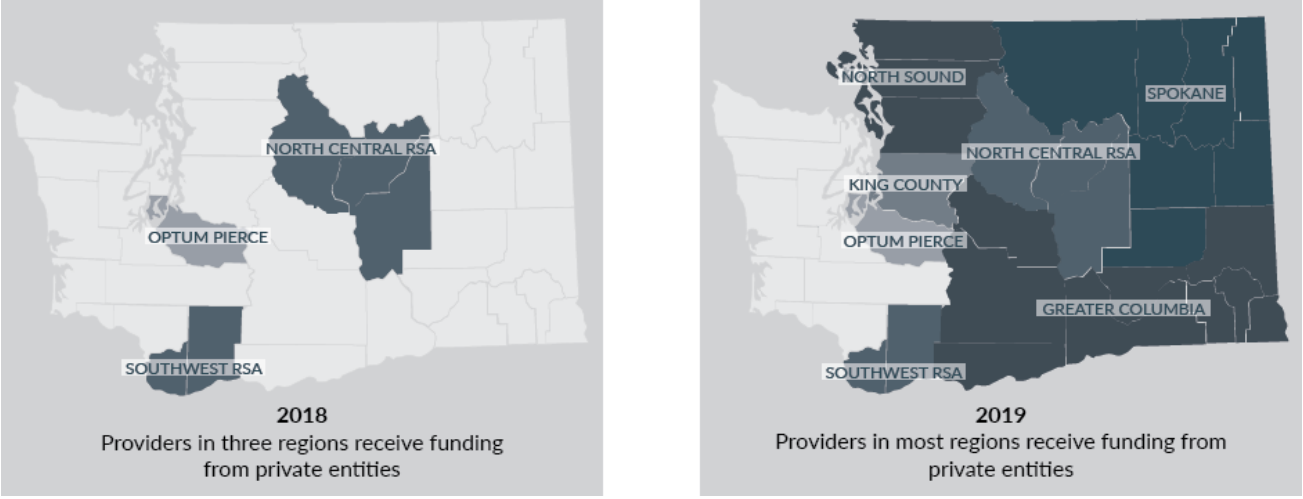
Fiscal Year	Beneficiary Savings
2016	$2,800,000
2017	$3,400,000
2018	$3,600,000
2019	$7,300,000
2017 -2019 Biennium	$10,900,000

Source: JLARC staff analysis of taxpayer deduction data and BHO expenditure data from DSHS.

By 2019, most health or social welfare organizations will be in integrated regions working with privately run health care entities

As more regions integrate Medicaid-funded behavioral and physical health care, qualified providers in integrated regions will be more likely to receive funding through private entities such as Managed Care Organizations and BH-ASOs. As a result, more providers will rely on this preference. BHOs will no longer exist so there will be no BHOs using the preference.

Exhibit 4.2: As regions integrate, more providers will receive funding through private entities



Source: JLARC staff analysis of Health Care Authority Data.

Indirect beneficiaries

Medicaid patients who receive behavioral health treatment are indirect beneficiaries of the preference. Since providers and BHOs can deduct B&O tax from the funds they receive, more money is available directly for behavioral health treatment. The preference also benefits some non-Medicaid patients who receive government-funded behavioral health services.

REVIEW DETAILS

5. Preference scheduled to expire in 2020

The expiration of the preference may reduce government funding for behavioral health services

The preference is currently scheduled to expire on January 1, 2020.

When this preference expires, some of the funding for behavioral health services will be taxed.

- Health or social welfare organizations will be subject to tax on the Medicaid funds they receive from privately-run Managed Care Organizations (MCOs). They will also be taxed on the non-Medicaid funding they receive from privately-run Behavioral Health-Administrative Service Organization (BH-ASO).
- MCOs and privately-run BH-ASOs will be taxed on the government funding they receive to manage behavioral health services.

Some providers may qualify for other deductions on the income they receive for behavioral health. For example, health or social welfare organizations that meet the definition of Community Health Centers may claim a deduction under RCW 82.04.431.

Without the preference, health or social welfare organizations, MCOs and non-government BH-ASOs will be taxed the same way as those that receive government funding for physical health services.

REVIEW DETAILS

6. Applicable statutes

RCW 82.04.4277

Deductions—Health and social welfare organizations—Mental health or chemical dependency services. (Effective January 1, 2018, until January 1, 2020.)

(1) A health or social welfare organization may deduct from the measure of tax amounts received as compensation for providing mental health services or chemical dependency services under a government-funded program.

(2) A behavioral health organization may deduct from the measure of tax amounts received from the state of Washington for distribution to a health or social welfare organization that is eligible to deduct the distribution under subsection (1) of this section.

(3) A person claiming a deduction under this section must file a complete annual tax performance report with the department under RCW 82.32.534.

(4) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Chemical dependency" has the same meaning as provided in *RCW 70.96A.020 through March 31, 2018, and the same meaning as provided in RCW 71.05.020 beginning April 1, 2018.

(b) "Health or social welfare organization" has the meaning provided in RCW 82.04.431.

(c) "Mental health services" and "behavioral health organization" have the meanings provided in RCW 71.24.025.

(5) This section expires January 1, 2020.

[2017 c 323 § 528; 2017 c 135 § 14; 2016 sp.s. c 29 § 532; 2014 c 225 § 104; 2011 1st sp.s. c 19 § 1.]

NOTES:

Reviser's note: *(1) RCW 70.96A.020 was repealed by 2016 sp.s. c 29 § 301, effective April 1, 2018.

(2) This section was amended by 2017 c 135 § 14 and by 2017 c 323 § 528, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Tax preference performance statement exemption—Automatic expiration date exemption—2017 c 323: See note following RCW 82.04.040.

Effective date—2017 c 135: See note following RCW 82.32.534.

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2014 c 225: See note following RCW 71.24.016.

Application—2011 1st sp.s. c 19: "This act applies to amounts received by a taxpayer on or after August 1, 2011." [2011 1st sp.s. c 19 § 4.]

RCW 82.04.431

"Health or social welfare organization" defined—Conditions for exemption—"Health or social welfare services" defined.

(1) The term "health or social welfare organization" means an organization, including any community action council, which renders health or social welfare services as defined in subsection (2) of this section, which is a domestic or foreign not-for-profit corporation under chapter 24.03 RCW and which is managed by a governing board of not less than eight individuals none of whom is a paid employee of the organization or which is a corporation sole under chapter 24.12 RCW. Health or social welfare organization does not include a corporation providing professional services as authorized in chapter 18.100 RCW. In addition a corporation in order to be exempt under RCW 82.04.4297 must satisfy the following conditions:

(a) No part of its income may be paid directly or indirectly to its members, stockholders, officers, directors, or trustees except in the form of services rendered by the corporation in accordance with its purposes and bylaws;

(b) Salary or compensation paid to its officers and executives must be only for actual services rendered, and at levels comparable to the salary or compensation of like positions within the public service of the state;

(c) Assets of the corporation must be irrevocably dedicated to the activities for which the exemption is granted and, on the liquidation, dissolution, or abandonment by the corporation, may not inure directly or indirectly to the benefit of any member or individual except a nonprofit organization, association, or corporation which also would be entitled to the exemption;

(d) The corporation must be duly licensed or certified where licensing or certification is required by law or regulation;

(e) The amounts received qualifying for exemption must be used for the activities for which the exemption is granted;

(f) Services must be available regardless of race, color, national origin, or ancestry; and

(g) The director of revenue must have access to its books in order to determine whether the corporation is exempt from taxes within the intent of RCW 82.04.4297 and this section.

(2) The term "health or social welfare services" includes and is limited to:

(a) Mental health, drug, or alcoholism counseling or treatment;

(b) Family counseling;

(c) Health care services;

(d) Therapeutic, diagnostic, rehabilitative, or restorative services for the care of the sick, aged, or physically, developmentally, or emotionally-disabled individuals;

(e) Activities which are for the purpose of preventing or ameliorating juvenile delinquency or child abuse, including recreational activities for those purposes;

(f) Care of orphans or foster children;

(g) Day care of children;

(h) Employment development, training, and placement;

(i) Legal services to the indigent;

(j) Weatherization assistance or minor home repair for low-income homeowners or renters;

(k) Assistance to low-income homeowners and renters to offset the cost of home heating energy, through direct benefits to eligible households or to fuel vendors on behalf of eligible households;

(l) Community services to low-income individuals, families, and groups, which are designed to have a measurable and potentially major impact on causes of poverty in communities of the state; and

(m) Temporary medical housing, as defined in RCW 82.08.997, if the housing is provided only:

(i) While the patient is receiving medical treatment at a hospital required to be licensed under RCW 70.41.090 or at an outpatient clinic associated with such hospital, including any period of recuperation or observation immediately following such medical treatment; and

(ii) By a person that does not furnish lodging or related services to the general public.

[2011 1st sp.s. c 19 § 3; 2008 c 137 § 1; 1986 c 261 § 6; 1985 c 431 § 3; 1983 1st ex.s. c 66 § 1; 1980 c 37 § 80; 1979 ex.s. c 196 § 6.]

NOTES:

Application—2011 1st sp.s. c 19: See note following RCW 82.04.4277.

Effective date—2008 c 137: See note following RCW 82.08.997.

Intent—1980 c 37: See note following RCW 82.04.4281.

Effective date—1979 ex.s. c 196: See note following RCW 82.04.240.

RCW 71.24.025 (as amended by 2018 2ESHB 1388, effective July 1, 2018)

Definitions.

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Acutely mentally ill" means a condition which is limited to a short-term severe crisis episode of:

(a) A mental disorder as defined in RCW 71.05.020 or, in the case of a child, as defined in RCW 71.34.020;

(b) Being gravely disabled as defined in RCW 71.05.020 or, in the case of a child, a gravely disabled minor as defined in RCW 71.34.020; or

(c) Presenting a likelihood of serious harm as defined in RCW 71.05.020 or, in the case of a child, as defined in RCW 71.34.020.

(2) "Alcoholism" means a disease, characterized by a dependency on alcoholic beverages, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning.

(3) "Approved substance use disorder treatment program" means a program for persons with a substance use disorder provided by a treatment program licensed or certified by the department as meeting standards adopted under this chapter.

(4) "Authority" means the Washington state health care authority.

(5) "Available resources" means funds appropriated for the purpose of providing community mental health programs, federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated under this chapter or chapter 71.05 RCW by the legislature during any biennium for the purpose of providing residential services, resource management services, community support services, and other mental health services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

(6) "Behavioral health organization" means any county authority or group of county authorities or other entity recognized by the director in contract in a defined region.

(7) "Behavioral health program" means all expenditures, services, activities, or programs, including reasonable administration and overhead, designed and conducted to prevent or treat chemical dependency and mental illness.

(8) "Behavioral health services" means mental health services as described in this chapter and chapter 71.36 RCW and substance use disorder treatment services as described in this chapter.

(9) "Child" means a person under the age of eighteen years.

(10) "Chronically mentally ill adult" or "adult who is chronically mentally ill" means an adult who has a mental disorder and meets at least one of the following criteria:

(a) Has undergone two or more episodes of hospital care for a mental disorder within the preceding two years; or

(b) Has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding year; or

(c) Has been unable to engage in any substantial gainful activity by reason of any mental disorder which has lasted for a continuous period of not less than twelve months. "Substantial gainful activity" shall be defined by the authority by rule consistent with Public Law 92-603, as amended.

(11) "Clubhouse" means a community-based program that provides rehabilitation services and is licensed or certified by the department.

(12) "Community mental health service delivery system" means public, private, or tribal agencies that provide services specifically to persons with mental disorders as defined under RCW 71.05.020 and receive funding from public sources.

(13) "Community support services" means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available twenty-four hours, seven days a week, prescreening determinations for persons who are mentally ill being considered for placement in nursing homes as required by federal law, screening for patients being considered for admission to residential services, diagnosis and treatment for children who are acutely mentally ill or severely emotionally disturbed discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program, investigation, legal, and other nonresidential services under chapter 71.05 RCW, case management services, psychiatric treatment including medication supervision, counseling, psychotherapy, assuring transfer of relevant patient information between service providers, recovery services, and other services determined by behavioral health organizations.

(14) "Consensus-based" means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, and may have anecdotal or case study support, or that is agreed but not possible to perform studies with random assignment and controlled groups.

(15) "County authority" means the board of county commissioners, county council, or county executive having authority to establish a community mental health program, or two or more of the county authorities specified in this subsection which have entered into an agreement to provide a community mental health program.

(16) "Department" means the department of health.

(17) "Designated crisis responder" means a mental health professional designated by the county or other authority authorized in rule to perform the duties specified in this chapter.

(18) "Director" means the director of the authority.

(19) "Drug addiction" means a disease characterized by a dependency on psychoactive chemicals, loss of control over the amount and circumstances of use, symptoms of tolerance, physiological or psychological withdrawal, or both, if use is reduced or discontinued, and impairment of health or disruption of social or economic functioning.

(20) "Early adopter" means a regional service area for which all of the county authorities have requested that the authority purchase medical and behavioral health services through a managed care health system as defined under RCW 71.24.380(6).

(21 "Emerging best practice" or "promising practice" means a program or practice that, based on statistical analyses or a well established theory of change, shows potential for meeting the evidence-based or research-based criteria, which may include the use of a program that is evidence-based for outcomes other than those listed in subsection (20) of this section.

(22) "Evidence-based" means a program or practice that has been tested in heterogeneous or intended populations with multiple randomized, or statistically controlled evaluations, or both; or one large multiple site randomized, or statistically controlled evaluation, or both, where the weight of the evidence from a systemic review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial.

(23) "Licensed physician" means a person licensed to practice medicine or osteopathic medicine and surgery in the state of Washington.

(24) "Licensed or certified service provider" means an entity licensed or certified according to this chapter or chapter 71.05 RCW or an entity deemed to meet state minimum standards as a result of accreditation by a recognized behavioral health accrediting body recognized and having a current agreement with the department, or tribal attestation that meets state minimum standards, or

persons licensed under chapter 18.57, 18.57A, 18.71, 18.71A, 18.83, or 18.79 RCW, as it applies to registered nurses and advanced registered nurse practitioners.

(25) "Long-term inpatient care" means inpatient services for persons committed for, or voluntarily receiving intensive treatment for, periods of ninety days or greater under chapter 71.05 RCW. "Long-term inpatient care" as used in this chapter does not include: (a) Services for individuals committed under chapter 71.05 RCW who are receiving services pursuant to a conditional release or a court-ordered less restrictive alternative to detention; or (b) services for individuals voluntarily receiving less restrictive alternative treatment on the grounds of the state hospital.

(26) "Mental health services" means all services provided by behavioral health organizations and other services provided by the state for persons who are mentally ill.

(27) Mental health "treatment records" include registration and all other records concerning persons who are receiving or who at any time have received services for mental illness, which are maintained by the department of social and health services or the authority, by behavioral health organizations and their staffs, or by treatment facilities. "Treatment records" do not include notes or records maintained for personal use by a person providing treatment services for the department of social and health services, behavioral health organizations, or a treatment facility if the notes or records are not available to others.

(28) "Mentally ill persons," "persons who are mentally ill," and "the mentally ill" mean persons and conditions defined in subsections (1), (10), (36), and (37) of this section.

(29) "Recovery" means the process in which people are able to live, work, learn, and participate fully in their communities.

(30) "Registration records" include all the records of the department of social and health services, the authority, behavioral health organizations, treatment facilities, and other persons providing services for the department of social and health services, the authority, county departments, or facilities which identify persons who are receiving or who at any time have received services for mental illness.

(31) "Research-based" means a program or practice that has been tested with a single randomized, or statistically controlled evaluation, or both, demonstrating sustained desirable outcomes; or where the weight of the evidence from a systemic review supports sustained outcomes as described in subsection (20) of this section but does not meet the full criteria for evidence-based.

(32) "Residential services" means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for persons who are acutely mentally ill, adults who are chronically mentally ill, children who are severely emotionally disturbed, or adults who are seriously disturbed

and determined by the behavioral health organization to be at risk of becoming acutely or chronically mentally ill. The services shall include at least evaluation and treatment services as defined in chapter 71.05 RCW, acute crisis respite care, long-term adaptive and rehabilitative care, and supervised and supported living services, and shall also include any residential services developed to service persons who are mentally ill in nursing homes, residential treatment facilities, assisted living facilities, and adult family homes, and may include outpatient services provided as an element in a package of services in a supported housing model. Residential services for children in out-of-home placements related to their mental disorder shall not include the costs of food and shelter, except for children's long-term residential facilities existing prior to January 1, 1991.

(33) "Resilience" means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

(34) "Resource management services" mean the planning, coordination, and authorization of residential services and community support services administered pursuant to an individual service plan for: (a) Adults and children who are acutely mentally ill; (b) adults who are chronically mentally ill; (c) children who are severely emotionally disturbed; or (d) adults who are seriously disturbed and determined solely by a behavioral health organization to be at risk of becoming acutely or chronically mentally ill. Such planning, coordination, and authorization shall include mental health screening for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment program. Resource management services include seven day a week, twenty-four hour a day availability of information regarding enrollment of adults and children who are mentally ill in services and their individual service plan to designated crisis responders, evaluation and treatment facilities, and others as determined by the behavioral health organization.

(35) "Secretary" means the secretary of the department of health.

(36) "Seriously disturbed person" means a person who:

(a) Is gravely disabled or presents a likelihood of serious harm to himself or herself or others, or to the property of others, as a result of a mental disorder as defined in chapter 71.05 RCW;

(b) Has been on conditional release status, or under a less restrictive alternative order, at some time during the preceding two years from an evaluation and treatment facility or a state mental health hospital;

(c) Has a mental disorder which causes major impairment in several areas of daily living;

(d) Exhibits suicidal preoccupation or attempts; or

(e) Is a child diagnosed by a mental health professional, as defined in chapter 71.34 RCW, as experiencing a mental disorder which is clearly interfering with the child's functioning in family or school or with peers or is clearly interfering with the child's personality development and learning.

(37) "Severely emotionally disturbed child" or "child who is severely emotionally disturbed" means a child who has been determined by the behavioral health organization to be experiencing a mental disorder as defined in chapter 71.34 RCW, including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers and who meets at least one of the following criteria:

(a) Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years;

(b) Has undergone involuntary treatment under chapter 71.34 RCW within the last two years;

(c) Is currently served by at least one of the following child-serving systems: Juvenile justice, child-protection/welfare, special education, or developmental disabilities;

(d) Is at risk of escalating maladjustment due to:

(i) Chronic family dysfunction involving a caretaker who is mentally ill or inadequate;

(ii) Changes in custodial adult;

(iii) Going to, residing in, or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient, residential treatment, group or foster home, or a correctional facility;

(iv) Subject to repeated physical abuse or neglect;

(v) Drug or alcohol abuse; or

(vi) Homelessness.

(38) "State minimum standards" means minimum requirements established by rules adopted and necessary to implement this chapter by:

(a) The authority for:

(i)Delivery of mental health and substance use disorder services; and

(ii) Community support services and resource management services;

(b) The department of health for:

(i) Licensed or certified services providers for the provision of mental health and subtance use disorder services; and

(ii) Residential services.

(39) "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances.

(40) "Tribal authority," for the purposes of this section and RCW 71.24.300 only, means: The federally recognized Indian tribes and the major Indian organizations recognized by the director insofar as these organizations do not have a financial relationship with any behavioral health organization that would present a conflict of interest.

[2016 sp.s. c 29 § 502; 2016 sp.s. c 29 § 501; 2016 c 155 § 12. Prior: 2014 c 225 § 10; 2013 c 338 § 5; 2012 c 10 § 59; 2008 c 261 § 2; 2007 c 414 § 1; 2006 c 333 § 104; prior: 2005 c 504 § 105; 2005 c 503 § 2; 2001 c 323 § 8; 1999 c 10 § 2; 1997 c 112 § 38; 1995 c 96 § 4; prior: 1994 sp.s. c 9 § 748; 1994 c 204 § 1; 1991 c 306 § 2; 1989 c 205 § 2; 1986 c 274 § 2; 1982 c 204 § 3.]

NOTES:

Reviser's note: The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

Effective dates—2016 sp.s. c 29: See note following RCW 71.05.760.

Short title—Right of action—2016 sp.s. c 29: See notes following RCW 71.05.010.

Effective date—2014 c 225: See note following RCW 71.24.016.

Application—2012 c 10: See note following RCW 18.20.010.

Intent—Findings—2008 c 261: See note following RCW 71.24.320.

Finding—Purpose—Intent—Severability—Part headings not law—Effective dates—2006 c 333: See notes following RCW 71.24.016.

Findings—Intent—Severability—Application—Construction—Captions, part headings, subheadings not law—Adoption of rules—Effective dates—2005 c 504: See notes following RCW 71.05.027.

Alphabetization—Correction of references—2005 c 504: See note following RCW 71.05.020.

Correction of references—Savings—Severability—2005 c 503: See notes following RCW 71.24.015.

Purpose—Intent—1999 c 10: "The purpose of this act is to eliminate dates and provisions in chapter 71.24 RCW which are no longer needed. The legislature does not intend this act to make, and no provision of this act shall be construed as, a substantive change in the service delivery system or funding of the community mental health services law." [1999 c 10 § 1.]

Alphabetization of section—1999 c 10 § 2: "The code reviser shall alphabetize the definitions in RCW 71.24.025 and correct any cross-references." [1999 c 10 § 14.]

Effective date—1995 c 96: See note following RCW 71.24.400.

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

Conflict with federal requirements—1991 c 306: See note following RCW 71.24.015.

Effective date—1986 c 274 §§ 1, 2, 3, 5, and 9: See note following RCW 71.24.015.

RECOMMENDATIONS & AGENCY RESPONSE

Legislative Auditor's Recommendation

Legislative Auditor recommends determining whether to continue the preference (policy decision)

The Legislature should determine whether to continue this preference. If the Legislature wants to continue the tax deduction for government-funded behavioral health care, it will need to take action. Otherwise, behavioral health will be treated the same as physical health and providers will pay B&O taxes beginning in 2020.

Legislation Required: Yes.

Fiscal Impact: Depends on legislative action.

State of Washington

Citizen Commission for Performance Measurement of Tax Preferences

Dr. Grant D. Forsyth, Chair
Avista Corp

Ronald Bueing, Vice Chair
PricewaterhouseCoopers

Diane Lourdes Dick
Seattle University School of Law

Dr. Justin Marlowe
Evans School of Public Policy and Governance, University of Washington

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October 18, 2018

The Honorable Representative Kristine Lytton
The Honorable Representative Ed Orcutt
The Honorable Representative Timm Ormsby
The Honorable Representative Bruce Chandler
The Honorable Senator Christine Rolfes
The Honorable Senator John Braun

Re: 2018 Tax Preference Reviews

I am pleased to forward to you the comments that the Citizen Commission for Performance Measurement of Tax Preferences unanimously adopted for this year's review of tax preferences.

We adopted the same position as the Legislative Auditor for all seven recommendations issued this year. The full text of our comments, as well as summaries of the JLARC staff's analysis and recommendations are linked here.

Tax preference reviews provide valuable information as the Legislature considers whether specific preferences are meeting the Legislature's policy objectives. With this year's report, there are now 12 years of tax preference evaluations available to the Legislature, comprising over 270 individual reviews.

I urge you to consider this year's and previous years' recommendations and comments on tax preference statutes in the upcoming legislative session.

The Commission is operating on a multi-year review schedule that goes through 2026. Next year's reviews will have an emphasis on the aerospace industry, but also include preferences for multi-family housing and wood waste (hog fuel) used to generate energy. More details on the reviews planned for 2019 are linked here.

As Chair of the Citizen Commission, I would be pleased to discuss the Commission's position and comments with you and any interested legislators. Please feel free to contact me at

grant.forsyth@leg.wa.gov or the Legislative Auditor, Keenan Konopaski at keenan.konopaski@leg.wa.gov or 360-786-5187.

Sincerely,

Grant D. Forsyth

Grant D. Forsyth, Chair
Citizen Commission for Performance Measurement of Tax Preferences

Cc: Members of Washington State Legislature
David Schumacher, Office of Financial Management
Marc Baldwin, Office of Financial Management
Jim Schmidt, Office of Financial Management
Randy Simmons, Washington State Department of Revenue
Gil Brewer, Washington State Department of Revenue
Kathy Oline, Washington State Department of Revenue

RECOMMENDATIONS & AGENCY RESPONSE

Commissioners' Recommendation

The Commission endorses the Legislative Auditor's recommendation with comment. Supports mental health services that can prevent more serious and costly health issues.

STATE OF WASHINGTON

October 1, 2018

TO: Keenan Konopaski, Legislative Auditor
Joint Legislative Audit and Review Committee

FROM: David Schumacher, Director
Office of Financial Management

Randy Simmons, Acting Director
Department of Revenue

SUBJECT: JLARC PRELIMINARY REPORT ON 2018 TAX PREFERENCE PERFORMANCE REVIEWS

The Office of Financial Management and the Department of Revenue have reviewed the Joint Legislative Audit and Review Committee's (JLARC) preliminary report on the 2018 tax preference performance reviews.

We appreciate JLARC's thorough analysis and the detailed assessment provided by the Citizen Commission for Performance Measurement of Tax Preferences. A system that provides for a continuous review of state tax preferences is critical to ensure that the state of Washington maintains a fair and equitable tax system.

While we have no specific comments on the 2018 preliminary report, we continue to support JLARC's recommendations for the inclusion of performance statements and specific public policy objectives for all tax preferences where they do not exist in statute today.

Thank you for the opportunity to provide comments on this material and the recommendations made by JLARC.

Washington Joint Legislative Audit and Review Committee

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