ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1515

AS AMENDED BY THE SENATE

Passed Legislature - 2023 Regular Session

State of Washington 68th Legislature 2023 Regular Session

By House Appropriations (originally sponsored by Representatives Macri, Davis, Simmons, Orwall, Taylor, Leavitt, Riccelli, Callan, Farivar, Alvarado, Reed, Fosse, Doglio, Berg, Ryu, Peterson, Fitzgibbon, Bateman, Eslick, Ormsby, Stonier, and Tharinger)

READ FIRST TIME 02/24/23.

AN ACT Relating to contracting and procurement requirements for behavioral health services in medical assistance programs; amending RCW 74.09.871 and 71.24.861; and creating new sections.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** (1) The legislature finds that:

(a) Medicaid enrollees in Washington are challenged with accessing needed behavioral health care. According to the Washington state department of social and health services, as of 2021, among medicaid enrollees with an identified mental health need, only 50 percent of adults and 66 percent of youth received treatment, while among medicaid enrollees with an identified substance use disorder need, only 37 percent of adults and 23 percent of youth received treatment. Furthermore, the national council for mental wellbeing's 2022 access to care survey found that 43 percent of adults in the United States who say they need mental health or substance use care did not receive that care, and they face numerous barriers to receiving needed treatment. Lack of necessary care can cause behavioral health conditions to deteriorate and crises to escalate, driving increasing use of intensive services such as inpatient care and involuntary treatment. As a result, the behavioral health system is reaching a crisis point in communities across the state.

(b) As of December 2022, 1,953,153 Washington residents rely on apple health managed care organizations to provide for their physical and behavioral health needs. During the integration of physical and behavioral health care pursuant to chapter 225, Laws of 2014, the health care authority most recently procured managed care services in 2018 and selected five managed care organizations to serve as Washington's apple health plans to provide for the physical and behavioral health care needs of medicaid enrollees. The health care authority has begun considering when to conduct a new procurement for managed care organizations, including an allowance for possible new entrants that do not currently serve Washington's medicaid population.

(c) Medicaid managed care procurement presents a need and an opportunity for the state to reset expectations for managed care organizations related to behavioral health services to ensure that Washington residents are being served by qualified and experienced health plans that can deliver on the access to care and quality of care that residents need and deserve.

(2) It is the intent of the legislature to seize this opportunity to address ongoing challenges Washington's medicaid enrollees face in accessing behavioral health care. The legislature intends to establish robust new standards defining the levels of medicaid-funded behavioral health service capacity and resources that are adequate to meet medicaid enrollees' treatment needs; to ensure that managed care organizations that serve Washington's medicaid enrollees have a track record of success in delivering a broad range of behavioral health care services to safety net populations; and to advance payment structures and provider network delivery models that improve equitable access, promote integration of care, and deliver on outcomes.

(3) The legislature finds that increased access to behavioral health services for American Indians and Alaska Natives, children in foster care, and the aged, blind, and disabled through the preservation and enhancement of the fee-for-service system is also critical to reducing health disparities among these vulnerable populations. The legislature also intends to increase access to timely and robust behavioral health services for American Indians and Alaska Natives, children in foster care, and the aged, blind, and disabled, in the fee-for-service system they access.

Sec. 2. RCW 74.09.871 and 2019 c 325 s 4006 are each amended to read as follows:

(1) Any agreement or contract by the authority to provide behavioral health services as defined under RCW 71.24.025 to persons eligible for benefits under medicaid, Title XIX of the social security act, and to persons not eligible for medicaid must include the following:

(a) Contractual provisions consistent with the intent expressed in RCW 71.24.015 and 71.36.005;

(b) Standards regarding the quality of services to be provided, including increased use of evidence-based, research-based, and promising practices, as defined in RCW 71.24.025;

(c) Accountability for the client outcomes established in RCW 71.24.435, 70.320.020, and 71.36.025 and performance measures linked to those outcomes;

(d) Standards requiring behavioral health administrative services organizations and managed care organizations to maintain a network of appropriate providers that is supported by written agreements sufficient to provide adequate access to all services covered under the contract with the authority and to protect essential behavioral health system infrastructure and capacity, including a continuum of substance use disorder services;

(e) Provisions to require that medically necessary substance use disorder and mental health treatment services be available to clients;

(f) Standards requiring the use of behavioral health service provider reimbursement methods that incentivize improved performance with respect to the client outcomes established in RCW 71.24.435 and 71.36.025, integration of behavioral health and primary care services at the clinical level, and improved care coordination for individuals with complex care needs;

(g) Standards related to the financial integrity of the contracting entity. This subsection does not limit the authority of the authority to take action under a contract upon finding that a contracting entity's financial status jeopardizes the contracting entity's ability to meet its contractual obligations;

(h) Mechanisms for monitoring performance under the contract and remedies for failure to substantially comply with the requirements of the contract including, but not limited to, financial deductions,

termination of the contract, receivership, reprocurement of the contract, and injunctive remedies;

(i) Provisions to maintain the decision-making independence of designated crisis responders; and

(j) Provisions stating that public funds appropriated by the legislature may not be used to promote or deter, encourage, or discourage employees from exercising their rights under Title 29, chapter 7, subchapter II, United States Code or chapter 41.56 RCW.

(2) At least six months prior to releasing a medicaid integrated managed care procurement, but no later than January 1, 2025, the authority shall adopt statewide network adequacy standards that are assessed on a regional basis for the behavioral health provider networks maintained by managed care organizations pursuant to subsection (1)(d) of this section. The standards shall require a network that ensures access to appropriate and timely behavioral health services for the enrollees of the managed care organization who live within the regional service area. At a minimum, these standards must address each behavioral health services type covered by the medicaid integrated managed care contract. This includes, but is not limited to: Outpatient, inpatient, and residential levels of care for adults and youth with a mental health disorder; outpatient, inpatient, and residential levels of care for adults and youth with a substance use disorder; crisis and stabilization services; providers of medication for opioid use disorders; specialty care; other facility-based services; and other providers as determined by the authority through this process. The authority shall apply the standards regionally and shall incorporate behavioral health system needs and considerations as follows:

(a) Include a process for an annual review of the network adequacy standards;

(b) Provide for participation from counties and behavioral health providers in both initial development and subsequent updates;

(c) Account for the regional service area's population; prevalence of behavioral health conditions; types of minimum behavioral health services and service capacity offered by providers in the regional service area; number and geographic proximity of providers in the regional service area; an assessment of the needs or gaps in the region; and availability of culturally specific services and providers in the regional service area to address the needs of communities that experience cultural barriers to health care

including but not limited to communities of color and the LGBTQ+ community;

(d) Include a structure for monitoring compliance with provider network standards and timely access to the services;

(e) Consider how statewide services, such as residential treatment facilities, are utilized cross-regionally; and

(f) Consider how the standards would impact requirements for behavioral health administrative service organizations.

(3) Before releasing a medicaid integrated managed care procurement, the authority shall identify options that minimize provider administrative burden, including the potential to limit the number of managed care organizations that operate in a regional service area.

(4) The following factors must be given significant weight in any medicaid integrated managed care procurement process under this section:

(a) Demonstrated commitment and experience in serving low-income populations;

(b) Demonstrated commitment and experience serving persons who have mental illness, substance use disorders, or co-occurring disorders;

(c) Demonstrated commitment to and experience with partnerships with county and municipal criminal justice systems, housing services, and other critical support services necessary to achieve the outcomes established in RCW 71.24.435, 70.320.020, and 71.36.025;

(d) The ability to provide for the crisis service needs of medicaid enrollees, consistent with the degree to which such services are funded;

(e) Recognition that meeting enrollees' physical and behavioral health care needs is a shared responsibility of contracted behavioral health administrative services organizations, managed care organizations, service providers, the state, and communities;

((~~(e)~~)) (f) Consideration of past and current performance and participation in other state or federal behavioral health programs as a contractor; ((~~and~~

~~(f)~~)) (g) The ability to meet requirements established by the authority((~~. (3)~~));

(h) The extent to which a managed care organization's approach to contracting simplifies billing and contracting burdens for community behavioral health provider agencies, which may include but is not

limited to a delegation arrangement with a provider network that leverages local, federal, or philanthropic funding to enhance the effectiveness of medicaid-funded integrated care services and promote medicaid clients' access to a system of services that addresses additional social support services and social determinants of health as defined in RCW 43.20.025;

(i) Demonstrated prior national or in-state experience with a full continuum of behavioral health services that are substantially similar to the behavioral health services covered under the Washington medicaid state plan, including evidence through past and current data on performance, quality, and outcomes; and

(j) Demonstrated commitment by managed care organizations to the use of alternative pricing and payment structures between a managed care organization and its behavioral health services providers, including provider networks described in subsection (b) of this section, and between a managed care organization and a behavioral administrative service organization, in any of their agreements or contracts under this section, which may include but are not limited to:

(i) Value-based purchasing efforts consistent with the authority's value-based purchasing strategy, such as capitated payment arrangements, comprehensive population-based payment arrangements, or case rate arrangements; or

(ii) Payment methods that secure a sufficient amount of ready and available capacity for levels of care that require staffing 24 hours per day, 365 days per year, to serve anyone in the regional service area with a demonstrated need for the service at all times, regardless of fluctuating utilization.

(5) The authority may use existing cross-system outcome data such as the outcomes and related measures under subsection (4)(c) of this section and chapter 338, Laws of 2013, to determine that the alternative pricing and payment structures referenced in subsection (4)(j) of this section have advanced community behavioral health system outcomes more effectively than a fee-for-service model may have been expected to deliver.

(6)(a) The authority shall urge managed care organizations to establish, continue, or expand delegation arrangements with a provider network that exists on the effective date of this section and that leverages local, federal, or philanthropic funding to enhance the effectiveness of medicaid-funded integrated care services

and promote medicaid clients' access to a system of services that addresses additional social support services and social determinants of health as defined in RCW 43.20.025. Such delegation arrangements must meet the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards.

(b) The authority shall recognize and support, and may not limit or restrict, a delegation arrangement that a managed care organization and a provider network described in (a) of this subsection have agreed upon, provided such arrangement meets the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards. The authority may periodically review such arrangements for effectiveness according to the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards.

(c) Managed care organizations and the authority may evaluate whether to establish or support future delegation arrangements with any additional provider networks that may be created after the effective date of this section, based on the requirements of the integrated managed care contract and the national committee for quality assurance accreditation standards.

(7) The authority shall expand the types of behavioral health crisis services that can be funded with medicaid to the maximum extent allowable under federal law, including seeking approval from the centers for medicare and medicaid services for amendments to the medicaid state plan or medicaid state directed payments that support the 24 hours per day, 365 days per year capacity of the crisis delivery system when necessary to achieve this expansion.

(8) The authority shall, in consultation with managed care organizations, review reports and recommendations of the involuntary treatment act work group established pursuant to section 103, chapter 302, Laws of 2020 and develop a plan for adding contract provisions that increase managed care organizations' accountability when their enrollees require long-term involuntary inpatient behavioral health treatment and shall explore opportunities to maximize medicaid funding as appropriate.

(9) In recognition of the value of community input and consistent with past procurement practices, the authority shall include county and behavioral health provider representatives in the development of

any medicaid integrated managed care procurement process. This shall include, at a minimum, two representatives identified by the association of county human services and two representatives identified by the Washington council for behavioral health to participate in the review and development of procurement documents.

(10) For purposes of purchasing behavioral health services and medical care services for persons eligible for benefits under medicaid, Title XIX of the social security act and for persons not eligible for medicaid, the authority must use regional service areas. The regional service areas must be established by the authority as provided in RCW 74.09.870.

((~~(4)~~)) (11) Consideration must be given to using multiple-biennia contracting periods.

((~~(5)~~)) (12) Each behavioral health administrative services organization operating pursuant to a contract issued under this section shall serve clients within its regional service area who meet the authority's eligibility criteria for mental health and substance use disorder services within available resources.

Sec. 3. RCW 71.24.861 and 2019 c 325 s 1047 are each amended to read as follows:

(1) The legislature finds that ongoing coordination between state agencies, the counties, and the behavioral health administrative services organizations is necessary to coordinate the behavioral health system. To this end, the authority shall establish a committee to meet quarterly to address systemic issues, including but not limited to the data-sharing needs of behavioral health system partners.

(2) The committee established in subsection (1) of this section must be convened by the authority, meet quarterly, and include representatives from:

(a) The authority;

(b) The department of social and health services;

(c) The department;

(d) The office of the governor;

(e) One representative from the behavioral health administrative services organization per regional service area; and

(f) One county representative per regional service area.

NEW SECTION. **Sec. 4.** If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by June 30, 2023, in the omnibus appropriations act, this act is null and void.

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