



Report to the Legislature

System Transformation Initiative

Chapter 333, Laws of 2006 and
Chapter 372 Section 204(i&j), Laws of 2006

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System Transformation Initiative

Executive Summary

Between 2005 and 2006, the confluence of several legal and policy decisions increased pressures for psychiatric inpatient beds in community and state hospitals. The state was prohibited from having waiting lists for individuals on 90 and 180 day involuntary commitment orders. The process being used for assigning financial penalties to Regional Support Networks (RSNs) which exceeded their allocation of state hospital beds was invalidated. Additionally, community psychiatric inpatient capacity continued to decline and lengths of stay in and variable utilization by RSNs of the two state psychiatric hospitals presented a concern.

Chapter 333, Laws of 2006, and Chapter 372 Section 204(i&j), Laws of 2006, provided direction and funds to begin a comprehensive transformation in the delivery of public mental health services for people with severe and persistent mental illness by calling for: 1) clarification of state hospital and RSN responsibilities with regard to people who require short and long-term care, 2) increased RSN accountability for managing state hospital admissions and discharges within established bed allocation targets, 3) linking the receipt of community funding to achievement of negotiated performance objectives that support recovery, and 4) an emphasis on the use of evidence-based practices including \$16.9 million of State General Funds for Program of Assertive Community Treatment (PACT) teams.

In order to inform this transformation effort, the legislature called for planning and studies on an expansion of housing options for people with persistent mental illness, a utilization management system to assure people receive appropriate levels and durations of inpatient care, a review of the state's involuntary commitment statute and alternative approaches to establishing Medicaid managed care rates, with particular emphasis on approaches that emphasize defined benefits levels and risk adjustment.

The Department of Social and Health Services (DSHS) Mental Health Division (MHD) managed these studies by using the overarching System Transformation Initiative, through which highly-respected consultants, national and local experts, allied systems, families and consumer stakeholders collaborated from June 2006 through September 2007. Each consultant-led study area had a standing expert/constituent Task Force, comprised of 35-40 members from a variety of interested parties, which met monthly. Additionally, three Community Forums were held that engaged approximately 450 stakeholders.

MHD analyzed the consultant reports and integrated the knowledge gained into a comprehensive package of recommendations for prioritization by policymakers to achieve the initiatives' long term goals. The following table provides a summary of the recommendations that MHD suggests be prioritized for implementation as

well as those which may require funding or policy changes in statute or rule. In addition to the recommendations included in the table, a number of recommendations specific to Tribal Governments are noted in the full report and will be developed further and prioritized through the MHD Tribal Mental Health Workgroup.

System Transformation Initiative Priority Recommendations	Req. \$	Policy Change
<i>Focus Area 1 - Improving Access/Promoting Best Practices</i>		
1.1 Do not propose any changes regarding the structure of Rehabilitative Services within Washington's Medicaid State Plan under the current federal climate.	No	No
1.2 Develop statewide standards for continuing care and discharge under the Access to Care Standards (ACS) in order to shift the utilization management focus of RSNs from front-end restrictions for all enrollees to proactive care management of services for enrollees with intensive, ongoing needs.	No	Yes
1.3 Prior to the next Medicaid waiver submission, conduct a full actuarial analysis of the financial impact of revising GAF (Global Assessment of Functioning) and C-GAS (Children's Global Assessment Scale) minimums for routine outpatient care and if financially feasible, raise the minimum functional levels to allow earlier intervention.	Yes	Yes
1.4 Prioritize the following 3 evidence based and promising practices for Statewide Implementation <ul style="list-style-type: none"> • Peer support services provided directly by Consumer and Family Run Organizations • Integrated Dual Disorder Treatment for persons with co-occurring mental health and substance use disorders • Collaborative Care Models for integrating medical and mental health treatment for populations most effectively served by clinicians located in primary care settings 	Yes	Yes
<i>Focus Area 2 - Increasing Access to Permanent Supportive Housing (PSH)</i>		
2.1 Directly support the development of 760 additional PSH units by: <ul style="list-style-type: none"> • Exploring options for securing rent subsidies funding for 35% of units that can't be funded through existing sources (260 units) • Exploring options for securing funding for operating subsidies (e.g. landlord incentives, risk mitigation funds) needed to encourage, support and sustain private landlords who rent to consumers • Determining whether additional funding for PSH case management and crisis services can be met through current RSN allocations or require additional funding 	Yes	No

System Transformation Initiative Priority Recommendations	Req. \$	Policy Change
2.2 Promote the creation of PSH at the RSN and local level by providing best practice information on models, partnerships and financing and by funding technical assistance to build capacity	Yes	Yes
2.3 Ensure the Prepaid Inpatient Health Plan (PIHP) benefit package includes flexible modality for services in home settings with rate sufficient to cover costs.	Yes	Yes
2.4 Suggest standard to identify number of crisis respite beds needed and identify funding if needed.	Yes	Yes
2.5 Develop a closer working relationship with the Washington State Department of Community, Trade & Economic Development (CTED) and consider opportunities to explore coordinated housing/services projects.	Yes	Yes
<i>Focus Area 3 - Continued Study of the Involuntary Treatment Act (ITA)</i>		
3.1 There should be no changes to the definition of “mental disorder” or “grave disability” at this time as there is a significant divide among stakeholders on these issues.	No	No
3.2 Narrowing the criteria for civil commitment should only occur after enhanced community services and resources are in place. These services must respond to the medical, psychological and psychosocial condition(s) that underlay the actions that prompt involuntary consideration and should not be limited by fund source. This is consistent with the direction given by the majority of stakeholders.	Yes	No
3.3 Parent-initiated treatment should be studied in the context of the implementation of HB 1088 with an emphasis on assuring appropriate parental involvement.	No	TBD
3.4 Conduct additional study in other ITA areas (e.g. forensic conversions, involuntary medications, and advanced directives in involuntary settings.)	Yes	TBD
<i>Focus Area 4 - Utilization Management (UM) /Making Best Use of a Limited Resource</i>		
4.1 Establish a statewide standardized UM protocol for both acute and extended (i.e., state hospital) inpatient admissions and continuing stays drawing from an analysis of raw data from selected UM instrument(s).	Yes	Yes
4.2 Track uniform data on discharge barriers across the state hospitals.	No	No
4.3 Consider hiring a Director of Inpatient Care Management or a Chief Medical Officer within the MHD versed in public behavioral health UM to provide the required medical expertise.	Yes	No
4.4 Complete a study of each RSN’s hospital diversion and discharge options in order to forecast needed areas of development.	Yes	No
4.5 Conduct a root cause analysis of why, at times, there are discordant data reports between the MHD and some RSNs.	No	No

System Transformation Initiative Priority Recommendations	Req. \$	Policy Change
4.6 Establish a dispute resolution and consumer appeals panel at each state hospital. Panel membership should include consumers, RSN and hospital staff and reflect recovery principles.	No	No
4.7 Review the financial incentives underlying involuntary treatment payments and align payments with the systems most appropriately responsible for ongoing care.	Yes	TBD
<i>Additional Recommendations and Options Pertaining to Tribal Governments</i>		
5.1 Develop a handbook to guide RSNs in their interactions with Tribal governments and Tribal providers.	No	Yes
5.2 Develop a clear policy for the involvement of Indian Health Service and 638 facility providers in 1915-B waiver networks including consideration of mechanisms for direct contracting with Tribes.	TBD	Yes
5.3 Convene a work group to develop recommendations on how to incorporate Tribal traditional healing practices within the public mental health benefit.	No	Yes
5.4 Incorporate specific provisions for the inclusion of Tribes in any systematic efforts to promote best practices.	TBD	No
5.5 Continue facilitation of statewide forums such as the Tribal Mental Health Work Group and ensure the participation of senior staff in these forums.	No	No
5.6 Explore options for allowing Tribes to detain individuals independent of RSN approval by giving Tribes and Tribal Courts the ability to appoint Tribal DMHPs with authority to order involuntary treatment independently.	TBD	Yes
5.7 Explore options for requiring RSNs to accept referrals for 72-hour detentions from Tribes, rather than, in the words of one focus group participant, “wasting resources” by engaging a DMHP to conduct an additional assessment.	TBD	Yes
5.8 Increase the resources available to Tribal governments for housing and services for mental health clients including access to support services and landlord risk mitigation funds.	Yes	TBD
5.9 Increase the coordination and collaboration between Tribal governments and local and state government.	No	TBD
5.10 While the consultants for the Utilization Management Study have not made formal recommendations specific to the Tribes, there has been significant input through the STI process and the MHD Tribal Mental Health Workgroup to provide access to voluntary inpatient beds for the tribes without having to go through RSN inpatient authorization processes.	TBD	Yes

System Transformation Initiative Legislative Report

1. Introduction

Between 2005 and 2006, the confluence of several legal and policy decisions increased pressures for psychiatric inpatient beds located in community and state hospitals. These challenges were exacerbated in September 2005 when a court ruling reduced the state's ability to maintain state hospital census, in accordance with funding levels, by:

- Prohibiting the state from having waiting lists for individuals on 90 and 180 day involuntary commitment orders.
- Invalidating a process being used for assigning financial penalties to Regional Support Networks (RSNs) which exceeded their allocation of state hospital beds.

Additional challenges facing the system at the time included:

- A continuing trend of reduced community psychiatric inpatient capacity.
- Variability in RSN per capita psychiatric inpatient utilization and lengths of stays.
- Long lengths of stay and disparities when comparing Washington's two state hospitals.

The Department of Social and Health Services (DSHS) Mental Health Division (MHD) developed a package of budget and policy options, many of which were incorporated by the 2006 State Legislature in Chapter 333, Laws of 2006, and Chapter 372 Section 204(i&j), Laws of 2006. These laws provided direction and funds to begin a comprehensive transformation in the delivery of public mental health services for people with severe and persistent mental illness including:

- Clarification of state hospital and Regional Support Network (RSN) responsibilities, with regard to people who require short- and long-term care.
- RSNs' accountability for managing state hospital admissions and discharges within established bed allocation targets.
- Emphasis on the use of evidence-based practices (EBPs) including:
 - Funding for the phased-in development and ongoing support of community-based alternatives to state psychiatric hospitalization including an additional \$16.9 million per year of non-Medicaid funds¹.

¹ This included development of 10 Program of Assertive Community Treatment (PACT) Teams implemented in 9 RSNs between July and October 2007. The 10 PACT teams will ultimately serve 640-800 individuals and are expected to allow for the eventual closure of 4 state hospital wards opened on a temporary basis to allow the state to handle the imminent shortage of inpatient beds noted above.

- Linking the receipt of community funding to achievement of negotiated performance objectives and for effectively supporting their recovery and return to the community.

Additional direction and funding was provided by the legislature for planning and studies related to four subject areas including:

- Preparation of a plan for the expansion of housing options for people with persistent mental illness.
- The development of a utilization management system to assure people receive appropriate levels and durations of inpatient care.
- A review of the state's involuntary commitment statute.
- A study of alternative approaches to establishing Medicaid managed care rates, with particular emphasis on approaches that emphasize defined benefits levels and risk adjustment.

These activities are being implemented as part of the MHD System Transformation Initiative (STI). This report has been prepared by the MHD to provide an update for the legislature on the four areas of planning and studies noted above.

2. Implementation Process

Implementation of the STI studies has been coordinated within a framework of extensive stakeholder participation. This has included the following elements:

- Consultants for each project were contracted through a Request For Proposals (RFP) process which occurred between June and September 2006 as follows:
 - Benefits Package/Rates- TRI West Group
 - Involuntary Treatment Act- Tri West Group/Advocates for Human Potential
 - Mental Health Housing Plan- Common Ground
 - External Utilization Review- Harborview Medical Center
- A standing representative STI Task Force including 40 representatives from the mental health system, allied service systems, consumers, family members, and law enforcement met monthly between October 2006 and June 2007 to provide input.
- Three large community forums were held between November 2006 and July 2007 with a large participation of consumers and family members.
- Three meetings with tribal leaders and follow-up focus groups were held between February 2007 and May 2007.
- Additional focus groups and key informant interviews were held between October 2006 and June 2007.

Reports incorporating the large volume of stakeholder input have been submitted from the contracted consultants with options and recommendations to MHD for improvements in the various subject areas. MHD has analyzed these reports and integrated the information into a comprehensive package of recommendations for prioritization by policymakers to achieve the long-term goals of these initiatives. The complete reports are available on the STI website at: http://www1.dshs.wa.gov/Mentalhealth/STI_Main.shtml.

3. Benefits Package/Rates Study

a. Scope of the Study

MHD contracted with TriWest Group to provide analysis and input regarding potential redesign of its benefit package for publicly-funded managed behavioral health care. TriWest was selected for their experience in assisting other states in the design of mental health benefit packages and implementation of evidence based practices (EBPs). The consultant was contracted to review select comparison states, Washington's mental health benefit design, RSN management processes, national evidence-based and promising practices, options allowed by the Deficit Reduction Act, and rate methodologies. Comparison states included Colorado, Pennsylvania, New Mexico, and Arizona. TriWest Group has submitted a final report incorporating the information into a final set of recommendations to MHD.

b. Benefit Package Study Primary Findings

The primary findings of the report relate to Washington's RSN Access to Care (ACS) standards and the 21 RSN services offered through Washington's State Plan and Federal Waiver. The ACS standards include the required diagnosis and functional impairment levels for accessing RSN services. Following is a brief summary of the report findings:

- i. Washington's eligibility requirements allow more diagnostic flexibility for early childhood mental health needs.
- ii. Washington is the only state of the five reviewed that imposes functional impairment requirements as a means of determining service eligibility.
- iii. The current ACS standards focus utilization management resources almost entirely on front-end limitations rather than on expensive levels of care such as day services, long-term case management and residential services.
- iv. Other states and their managed care organizations (MCOs) have generally evolved the focus of their utilization management activities away from across-the-board front-end restrictions (e.g. ACS standards) in order to focus limited care management resources on more expensive services.

- v. Washington is the only state of the five reviewed that holds its MCOs to be at-risk for acute inpatient care, but only requires them to coordinate the delivery of such care, rather than directly deliver the service through their regional networks.
- vi. Washington operates independent managed care plans with relatively few covered lives, including four regions with fewer than 25,000 lives and six with fewer than 60,000.²
- vii. Washington has a very broad State Plan sufficiently flexible to promote best practices and maximize federal participation.
- viii. The Center for Medicare and Medicaid Services (CMS) has increased scrutiny over Rehabilitative Services resulting in other states losing flexibility and federal participation when amending their State Plans.
- ix. There are major limitations applying evidence based and promising practices in “real world” settings.
- x. It does not work to simply mandate Best Practices across the board without development of infrastructure (training, monitoring, rates, and sufficient time).

c. Benefit Package Study Recommendations Identified by MHD for Further Development

MHD has identified the following recommendations from the benefit design study for further development:

- i. Do not propose any changes to CMS regarding the structure of Rehabilitative Services within Washington’s Medicaid State Plan under the current federal climate.
- ii. Develop statewide standards for continuing care and discharge under ACS in order to shift the utilization management focus of RSNs from front-end restrictions for all enrollees to proactive care management of services for enrollees with intensive, ongoing needs.³
- iii. Prior to the next waiver submission, conduct a full actuarial analysis of the financial impact of revising GAF (Global Assessment of Functioning) and C-GAS (Children's Global Assessment Scale) minimums for routine outpatient care and if financially feasible, raise the minimum functional levels to allow earlier intervention.⁴

² Of the comparison states reviewed, none operate regions with fewer than 40,000 covered lives and only Colorado operates regions with fewer than 60,000 lives.

³ This will require the development of statewide medical necessity standards for all levels of care, including criteria for initial and concurrent reviews. RSNs have always set their own level of care standards.

⁴ It is difficult to assess the true impact of changing ACS standards as there is no clear data source available to quantify individuals who did not meet ACS due to functional impairment. In addition, it is impossible to quantify how many individuals are not referred for RSN services because people believe they will not meet ACS functional requirements. For this reason, it may be best to conduct a pilot study to extend coverage to additional individuals including those who fall outside the Health Options program by relaxing the functional requirements for ACS.

- iv. Prioritize the following EBPs and promising practices for Statewide Implementation⁵:
 - Peer support services provided directly by Consumer and Family Run Organizations.⁶
 - Integrated Dual Disorder Treatment for persons with co-occurring mental health and substance use disorders.
 - Collaborative Care Models for integrating medical and mental health treatment for populations most effectively served by clinicians located in primary care settings.
 - Two EBPs were recommended for children (MTFC & Wraparound) and will be considered in conjunction with a stakeholder input process being conducted related to implementation of SHB 1088.

4. Housing Action Plan

a. Scope of Study:

MHD contracted with Common Ground for the development of a Mental Health Housing Action Plan. The plan is intended to address a critical element of the high utilization of Eastern and Western State Hospitals: the lack of appropriate community-based housing for people with severe mental illnesses. Stable housing is an integral element of recovery for every individual with a mental illness.

Common Ground was selected for their experience within Washington in the development of specialized housing programs for individuals with mental illness. Common Ground was contracted to analyze state and federal housing resources and policies, review housing programs at the RSN and mental health provider level in six RSNs, and develop an action plan with strategies to address the key barriers to securing housing for people with mental illnesses. Common Ground has submitted a report incorporating the information into a final set of recommendations to MHD.

⁵ While rough estimates and a methodology for costing out statewide implementation of identified EBPs were provided, the report recommends that for any EBPs promoted statewide and paid for under Medicaid, a formal actuarial analysis should be conducted prior to implementation and at the end of each year to determine if RSNs have developed the service. The report also suggests Centers of Excellence be developed to support the implementation of those best practices prioritized for statewide implementation which is under further consideration by DSHS.

⁶ While Peer Support services are not classified as an EBP at this time, the consultant report cited a number of recent studies in which Peer Support services was associated with positive outcomes.

b. Housing Plan Primary Findings

The primary focus of the housing plan relates to the largest gap in the housing options for people with mental illnesses, the lack of permanent supportive housing (PSH) available and affordable to mental health consumers. The PSH model combines an apartment or single family home, leased by the consumer, with flexible supporting services. Services are titrated to meet individual needs and are provided in home and community settings. Primary findings of the plan include:

- i. All RSNs need a range of housing options including licensed residential facilities, community based housing, and crisis respite beds.
- ii. Key barriers to securing housing for people with mental illness include:
 - Lack of affordable housing stock.
 - Insufficient case management services.
 - Histories of poor credit or felony convictions; cultural and language barriers.
 - Insufficient prevention and crisis management services.
 - Incompatible or uncoordinated policy and resource decisions among public agencies at the state and local level.
- iii. PSH is the most appropriate setting for most mental health consumers.
- iv. All RSNs need additional PSH units:
 - Estimated need for up to additional 5000 units in Washington for people served by the public mental health system.
 - Initial goal should be for development of 760 PSH units for mental health consumers between 2007-2010.
- v. Features of successful PSH models include:
 - Case manager caseloads of 1:8-1:20.
 - Consumer and landlord access to case management staff around the clock
 - Landlord access to risk mitigation funds that cover excess costs related to renting to people with mental illnesses.
 - Option of master leasing units to a mental health provider.
 - Consumer access to short-term respite care, if the consumer's illness spikes, without loss of his or her apartment.
- vi. Some RSNs and providers report difficulty in fitting the work required through the PSH model in the current Medicaid state plan and waiver service definitions.
- vii. Key elements to successful implementation of 760 PSH units include:
 - Capital financing for new units- approximately 60% of needed dollars are committed and there are sufficient capital investment dollars available within current state and federal

- Rental subsidies (Section 8 wait lists) - 65% of units can be funded through existing sources leaving a gap of 35% (260 units).
- Operating subsidies (e.g. landlord incentives, risk mitigation funds) - for excess costs related to renting to mental health consumers based on \$1200 per unit per year.
- Access to on-site supportive services estimate that 480 of 760 units can be supported by new PACT or programs created related to PALS community funds and the remainder of services will need to come from either new funds or redirection of current RSN service dollars.

a. Housing Plan Recommendations Identified by MHD for Further Development

MHD has identified the following recommendations from the Housing Plan report for further development:

- i. Directly support the development of 760 additional PSH units by:
 - Exploring options for securing rent subsidies funding for 35% of units that can't be funded through existing sources (260 units).
 - Exploring options for securing funding for operating subsidies (e.g. landlord incentives, risk mitigation funds)- for excess costs of renting to consumers.
 - Identifying whether additional funding for PSH case management and crisis services can be met through current RSN allocations or require additional funding.
- ii. Promote the creation of PSH at the RSN and local level by providing best practice information on models, partnerships, and financing and funding technical assistance to build capacity.
- iii. Ensure the Prepaid Inpatient Health Plan (PIHP) benefit package includes flexible modality for services in home settings with rate sufficient to cover costs.
- iv. Suggest standard to identify number of crisis respite beds needed and identify funding if needed.
- v. Develop a closer working relationship with the Washington State Department of Community, Trade & Economic Development (CTED) and consider opportunities to explore coordinated housing/services projects.

5. Involuntary Treatment Act Study

a. Project Scope

MHD contracted with TriWest Group and Advocates for Human Potential to provide analysis and input regarding options related to the mental health Involuntary Treatment Act (ITA). The project lead was selected for their national expertise in development of policy recommendations related to involuntary treatment issues. This included mental health policy work for the United States Senate as well as the National Association of Mental Health Program Directors.

Washington's statutes were compared with other states including Arizona, Colorado, Iowa, Massachusetts, New Mexico, and Oregon. TriWest Group/Advocates for Human Potential have submitted a final report incorporating the information reviewed into options for consideration by MHD and policymakers.

b. ITA Study Primary Findings

The primary findings of the ITA study relate to: 1) The definition of “grave disability” in Washington’s civil commitment statute, 2) The definition of “mental disorder” in Washington’s civil commitment statute, and 3) Washington’s “age of consent” for receiving mental health services, including a review of the law permitting parent-initiated treatment. The report concludes that stakeholders in Washington expect involuntary treatment laws to meet many different, and sometimes competing, policy objectives. Primary findings of the ITA study include:

- i. There is no “model” statute or approach to civil commitment that is implemented by a majority of states. Rather, every state has a unique set of definitions and criteria based on the state’s specific policy objectives and available resources.
- ii. Washington’s statutory definition of “mental disorder” is broader than that of most other states in that it is not limited to specific diagnoses or types of mental illness and does not specifically exempt certain categories of impairments such as developmental disabilities.⁷
- iii. Washington is among approximately half of states that permit civil commitment under a “gravely disabled” or similar standard based on the person’s need for treatment as perceived by professionals or others.
 - Washington’s definition of “gravely disabled” effectively permits the civil commitment of people who are experiencing a severe deterioration in functioning and who are not

⁷ Many stakeholders in Washington State – including a consensus of those serving on the Task Force providing guidance to this project – expressed concern that this broad definition results in the civil commitment of people who may not be best served in a psychiatric setting. Specifically, they noted that certain populations, such as people with dementia, traumatic brain injury, or developmental disabilities may not benefit from inpatient psychiatric treatment and might be better served in other settings.

- receiving care essential for their health or safety – even if other essential human needs are being met.⁸
- Supporters of the current statute note that “even though the grounds for commitment are present, a Designated Mental Health Professional (DMHP) does not necessarily need to detain. However, if you shrink the available grounds for commitment, a DMHP will be unable to detain, even when the need to detain is great.”
- iv. A broad range of Washington stakeholders believe that use of detention and civil commitment would decline, and lengths of stay for people who are civilly committed would decrease, if Washington State would develop effective alternatives to involuntary treatment.
 - v. A broad range of Washington stakeholders believe that the actual statutory language of Washington’s involuntary treatment laws has less impact on the use of civil commitment than other factors, especially insufficient access to community mental health services and a lack of residential crisis alternatives.
 - vi. Community Forum participants ranked the factors they believe most affects the use of civil commitment in Washington State in the following order:
 - Insufficient access to mental health services (eligibility and availability).
 - Lack of residential crisis alternatives.
 - Insufficient access to services, like PACT, for people with the most severe illnesses who have not benefited from traditional services.
 - Insufficient access to mental health services that consumers want.
 - Lack of housing and other community residential options.
 - Lack of specialized community services for special populations.
 - Subjective interpretations of the law by DMHPs.
 - Reaction by DMHPs and courts to high-profile incidents
 - Actual language used in the ITA statute.
 - Lack of employment options.
 - vii. Many states have laws permitting minors to access mental health and/or substance abuse treatment without the consent of their parents.⁹
 - viii. Parent-initiated treatment for minors, as provided at RCW 71.34.600 – 71.34.660 is designed to address family and legislative concerns regarding the age of consent but does not appear to be used for a variety of reasons which may include:

⁸ The report notes this is an important concern for many family members who want to ensure that their loved ones receive treatment before they pose a danger to themselves or others.

⁹ The ITA report finds the actual age of consent varies from State to State, with many States permitting minors to consent to mental health treatment and/or substance abuse treatment at the age of 16, 14, or even 12.

- Parents may be unaware of this option.
- There is a perceived lack of clarity regarding due process procedures for minors who do not consent.
- There may be concern regarding independent reviews of provider admission decisions and/or other reimbursement issues.

c. Options Provided for Statutory Reform

The options below were provided in the report for potential statutory reform in the areas discussed.

- i. The statutory definition of “mental disorder” could be narrowed to include only certain mental illnesses or to exclude specific conditions, such as developmental disabilities, traumatic brain injury, or dementia.
- ii. The statutory definition of “grave disability” could be narrowed to:
 - Permit civil commitment only when the person is unable to make their own informed judgment about treatment.
 - Include a requirement that the person’s deterioration is likely to result in the person becoming a danger to themselves or others.
 - Include a requirement that the person’s deterioration is likely to result in the person requiring hospitalization.
- iii. More research is needed to better understand why parent-initiated treatment is not used before more sweeping options, such as increasing the age of consent, are considered.

d. MHD Recommendations Related to ITA Options for Reform

- i. MHD does not recommend making any changes to the definition of “mental disorder” or “grave disability” at this time as there is a significant divide among stakeholders on these issues.¹⁰
- ii. MHD concurs with the majority of stakeholders who expressed that narrowing the criteria for civil commitment should only occur after enhanced community services and resources are in place. These services must respond to the medical, psychological and psycho-social condition(s) that underlay the actions that prompt involuntary consideration and should not be limited by fund source.
- iii. MHD concurs with the recommendation for additional study related to parent initiated treatment and will do so in the context of the implementation of HB 1088 with an emphasis on assuring

¹⁰ Of 124 participants responding at a May 2007 community forum, 47% disagreed with the statement that “the definition of “mental disorder” in Washington State is too broad, resulting in detention and civil commitment of people who are not best served in an inpatient psychiatric setting.” 67% of respondents disagreed with the statement that “the definition of “gravely disabled” in Washington State is too broad, resulting in the over-use of detention, civil commitment, and inpatient services.”

appropriate parental involvement.

e. Additional Findings Related to the ITA Study

Throughout the stakeholder input process, a number of additional issues were identified by stakeholders that fell beyond the scope of the study. The MHD concurs with the recommendation of the report that additional study be focused in these areas including:

- i. Provisions of RCW 10.77 and implementation of the competency to stand trial and “forensic conversion” processes that result in people with mental illnesses remaining in jail longer than is needed. Issues identified included:
 - Difficulty of determining whether a defendant charged with a misdemeanor has a history of one or more violent acts that would require mandatory detention for competency restoration.
 - Ambiguous statutory language regarding the timeframe during which a competency examination must take place.
 - Unnecessary and cumbersome requirements for content of competency examination reports.
 - Mandatory competency restoration requirements for misdemeanor defendants with a history of one or more violent acts, even if the crime they are charged with is not serious.
- ii. Consumer concerns regarding the involuntary administration of psychotropic medications under the ITA.
- iii. Washington’s definition of “Likelihood of Serious Harm” to include allowing civil commitment of a person if there is a substantial risk that “physical harm will be inflicted by a person upon the property of others.
- iv. Desire for a more robust use of advance directives to permit earlier intervention consistent with a person’s own wishes, rather than relying on civil commitment and objection to a provision in the law providing that advance directives will not apply when a person is civilly committed under RCW 71.05.
- v. Need for more uniform training of DMHPs provided by the state to address concerns about variation in detention rates across RSNs.
- vi. Reported barriers for people who are detained under the involuntary treatment statute to convert their status and receive treatment on a voluntary basis.

6. Utilization Management Study

a. Scope of Study

MHD contracted with Harborview Medical Center to provide analysis and

recommendations related to utilization review (UR) criteria and utilization management (UM) processes for community and state psychiatric hospitals in Washington. The goal of improved UR criteria and UM processes is to ensure appropriate levels of state and community psychiatric inpatient and community-based services which support the recovery of individuals with severe and persistent mental illness. Harborview was selected for their unique perspective on community psychiatric inpatient utilization within Washington.

The study included a review of UM practices at Western State Hospital, Eastern State Hospital, Child Study Treatment Center, and at RSNs that manage utilization of community psychiatric hospital beds for publicly-funded clients. The study also included a peer state analysis conducted by a subcontractor (TriWest Group) on: organization of the states' managed care systems, organization of involuntary treatment systems, and approaches to UM in community and state hospitals. The comparison states were Arizona, Colorado, New Mexico and Pennsylvania. Harborview Medical Center has submitted a final report with options for MHD and policymakers to consider.

b. Primary Findings of the UM Study

The UM Study focused on the lack of consistency and standardization in RSN and state hospital practices, lack of adequate information for effective UM processes, and barriers to timely state hospital discharges. In addition, the report identified a number of areas in which Washington's UM practices vary significantly from comparison states. Key findings include:

- i. Unlike comparison states managed care entities, RSNs in Washington State do not directly contract with inpatient providers. Because of this, Washington's RSNs have fewer tools to manage inpatient utilization and expenditures.
- ii. Washington State's current policy of holding RSNs accountable for all involuntarily admitted individuals, regardless of Medicaid status, challenges effective UM practices at the RSN level and is a system not found in other comparison states.
- iii. Unlike Washington, a number of comparison states use customized and comprehensive medical necessity criteria as guidelines for accessing inpatient care.¹¹
- iv. Like Washington State, comparison states do not have standardized UM procedures at their state hospitals.
- v. There is a lack of consistency and standardization in carrying out UM functions throughout the state and many key informants

¹¹ The report noted that none have been scientifically tested for validity or reliability so their actual utility is unclear.

- identified the need for centralized UM leadership and expressed the need for a reliable and valid instrument for UM functions.
- vi. Analyses of administrative data raised questions about why some individuals have unusually long stays at state hospitals and why 27% of people discharged from state hospitals are readmitted within one year of discharge, yet data on why were not available.
 - vii. Barriers to timely state hospital discharges to the community include:
 - Lack of placements for specialized populations, lack of structured residential placement, and lack of housing and services for unfunded consumers.
 - No disincentives for RSNs to have consumers remain in state facilities except when the RSN has exceeded their allotted bed census.
 - Discharge barriers are not being tracked and reported in a systematic way.

c. Utilization Management Study Recommendations Identified by MHD for Further Development

MHD has identified the following recommendations from the UM report for further development:

- i. Establish a statewide standardized UM protocol for both acute and extended (i.e., state hospital) inpatient admissions and continuing stays.¹²
- ii. The MHD should analyze raw data provided from selected UM instrument(s).¹³
- iii. Uniform data on discharge barriers should be tracked across the state hospitals.
- iv. Statewide medical expertise is essential to a successful UM program. The MHD should consider hiring a Director of Inpatient Care Management or a Chief Medical Officer versed in public behavioral health UM.¹⁴
- v. Study of each RSN's hospital diversion and discharge options must be conducted in order to forecast needed areas of development.¹⁵
- vi. Conduct a root cause analysis of why, at times, there are discordant data reports between the MHD and some RSNs.
- vii. A dispute resolution and consumer appeals panel should be established at each state hospital. Panel membership should

¹² HRSA/MHD has launched a new initiative to begin standardizing the processes, clinical elements, and forms, which the RSNs use for authorization and concurrent review. The consultant recommends that the standardization be extended to include objective criteria and this data be systematically collected.

¹³ Harborview recommends Provider One should be used to collect standardized data on initial admission authorizations, continued stay reviews, and discharge barriers for both community and state hospitals. Provider One is set up to track data on initial authorizations but not for continued stay and discharge barriers.

¹⁴ This recommendation must be considered with a focus on mental health across many levels throughout DSHS.

¹⁵ Harborview suggests prior Public Consulting Group, Inc. (PCG) studies related to residential and inpatient capacity are still relevant and can be used as an immediate source of identified needs.

include consumers, RSN and hospital staff, and reflect recovery principles.

d. Additional Recommendations not Identified by MHD for Priority Implementation:

The report made the following additional recommendations which are not identified by MHD for priority implementation at this time:

- i. Develop a new model for aligning incentives to create community based options (e.g. fiscal responsibility for continued hospital stay of individuals supported by other DSHS divisions who do not meet the RSN Access to Care Standards).
- ii. Require RSNs to take a more assertive role in reviewing each individual being considered for admission to the state hospitals on 90 or 180-day court orders.
- iii. Further studies including:
 - Review of a subset of state hospital patients whose extended stays account for a disproportionate number of bed days.
 - Review of individuals who are re-admitted to state hospitals or who enter community hospitals in the year following discharge from a state hospital.
- iv. Development of processes, procedures and other mechanisms that result in the RSNs assuming the authority to contract directly with hospitals for the provision of acute inpatient care on a regular and ongoing basis.

7. Additional Recommendations and Options Pertaining to Tribal Governments

In developing the STI reports, consultants sought information directly from representatives of Tribal Governments, Recognized American Indian Organizations (RAIOs), and DSHS Indian Policy and Support Services (IPSS) managers. Three Tribal Forums and additional focus groups were held in 2007. Some of the information gathered through these processes is incorporated in the other recommendations noted above. There were additional issues and recommendations raised specific to the Tribes.

MHD has developed active involvement with Tribal Governments through the Tribal Mental Health Workgroup. The workgroup which has representatives from all Tribal nations meets monthly and is used to inform and seeks advice when developing policies and procedures that will have a unique effect on Tribes or Recognized American Indian Organizations. MHD recommends that all of the following additional recommendations/options made by the consultants specific to Tribal issues be further developed and prioritized for potential implementation through this workgroup.

a. Tribal Specific Benefits Package Recommendations

- i. Develop a handbook to guide RSNs in their interactions with Tribal governments and Tribal providers.
- ii. Develop a clear policy for the involvement of Indian Health Service and 638 facility providers in 1915-B waiver networks including consideration of mechanisms for direct contracting with Tribes.
- iii. Convene a work group to develop recommendations on how to incorporate Tribal traditional healing practices within the public mental health benefit.
- iv. Incorporate specific provisions for the inclusion of Tribes in any systematic efforts to promote best practices.
- v. Continue facilitation of statewide forums such as the Tribal Mental Health Work Group and ensure the participation of senior staff in these forums.

b. Tribal Specific Involuntary Treatment Options

- i. Explore options for allowing Tribes to detain individuals independent of RSN approval by giving Tribes and Tribal Courts the ability to appoint Tribal DMHPs with authority to order involuntary treatment independently.
- ii. Explore options for requiring RSNs to accept referrals for 72-hour detentions from Tribes, rather than, in the words of one focus group participant, “wasting resources” by engaging a DMHP to conduct an additional assessment.

c. Tribal Specific Housing Plan Recommendations:

- i. Increase the resources available to Tribal governments for housing and services for mental health clients including access to support services and landlord risk mitigation funds.
- ii. Increase the coordination and collaboration between Tribal governments and local and state government.

d. Utilization Management:

While the consultants for the Utilization Management Study have not made formal recommendations specific to the Tribes, there has been significant input through the STI process and the MHD Tribal Mental Health Workgroup to provide access to voluntary inpatient beds for the tribes without having to go through RSN inpatient authorization processes.

Appendix 1

Benefits Package Executive Summary

Statewide Transformation Initiative
Mental Health Benefit Package Design
Final Report

Executive Summary

submitted to

*The State of Washington
Department of Social and Human Services
Health and Recovery Services Administration
Mental Health Division*

July 2007



TriWest Group
6549 First Avenue NW
Seattle, WA 98117

Executive Summary

The Washington State Mental Health Division (MHD) contracted with TriWest Group to provide policy guidance and input regarding potential redesign of its benefit package for publicly-funded managed behavioral health care. This work is one part of MHD's broader System Transformation Initiative (STI). Building on the findings and recommendations of a preliminary report submitted in February 2007,¹⁶ this Final Report integrates a review of comparison states, Washington's benefit design and management processes, national evidence-based and promising practices, Deficit Reduction Act options, and rate methodologies into a final set of options and recommendations for MHD. The recommendations include:

1. Recommendations related to how best to promote current national best practices for adults and older adults, as well as children and families, within the overall recommended benefit design, and
2. Recommendations regarding Washington's Medicaid State Plan and overall mental health benefit design.

Recommendations Related to Mental Health Best Practices

System Level Recommendations for Promoting Best Practices

Best Practice (BP) Recommendation #1: While continuing to promote Evidence-Based Practices (EBPs), be mindful of their limitations. Inherent limitations in the research base for evidence-based practices (for example, a lack of research that addresses the complexities of typical practice settings such as staffing variability due to vacancies, turnover, and differential training) often lead providers, consumers, and other stakeholders to question the extent to which EBPs are applicable to their communities. In addition, many consumers are understandably concerned that having policy makers specify particular approaches might limit the service choices available, and many providers are reluctant to implement EBPs due to the costs and risks involved in training and infrastructure-building, processes that require commitments over years rather than months. Successful EBP promotion begins with an understanding of the real world limitations of each specific best practice, so that the inevitable stakeholder concerns that emerge can be anticipated and incorporated into the best practice promotion effort.

BP Recommendation #2: Specifically address the lack of research on cross-cultural application of EBPs. There is wide consensus in the literature that little research has been carried out to document the differential efficacy of EBPs across cultures. Given that few EBPs have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that EBPs be implemented within the context of ongoing evaluation efforts to determine whether they are effective for the local populations being served.

¹⁶ See the following website for a full copy of that report:
http://www1.dshs.wa.gov/pdf/hrsa/mh/Mental_Health_Benefit_Package_Design_Report_DRAFT_4_16_2007.pdf.

BP Recommendation #3: Specify the level of consumer and family involvement for each service in the array of best practices to be promoted. The best practices described in this report include a range of consumer and family involvement that varies across practices. In this report, we define the degree to which the best practices reviewed are consumer and family driven, focusing on the levels at which the services involve consumer and family member guidance and input through the following scale:

- **Consumer/Family Run and Operated** – Services delivered by consumers or family members within organizations that are majority owned or otherwise autonomously governed and run by at least 51% consumers or family members.
- **Fully Consumer/Family Delivered** – Services and supports that are delivered by consumers or family members within organizations that are run by professionals.
- **Partially Consumer/Family Delivered** – Services and supports jointly delivered by consumers or family members in partnership with professionals.
- **Consumer/Family Involved** – Services and supports delivered by professionals that include formal protocols for ensuring and enhancing the involvement of consumer and family members in the planning and delivery of the service.
- **Professionally Run and Delivered** – Services designed to be delivered by professionals within organizations run and operated by professionals.

BP Recommendation #4: Ground the promotion of specific best practices within a broader Evidence Based Culture. The increasingly common approach taken by many states of mandating the use of specific EBPs in and of itself has not necessarily led to improved outcomes and does little to help agencies, provider organizations, and communities understand how best to select and implement effective interventions. States that have been more successful in their implementation of EBPs have focused on the need for system and organizational infrastructures to support the implementation, broad dissemination, and ongoing scrutiny of evidence-based practices. Such infrastructures involve the policy, procedural, and funding mechanisms to sustain evidence-based interventions, and they need to be based in system and organizational cultures and climates that value the use of information and data tracking as a strategy to improve the quality of services and increase the likelihood of achieving desired outcomes (a data and learning-centered construct implicit in an array of constructs, including “learning organizations,” “continuous quality improvement,” and others). Some researchers use the term “evidence based culture” to describe the constellation of policy, procedural, and funding mechanisms in concert with a favorable culture and climate that support successful practice.

BP Recommendation #5: Develop Centers of Excellence to support the implementation of those best practices prioritized for statewide implementation.

There are increasing efforts by states to develop their own local “centers of excellence” (COE) to provide ongoing sources of expertise, evaluation, training, and guidance to support the initiation and ongoing development of EBPs and promising practices. While there are no definitive studies yet available of what factors best support system-wide EBP promotion, emerging research suggests that states implementing COEs are further along in EBP promotion than those that do not. Washington State has its own emerging COEs through its comprehensive contract with the Washington Institute for Mental Illness Research and Training to develop ACT capacity statewide and the children’s mental health evidence-based practice institute at the University of Washington established under House Bill (HB) 1088. The critical components of COEs for promoting EBPs

include: training, ongoing technical assistance and support, quality improvement and fidelity tracking, outcome monitoring, and dedicated staff for each EBP promoted.

BP Recommendation #6: Develop encounter coding protocols to allow MHD and RSNs to track the provision of other best practices. Currently, the service codes used for encounter reporting lack the specificity needed to differentiate best practices, complicating the promotion of best practices by providing the same reimbursement across different types of best practices, providing the same reimbursement for generic and best practices, limiting the ability of MHD to monitor best practice availability, and limiting the ability of actuarial analysis to factor in the additional costs incurred by the delivery of best practices that require specialized training, reduced productivity, and/or fidelity monitoring. We recommend that MHD develop additional HIPAA-compliant encounter coding modifiers so that all best practices of interest within the public mental health system are tracked, using a mix of coding strategies, including procedure codes, procedure code modifiers, and program codes identifying specific groups of individual providers within agencies. In addition, protocols governing the use of these codes will need to be defined and enforced.

Recommended Priority Best Practices

To prioritize among the 41 best practices analyzed in this report, criteria were developed that included balancing of the selection of best practices across age groups (children, adults, and older adults) and each best practices' documented potential to reduce inappropriate use of restrictive services (inpatient and residential), promote cross-system integration, support culturally relevant and competent care, and facilitate recovery for adults and resilience for children and their families. These criteria were used to identify five priority practices.

BP Recommendation #7: MHD should prioritize three to five of the following best practices for statewide implementation:

- **Peer support services provided directly by Consumer and Family-Run Organizations,**
- **Integrated Dual Disorder Treatment (IDDT)** for persons with severe co-occurring mental health and substance use disorders,
- **Wraparound Service Coordination** for children with severe emotional disturbances and their families who are served by multiple state agencies,
- **Multidimensional Treatment Foster Care (MTFC)** for children needing intensive out-of-home services, but able to receive care safely in a family-based setting, and
- **Collaborative Care in Primary Care Settings** for populations, such as older adults, most effectively served by mental health clinicians located in primary care settings.

To guide MHD and other stakeholders as they seek to determine the feasibility of implementing these services, TriWest has developed a unit cost methodology for estimating their potential costs. This model was based on the approaches described in the June 2005 Rate Certification by Milliman, Inc., and the approach and specific

applications were reviewed in with the actuarial team. Key cost findings based on this model for the five practices are presented below.

Consumer and Family Run Services – We recommend that Washington State establish a new provider type under an amended 1915(b) waiver authority modeled on the State of Arizona’s certification model for providers of “non-licensed behavioral health services” referred to as Community Service Agencies (CSAs). CSA staff members providing services covered by Medicaid must meet the same criteria that staff in more traditional provider settings must meet (such as experience and supervision requirements) for any specific service type provided. The primary service type that we recommend covering is Peer Support. Experience, supervision, and documentation requirements in Washington’s State Plan and state-level regulations would need to be met.

We estimate that the cost per unit of Peer Support delivered through a CSA is comparable to that delivered currently through a community mental health agency (CMHA). We therefore believe that the service costs for this modality were already added to the system based on Washington’s 2005 actuarial study. However, adequate costs to promote the infrastructure necessary to develop CSAs were not. This may very well be a contributing reason to why current levels of peer support provision by most RSNs remain below expectations.

Expanding the current peer specialist certification program into a COE able to promote the provision of Peer Support across an expanded group of potential providers (both CMHAs and the new CSA providers) could help bring Peer Support service delivery up to the levels factored into the current rates. We estimate that this would cost \$425,000 a year and be able to be covered within the Medicaid program, therefore requiring \$215,000 in state expenditures (to cover the Medicaid match). Further assuming that replacing the \$150,000 in federal block grant funding currently spent on Peer Support training could free up State General Funds currently going to pay for other purposes (and thereby allow these State General Funds to be shifted to other mental health priorities), the annual costs would be reduced to \$65,000.

Integrated Dual Disorder Treatment. Integrated Dual Disorder Treatment (IDDT) involves the provision of mental health and substance abuse services through a single treatment team for people with severe needs. We estimated the unit costs to provide IDDT to be \$780 per recipient per month. Looking only at the Medicaid-enrolled population (which does not include state-funded recipients or people who lose Medicaid coverage during periods of a spend-down), we further estimated that 1% of all Medicaid-eligible adults (ages 19 to 59) would be in need of IDDT services, yielding a projection of need for intensive IDDT services across all enrolled adults of 2,971 adults statewide per year. We also estimated the costs of implementing a COE to support this level of IDDT implementation. To serve 2,971 adults with IDDT, an estimated 37 teams would be needed (each serving 80 people, on average). If we assume that statewide implementation of IDDT will occur over a three year period (20 teams in Year One, 10 additional teams in Year Two, and 10 additional teams in Year Three), we estimate a total annual COE cost of \$460,000. We recommend building the COE support into the fee paid to providers given that it represents an additional cost incurred by IDDT providers in order to be certified by the COE as able to deliver IDDT services. As a provider cost, it can be included in the amount reimbursable by Medicaid.

Inclusive of all new costs and backing out anticipated cost offsets and the costs of current service provision, we developed a multi-year cost projection summarized in the table below.

IDDT Multi-Year Utilization Projection				
Variables	Year One	Year Two	Year Three	Year Four
Total Teams	20	30	37	37
Core Team Operating Costs	\$14,976,000	\$22,464,000	\$27,705,600	\$27,705,600
COE Costs	\$ 460,000	\$ 460,000	\$ 460,000	\$ 460,000
Total Cost	\$15,436,000	\$22,924,000	\$28,165,600	\$28,165,600
Average Medicaid Recipients Served Per Month	1,000	2,100	2,750	2,960
Medicaid Revenue (\$793 per person served per month)	\$ 9,516,000	\$19,983,600	\$26,169,000	\$28,167,360
Cost Offsets for Persons Served (\$513 per person served per month)	\$ 6,156,000	\$12,927,600	\$16,929,000	\$18,221,760
Additional Medicaid Costs (Revenue minus Offsets)	\$ 3,360,000	\$ 7,056,000	\$ 9,240,000	\$ 9,945,600
Additional State-Only Funding Needed (Total Cost minus Medicaid Revenue)	\$ 5,920,000	\$ 2,940,400	\$ 1,996,600	\$ -

Wraparound Service Coordination. Wraparound Service Coordination is an intervention designed to coordinate a set of individually tailored services to a child and their family using a team-based planning process. It is important to keep in mind when reviewing the cost analysis provided that Wraparound is not a treatment in itself, but is instead a coordinating intervention to ensure the child and family receives the most appropriate set of services possible. To estimate unit costs, we used the staffing model used by Wraparound Milwaukee, a national benchmark program, yielding an estimated unit cost of \$790 per month. To estimate potential utilization, we averaged estimates from three RSNs currently delivering a version of Wraparound (Clark, Greater Columbia, King) to yield the projection of 0.56 percent of Medicaid-enrolled children (9.1% of children served) or 3,143 children statewide. This estimate compares favorably with information compiled by MHD regarding the number of children with intensive service needs (December 2006 analysis by MHD based on FY2004 data). We estimate the average utilization per user to be 16 months, based on information from national experts (B. Kamradt, M. Zabel), so the total number of service recipients once the program is fully up and running will be 4,191 (one and one-third times the annual need). In addition, we estimate that it would add an additional \$13 per recipient per month to cover the costs of a statewide Center of Excellence to support delivery of Wraparound. The total cost to deliver Wraparound to a single child per month is therefore \$806 in our model (\$793 for the core service and \$13 for the COE support). The cost per recipient is offset by expected reductions in MHD inpatient and residential costs currently incurred in the system totaling \$63 per recipient per month. This estimate likely significantly understates the potential cost savings.

Furthermore, this estimate only covers the Medicaid-reimbursable costs associated with the intervention. It does not include additional funds for ancillary supports critical to the successful implementation of Wraparound, such as flexible funds (which we would

estimate at an additional \$500 per family per year, which would not be reimbursable under Medicaid), transportation supports, and direct services provided to family members of the covered child.

Based on this, the costs to develop teams and provide Wraparound Service Coordination per year varies by year of implementation as a function of the number of teams implemented each year. The amount of Medicaid revenue that can be earned by each team to support both program and COE costs is a function of how quickly each team can ramp up to full capacity. Assuming that it takes nine months for each team to ramp up to full capacity (serving no people in month one, then adding 8 people a month through the end of month nine), 62.5% of costs for each team in their first year of operation can be covered by Medicaid costs (assuming 100% of people served have Medicaid coverage), summarized in the table below.

Wraparound Service Coordination Multi-Year Utilization Projection				
Variables	Year One	Year Two	Year Three	Year Four
Total Teams	22	44	65.5	65.5
Core Team Operating Costs	\$13,339,480	\$26,678,960	\$39,715,270	\$39,715,270
COE Costs	\$ 500,000	\$ 500,000	\$ 500,000	\$ 500,000
Total Cost	\$13,839,480	\$27,178,960	\$40,215,270	\$40,215,270
Average Medicaid Recipients Served Per Month	880	2,288	3,676	4,191
Medicaid Revenue (\$806 per person served per month)	\$ 8,511,360	\$22,129,536	\$35,554,272	\$40,535,352
Cost Offsets for Persons Served (\$63 per person served per month)¹⁷	\$ 665,280	\$ 1,729,728	\$ 2,779,056	\$ 3,168,396
Additional Medicaid Costs (Revenue minus Offsets)	\$ 7,846,080	\$20,399,808	\$32,775,216	\$37,366,956
Additional State-Only Funding Needed (Total Cost minus Medicaid Revenue)	\$ 5,328,120	\$ 5,049,424	\$ 4,660,998	\$ (320,082)

¹⁷ This figure does not include significant cost-offsets in inpatient, residential and institutional services delivered by CA, JRA, and DASA. Cost-offsets are therefore likely underestimated by a significant factor.

Multidimensional Treatment Foster Care (MTFC). The selection of MTFC as a priority for statewide development centered on the need for additional mental health out-of-home treatment capacity. MTFC is a type of therapeutic foster care provided to children and youth living with foster parents or for families who require an intensive period of treatment before reunification. That being said, it is not clear that the MTFC should be implemented in all instances with rigid adherence to the parameters articulated by its purveyor, TFC Consultants, Inc. It seems critical from our discussions with MHD and Children's Administration (CA) staff closely involved with the current MTFC pilots that some additional flexibility in the model is needed, particularly in terms of the purveyors' insistence that the model operate with 10 beds. To be of use in more rural areas, it seems important that the model be able to operate with fewer beds (i.e., 5 bed models). Given the importance that family-based interventions be carried out close enough to parents and caregivers that they can be regularly involved, allowing smaller programs in rural areas seems preferable to larger programs located further from families.

MHD is currently estimating costs for MTFC in its Kitsap pilot at \$184 a day. Of these costs, approximately half (\$92) is reimbursable by Medicaid (half of which is funded by the State and half of which is federal financial participation) and the remaining half (\$92) must be paid entirely with State Funds. We are recommending that this service be paid for entirely by MHD in order to spare families the need to coordinate with yet another agency. This assumes that, if families are already involved with CA, CA will cover the costs of needed out-of-home care (outside of the cost estimates in this report). The cost estimates in this report cover only the costs of MTFC delivered by RSNs to mental health consumers not involved with CA. We realize that in many cases out-of-home costs are currently split by CA and RSNs. We have attempted to factor this into our cost-offset calculations by estimating reductions in the use of the portion of these services replaced by the MHD-funded MTFC.

Based on discussions with MHD and CA staff, we projected three utilization scenarios:

- Low Range: A primarily acute care model with 105 beds (five 10-bed programs, plus 11 5-bed programs for smaller RSNs) and ALOS of 6 months.
- Mid-Range: An acute and intermediate stay model with 165 beds (seven 10-bed programs, plus 13 5-bed programs for smaller RSNs) and ALOS of 7.5 months.
- High Range: A more intermediate-term care model with 230 beds (18 10-bed programs, plus 10 5-bed programs for smaller RSNs) and ALOS of 9 months.

The total cost to deliver MTFC to a single child per month in all of the scenarios is \$2,798 per recipient for Medicaid treatment (\$92 per day times 30.4 days per month), \$2,798 per recipient for State funds to support room and board (\$92 per day times 30.4 days per month). The cost per recipient is offset by expected reductions in the costs of currently delivered outpatient services, plus reduced MHD inpatient and residential costs currently incurred in the system, totaling \$1,124 per recipient per month. This estimate likely significantly understates the potential cost savings. In addition, the cost analysis assumes that first year training and fidelity monitoring costs (inclusive of consulting costs and travel) will be \$50,000 for each 10-bed team (\$25,000 for 5-bed teams, assuming that two 5-bed teams meet jointly with the consultants). Second year and following costs are assumed to be \$10,000 for each 10-bed team (\$5,000 for 5-bed teams, again assuming that two 5-bed teams meet jointly).

Based on our analysis, the costs to develop and provide MTFC per year varies by year of implementation as a function of the number of teams implemented each year. The number of teams needed, persons served by the end of the six year implementation schedule, potential cost offsets, and total costs are summarized in the table below for each of the three estimates.

MTFC Multi-Year Utilization Projections			
Variables	Low Range	Medium Range	High Range
Total Teams in Year Six	16	20	28
Full (10 beds)	5	7	18
Half (5 beds)	11	13	10
Total Cost in Year One	\$1,443,200	\$1,443,200	\$3,968,800
Total Cost in Year Six	\$7,156,800	\$9,201,600	\$15,676,800
Average Medicaid Recipients Per Month in Year Six	105	135	230
Medicaid Cost Offsets in Year Six (\$1,124 per person served)	\$1,416,240	\$1,820,880	\$ 3,102,240
Additional Medicaid Costs in Year Six (Revenue minus Offsets)	\$1,306,942	\$1,680,354	\$ 2,862,825
Additional State-Only Funding Needed in Year Six (\$92 per person served per day, other costs)	\$4,433,618	\$5,700,366	\$ 9,711,735

Collaborative Care in Primary Settings. Collaborative Care is a model of integrating mental health and primary care services in primary care settings. If RSNs are to deliver Collaborative Care, the primary barrier will be the current Access to Care Standards (ACS) that prohibit the delivery of mental health services to people with functional impairments in the moderate (above a GAF/C-GAS score of 50) to mild (above a GAF/C-GAS score of 60) range, depending on diagnosis. A core premise of the delivery of Collaborative Care is that mental health services be provided in primary care settings with minimal barriers. In order to overcome the barriers to the effective delivery of mental health services in primary care settings, mental health clinicians must be willing to take all referrals and not attempt to exclude any persons referred based on functioning.

Much of the leading research nationally related to Collaborative Care is currently conducted by faculty at the University of Washington's Department of Psychiatry and Behavioral Services and Department of Family Medicine. The costs to establish a Center of Excellence for Collaborative Care would depend on the number of sites being implemented. We estimate that a budget of approximately \$300,000 would be needed to support the development of 10 teams across the state.

The unit costs for Collaborative Care are comparable to those already reimbursed in the system. The primary driver of any cost increases if Collaborative Care is promoted would be increased utilization of services. We would not expect any measurable cost offsets within the mental health system attributable to the provision of Collaborative Care, though more effective treatment of depression (the diagnosis most frequently targeted for improved service delivery with older adults in Collaborative Care models) would very likely decrease the use of other health care services. People suffering from depression

who are receiving services through the primary care system use three to four times as many services for physical health complaints as people without depression.

Given that current data on unmet mental health needs in primary care settings and the potential cost-offsets in primary health care services costs were not available to this project, it is not possible to give a precise estimate of potential costs for expanded delivery of Collaborative Care in primary care settings. However, we believe that the potential cost increases would likely be in the range of other analyses to expand access for the delivery of mental health care to broad populations such as the recent expansion of Healthy Options and fee-for-service benefit limits. Adding these costs to those estimated for a COE to support Collaborative Care, we would estimate the costs of initial Collaborative Care efforts to range between \$1.1 million to \$2.5 million annually.

Other Priority Services. In addition to these five priority services for which we completed comprehensive cost estimates based on the unit cost methodology, the report recommends the continued delivery and development of the following best practices by MHD:

- Supported Employment for adults with serious mental illness,
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT) for children and adolescents,
- Parent-Child Interaction Therapy (PCIT), and
- Multisystemic Therapy (MST).

BP Recommendation #8: For any best practices promoted statewide and paid for under Medicaid, conduct a formal actuarial analysis of costs prior to implementation and conduct additional analysis at the end of each year to determine if RSNs have developed the funded services. For any RSN that has not provided the level of targeted best practices that was funded, the difference between the documented costs incurred for targeted best practice services provided and the amount allocated should be paid back to MHD and the federal portion paid back to CMS.

The cost analyses included in this report were never intended by MHD or TriWest Group to be a substitute for actuarial analysis of any change in benefit funding eventually undertaken.

In addition, one of the risks in funding services prospectively through capitation payments is that the services funded may not be delivered. We recommend that DSHS allocate additional actuarial time to MHD to allow for analysis of these factors. The specific analyses should be identified and priced by the actuarial contractor prior to carrying them out.

Recommendations Based on Medicaid State Plan Analysis

Washington's Medicaid managed mental health care system has undergone several significant developmental changes since 2002. These include development of the Access to Care Standards and significant changes to the State Medicaid Plan in 2003 in response to critical reviews from the Center for Medicare and Medicaid Services (CMS), as well as implementation of an External Quality Review (EQR) process in 2004. They also include the enhanced oversight and standardized managed care requirements for RSNs established legislatively by E2SHB 1290 and the 2005-06 RSN procurement process.

The Current Federal Climate. These changes also took place in the context of wider changes at the federal Center for Medicare and Medicaid Services (CMS) that affected all states delivering Medicaid managed care services. These included: August 2002 changes in the required rate calculation methodology from upper payment limits (UPL) to actuarially sound rates, enhanced quality standards for managed care plans set by the Balanced Budget Act of 1997 (implemented in August 2003 under 42 CFR 438), enhanced scrutiny of rehabilitative services, and additional scrutiny under the Deficit Reduction Act of 2005. This federal context was particularly relevant to the development of two system features that are a major focus of this report: (1) The current 18 modalities defined under the Rehabilitative Services section of Washington's Medicaid State Plan, which were developed in response to CMS concerns expressed immediately following the shift from the UPL rate methodology to the actuarially sound rate requirements, and (2) The Access to Care Standards which govern both eligibility and medical necessity determinations for the current Medicaid system, which were developed in response to a contingency from CMS on Washington's 2001 waiver renewal.

Washington's Current Medicaid Managed Care System. Washington's Medicaid mental health benefit is primarily structured by four components from Washington's Medicaid State Plan: Inpatient Hospital Services, Under 21 Inpatient Services, Physician Services, and Rehabilitative Services. The primary focus of the RSN's PIHP programs is the 18 Rehabilitative Services modalities. In addition to the State Plan services, Washington is able to provide three additional non-traditional service types defined within its waiver under the authority of Section 1915(b)(3): Mental Health Clubhouse, Respite, and Supported Employment.

Comparisons with Other States: Arizona, Colorado, New Mexico, and Pennsylvania. Four states were selected for comparison to Washington that, across their various features, represent most of Washington's current system components. These states also allow us to look at Medicaid benefit designs funded at levels comparable to Washington's (AZ and CO), as well as much lower (NM) and much higher (PA). That being said, several structural features are unique to Washington:

- Washington's eligibility requirements include the DC:0-3 standards for infants and toddlers, allowing more diagnostic flexibility for early childhood mental health needs.
- Washington is the only state of the five that imposes functional impairment requirements as a means of determining service eligibility. Other states incorporate impairment scores such as the GAF into discrete level of care

guidelines for medical necessity, but none require such impairment for entry into the system.

- Washington is the only state of the five (and the only 1915(b) waiver state of which we are aware) that holds its managed care organizations to be at-risk for acute inpatient care, but only requires them to coordinate the delivery of such care, rather than directly deliver the service through their regional networks.
- Washington operates independent managed care plans with very relatively few covered lives, including four regions with fewer than 25,000 lives and six with fewer than 60,000. Of the comparison states reviewed, none operate regions with fewer than 40,000 covered lives and only Colorado operates regions with fewer than 60,000 lives.

Medicaid State Plan and Waiver (MSP&W) Recommendation #1: Do not propose any changes to CMS regarding the structure of Rehabilitative Services within Washington's Medicaid State Plan. Our analysis of Washington's State Plan found that the language of the 18 Rehabilitative Services modalities is sufficiently flexible to promote all of the prioritized best practices summarized in the previous major section of this report. Furthermore, in light of the enhanced scrutiny of Rehabilitative Services that CMS has engaged in over the last two years, resulting in actions by CMS in dozens of states either limiting service flexibility or disallowing current costs under their Rehabilitative Services option, we do not recommend proposing any State Medicaid Plan change to CMS involving Rehabilitative Services. However, if CMS adopts new regulations for Rehabilitative Services under development at the time of this report (July 2007), Washington State will need to revisit the need for possible State Plan changes to respond to those regulations.

While no changes are currently recommended in the language of Washington's Medicaid State Plan, we offer several recommendations regarding implementation of the State's 1915(b) Waiver.

MSP&W Recommendation #2: Develop statewide standards for continuing care and discharge under ACS in order to shift the utilization management focus of RSNs from front-end restrictions for all enrollees to proactive care management of services for enrollees with intensive, ongoing needs. This will require the development of statewide medical necessity standards for all levels of care, including criteria for initial and concurrent reviews. It is our opinion that Washington's current waiver, combined with the Balanced Budget Act of 1997 requirements under 42 CFR 438 implemented in Washington under E2SHB 1290, gives MHD the authority to proceed with more refined and standardized implementation of the ACS for the Medicaid benefit. The current implementation of the standards is problematic, particularly their exclusive focus on front-end access to care in general and their lack of (1) standards for continuing access, (2) differential criteria for access to levels of care more intensive than routine outpatient, and (3) formal mechanisms whereby ACS numeric functioning score cut-offs can be overridden based on clinical assessment, medical necessity, and individual need.

The current ACS standards include only criteria for limiting front-end access across the board. As such, they are a crude tool for managing care, focusing utilization management resources almost entirely on front-end limitations to outpatient care and shifting the focus of utilization management too much toward management of low-intensity, low cost outpatient care rather than more expensive levels of care such as day services, long-term

case management, and residential services. Other states and their managed care organizations (MCOs) have generally evolved the focus of their utilization management activities away from across-the-board front-end restrictions in order to focus limited care management resources on more expensive services. This approach has generally been found to be more cost-effective over time, with any increase in service use more than offset by: (1) better use of utilization management resources for high-end cases, (2) savings through earlier intervention, and (3) reductions in the cost of managed care oversight.

MSP&W Recommendation #3: Prior to the next waiver submission, conduct a full actuarial analysis of the financial impact of revising GAF and C-GAS minimums for routine outpatient care. If financially feasible, raise the GAF and C-GAS minimums to at least 70 for all covered diagnoses. Currently, there is no substantive mental health benefit for Medicaid enrollees outside of the Healthy Options program, an important subgroup since all disabled adults fall outside the Healthy Options program. The most efficient way to extend coverage to these individuals would be to relax the functional requirements for ACS. The primary barrier is that this is likely to cost more money. If these criteria are relaxed, multiple informants reported that there would be a significant increase in referrals to RSNs. However, given recent benefit changes for these programs (the recent expansion of Healthy Options and fee-for-service benefit limits from 12 to 20 visits annually and expanding the types of eligible providers), eligible providers in RSN networks are now able to provide these additional services. Therefore, it is not clear what additional costs would be entailed by integrating these fee-for-service benefits within the RSN structure.

MSP&W Recommendation #4: Revise Current RSN Contract Requirements for Statewideness and Provide Definitive Guidance to RSNs on Implementation. To better reflect all pertinent federal standards, we recommend that the language of the RSN contracts be revised from an emphasis on statewideness under 42 CFR 41.50 to an emphasis on network adequacy under 42 CFR 438.206 and 438.207. This will shift the focus of RSN requirements so that they must demonstrate how needs are documented and met, rather than simply document that the network includes a provider from somewhere in the state that provides a given modality.

Appendix 2

Housing Plan Executive Summary



Mental Health Housing Action Plan

Executive Summary

October 2007

Prepared by:

Common Ground

With assistance from:

Building Changes *(formerly known as AIDS Housing of Washington)*

Executive Summary

The Mental Health Housing Action Plan is a component of the System Transformation Initiatives, a package of budget and policy initiatives, passed in the 2006 Legislative Session. The Plan addresses one critical element of the high utilization of Eastern and Western State Hospitals: the lack of appropriate community-based housing for people with mental illnesses.

Underlying Philosophy

Stable housing is an integral element of recovery for every individual with a mental illness. In a recovery-based system, there is an increased emphasis on consumer choice and a preference for housing models that promote independence. Every community in Washington State needs a range of housing options. Among the most effective housing alternatives that respond to the tenets of recovery is permanent supportive housing (PSH). There is solid evidence that providing community-based PSH is a cost-effective alternative to the revolving door of the street, shelter, emergency rooms, psychiatric hospitals, jails, and prisons.

Target Population

People currently served by the public mental health system (primarily adults with schizophrenia, bipolar disorder, or major depression and children with serious emotional disturbances) are the target population for this housing, including those receiving Medicaid-supported services through the Prepaid Inpatient Health Plans (PIHP) contracts with RSNs and those receiving crisis response, Program of Assertive Community Treatment (PACT) services, or Program for Adaptive Living Skills (PALS) alternative services through state-only funds contracted through RSNs.

In 2007, the estimated unmet need for community-based housing for people served in the public mental health system is approximately 5,000 units. This number includes single adults, families where a parent has a mental illness or a child has a serious emotional disturbance, and seniors.

Initially, the majority of units will be created in RSNs with the largest populations of people with mental illnesses and the highest utilization of state hospitals. Approximately 65–70 percent of the units are targeted for single adults, 20–25 percent for families, and 10–15 percent for seniors.

Approximately 70 percent of the units will target people who are served by the public mental health system and are homeless, many of whom are individuals or families with a history of cycling through the streets, shelters, hospital emergency rooms, jails, and/or local and state hospitals. The definition of homeless includes people who are on the street, in a shelter or transitional housing, or who are discharged from a state or local institution without housing.

Gaps and Barriers

The RSNs, providers, and consumers who contributed to this plan agree that the key barriers to securing housing for people with mental illnesses include: a lack of affordable housing stock; insufficient case management services; histories of poor credit or felony convictions; cultural and language barriers; insufficient prevention and crisis management services; and incompatible or uncoordinated policy and resource decisions among public agencies at the state and local level. The Plan includes strategies to address these barriers.

Housing Model

This Plan addresses the largest gap in the housing options for people with mental illnesses, the lack of PSH available and affordable to mental health consumers. The Plan proposes 760 units of PSH to be created and placed in service between 2007 and 2010, including 500 units developed through acquisition and rehabilitation or new construction, and 260 units leased from existing housing stock and made affordable with rent subsidies. The Plan also proposes an additional 1,600 units of PSH by 2015, including 1,050 units acquired, rehabilitated or built, and 550 units that are leased from existing housing stock.

The basic model combines an apartment or single-family home leased by the consumer with flexible supporting services. Services are titrated to meet individual needs and are provided in home and community settings. Features of successful PSH models include: case manager caseloads of 1:8–1:15; consumer and landlord access to case management staff 24/7; landlord access to risk mitigation funds that cover any excess costs related to renting to people with mental illnesses; and consumer access to short-term respite care, if the consumer's illness spikes, without loss of his or her apartment.

One type of PSH that has been demonstrated to be successful for people whom the more traditional housing and service models have failed is Housing First. The model moves people directly into housing and then begins engagement for supporting services. While there is a rich package of services available, participation is not required to secure housing.

Because the Plan proposes over 700 units come from existing housing stock, there is a need for landlord incentives to address traditional barriers for people with mental illnesses. Key elements include landlord access to service staff 24/7, option of master leasing units to a mental health provider, and access to a risk fund that pays for any extra costs related to unit damage or higher than expected turnover and/or eviction costs. An operating subsidy/landlord incentive/risk mitigation fund is included in the Plan.

2007–2010 Financing Requirements for 760 Units

The estimated capital financing for the bricks and mortar of 500 units is \$115 million (at an average cost per unit of \$220,000 in 2007; estimated costs are adjusted for inflation through 2010). Approximately 60 percent of the capital funds for the 500 units are committed. There are sufficient capital dollars available within current allocations to support the remaining capital costs, **if** rent subsidies and service funds are secured to assure affordability of the housing for people with limited incomes over the 40–50 year period required by public capital financing sources.

The total cost of rent subsidies for 760 units is estimated at \$7.3 million, based on an annual subsidy of \$6,500 per unit. There may be sufficient rent subsidy available within existing resources to cover these. However, the subsidy sources are oversubscribed and housing for people with mental illnesses must compete with housing for many other deserving populations. The Plan assumes that 65 percent of the 760 units will receive rent subsidy from existing sources, leaving a gap of \$2.8 million for the remaining 35 percent (260 units).

The cost of operating subsidies (a.k.a. landlord incentives/risk mitigation funds) for excess costs related to renting to mental health consumers is modeled at \$3.8 million for the 2007–2010 period and based upon \$1,200/unit per year.

The residents of all 760 units will require supporting services, estimated at \$14.9 million for 2007–2010. The range of service costs in PSH projects is \$3,000 to \$15,000 per year in 2007. In this Plan, the services costs are modeled using \$8,000 per year for single adults and \$10,000/year for families.

For those units housing people with PACT (450 units) or some of PALS alternative services (30 out of 100), current funding is sufficient to support the PSH model. The remaining 280 units require \$2.69 million worth of supporting services. Determining how much of that is available within current funding levels for RSNs is beyond the scope of this Plan. However, it is clear that 1) RSNs/providers do provide PSH to some PIHP consumers now; 2) providing services in home and community settings, as required for PSH, does replace some or all clinic-based mental health services for the consumer (all in the case of PACT); 3) the cost of providing home or community-based services is higher than for clinic-based services; and 4) there are not sufficient service dollars available for people in the target population who are not enrolled or not yet enrolled in the PIHP, PACT, or PALS alternative services.

2011–2015 Financing Requirements for 1,600 Units

The 1,600 units proposed to be created in 2011–2015 will require additional capital, rent subsidy, and service dollars, both from increases in existing sources and from new sources. Two sources that may provide more resources for PSH and should be explored are the Criminal, Educational, Penal, and Reformatory

Institution Trust Fund (CEP&RI) and the .1 percent local sales tax for mental health services. The estimated capital cost for the 1,050 units proposed by 2015 is \$284 million. The estimated costs for operating and maintaining 760 units created between 2007–2010 and phasing in an additional 1,600 units over the 2011–2015 period are estimated at \$26.5 million. The estimated service cost to maintain the 760 units and phase-in an additional 1,600 by 2015 is \$55 million. The operating subsidy/landlord incentive/risk mitigation fund for the total 2,360 units phased in by 2015 is \$14 million.

Implementation Steps

Key 2007–2008 action steps to implement the Plan include:

- Promote the creation of PSH at the RSN and local level by providing best practice information on models, partnerships, and financing; funding technical assistance to build the capacity of RSNs to support and mental health providers to develop and manage PSH; building new partnerships and resources for PSH; and proposing additional funding where appropriate.
- Ensure PHP benefit design includes flexible modality for services in home and community settings and that the rate is sufficient to cover costs
- Suggest standards for RSNs to determine the number of crisis respite beds needed to cover both step-down (from hospital settings) and step-up (from community-based housing) needs. Identify additional funding for crisis respite beds if necessary.
- Identify any additional service dollar needs to meet PSH model requirements for units to be placed in service by 2010. Identify additional operating or rent subsidy requirements for units to be placed in service by 2010. Finalize the landlord risk mitigation program and financing requirements. Consider developing a joint PSH funding proposal with CTED for 2009 Governor and Legislature consideration.
- Explore the use of the Charitable, Educational, Penal, and Reformatory Institutions Trust fund to support the creation of more PSH for mental health consumers
- Review the physical building conditions and services in all licensed residential facilities funded for mental health consumers statewide and ask RSNs to establish long-term plans for maintaining, rehabilitating and/or replacing units with PSH.
- Develop a closer working relationship with CTED’s Housing Division. Opportunities for closer collaboration include, at least, adding MHD housing staff to key housing advisory committees; coordinating technical assistance and pilot project funding for PSH; adding MHD consultation into the CTED funding decisions on projects with units for people with

mental illnesses; investigating opportunities to more effectively tap state Housing Trust Fund, 2060 Operating and Maintenance funds, State Housing Grant Assistance Program (HGAP) and other CTED resources; and investigating options to allow people leaving state hospitals, without housing options, to be eligible for homeless housing units.

- Capitalize on the opportunities offered through the Governor's Mental Health Transformation Grant to further the design and delivery of the landlord incentive package and peer support for PSH.
- Collect data at RSN/provider level and publish an annual statewide report on the housing status and tenure of all consumers served in the public mental health system.

Appendix 3

ITA Executive Summary

Statewide Transformation Initiative
Involuntary Treatment Act (ITA) Review

Final Report

Submitted to

*The State of Washington
Department of Social and Human Services
Health and Recovery Services Administration
Mental Health Division*

June 29, 2007



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Executive Summary

Involuntary treatment, including civil commitment, is perhaps the most divisive and controversial topic within the mental health stakeholder community. Within Washington State, stakeholders present a broad range of strongly-held and often conflicting viewpoints – ranging from the belief that involuntary treatment should never be imposed to the view that involuntary treatment should be provided whenever mental health professionals believe that a person is in need of treatment and the person is unwilling to receive treatment voluntarily.

Primary Findings. Despite this range of opinions, however, many stakeholders share certain important beliefs about civil commitment in Washington. In particular, a broad range of stakeholder groups believe that:

- The use of involuntary treatment is not always unavoidable. The use of detention and civil commitment would decline, and lengths of stay for people who are civilly committed would decrease, if Washington State would develop effective alternatives to involuntary treatment.
- The actual statutory language of Washington’s involuntary treatment laws has less impact on the use of civil commitment than other factors, especially insufficient access to community mental health services and a lack of residential crisis alternatives.

There is no “model” statute or approach to civil commitment that is implemented by a majority of States. Rather, every State has a unique set of definitions and criteria based on the State’s specific policy objectives and available resources. Nonetheless, a review of statutes from a sample of comparison States suggests the following about Washington State’s Involuntary Treatment Act (ITA) for adults, which is found at §71.05 of the Revised Code of Washington (RCW):

- **Definition of “mental disorder.”** Washington’s statutory definition of “mental disorder” is broader than that of most other States in that it is not limited to specific diagnoses or types of mental illness and does not specifically exempt certain categories of impairments such as developmental disabilities.

Many stakeholders in Washington State – including a consensus of those serving on the Task Force providing guidance to this project – expressed concern that this broad definition results in the civil commitment of people who may not be best served in a psychiatric setting. Specifically, they noted that certain populations, such as people with dementia, traumatic brain injury, or developmental disabilities may not benefit from inpatient psychiatric treatment and might be better served in other settings.

The statutory definition of “mental disorder” could be narrowed to include only certain mental illnesses or to exclude specific conditions, such as developmental disabilities, traumatic brain injury, or dementia.

- **Definition of “gravely disabled.”** Washington is among approximately half of States that permit civil commitment under a “gravely disabled” or similar standard based on the person’s need for treatment as perceived by professionals or others. Washington’s definition of “gravely disabled” includes a person who is experiencing severe deterioration in routine functioning, as evidenced by repeated and escalating loss of cognitive or volitional control, and who is not receiving care that is essential for their health or safety.

This law could be amended to permit civil commitment only when a person is a danger to themselves or others and is unable to care for their essential human needs such as food and shelter. As an alternative, the law could be modified to permit civil commitment only when a person meets existing gravely disabled criteria *and* their judgment is so impaired by their mental illness that they are unable to make an informed decision about their own treatment. Another possible approach would be to permit commitment only when the person’s deterioration is likely to result in their meeting other civil commitment criteria (danger to self or others) and/or hospitalization.

Some consumers and advocates support modifying this law to narrow the grounds for civil commitment, but most stakeholders indicated that this is not as important to them as developing an effective community-based system of care that would minimize the need for involuntary treatment. Many stakeholders, including providers, family members, and prosecutors experienced with civil commitment, oppose modifications to this law.

Age of Consent for Minors. Some parents of minor children and inpatient providers have proposed changes to §71.34.500 and §71.34.530, which permit minors over 13 years to seek and receive mental health inpatient and outpatient treatment without the consent of their parents. Many States have similar laws permitting minors to access mental health and/or substance abuse treatment without the consent of their parents. The actual age of consent varies from State to State, with many States permitting minors to consent to mental health treatment and/or substance abuse treatment at the age of 16, 14, or even 12.

In Washington, concerns about the age of consent appear to be linked most directly to minors’ ability to *refuse* treatment even when their parents and mental health professionals believe it is in their best interests. One option to address these concerns is to increase the age of consent to mental health treatment, but consequences of this approach may include dissuading some minors from seeking

treatment. A second option would be to permit parents, in consultation with providers, to initiate treatment for minors, with a separate process to ensure that treatment is medically necessary and consistent with the minor's legal rights.

In fact, a law designed to accomplish this exists at RCW §71.34.600, but it is seldom used. Parents and providers suggested that this law is not used for a number of reasons, including that most parents are unaware of the law and providers are not clear about the rights of minors under the law and how minors can access the legal system if they object to treatment. More research is needed to better understand why parent-initiated treatment is not used before more sweeping options, such as increasing the age of consent, are considered.

Other Issues Outside the Scope of This Study. Stakeholders expressed several additional concerns related to the ITA that are outside the scope of the current review. The most important of these is the statutory procedure for the involuntary administration of psychotropic medications, which a broad range of stakeholders agree should be examined and possibly reformed.

Before implementing any changes to the ITA or other involuntary treatment laws, Washington should consult with and carefully consider implications for consumers and other service systems, including criminal justice, developmental disabilities, aging, and long term care.

Appendix 4

UM Executive Summary

Washington Inpatient Utilization Management Project

For the Washington State Division of Mental Health
Systems Transformation Initiative

July 2007
FINAL REPORT
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EXECUTIVE SUMMARY

As part of its Systems Transformation Initiative (STI), the Mental Health Division (MHD) contracted with University of Washington at Harborview Medical Center (HMC) to undertake a study of current utilization management (UM) practices in state and community hospitals that care for Medicaid and other state-funded consumers. For purposes of this study, UM is defined as the standards and procedures used to ensure appropriate use of publicly funded mental health resources statewide. This summary represents the key findings and recommendations of the study.

A key factor in recovery-oriented systems is that services are available to individuals that are oriented toward recovery. UM principles are based on a continuum of care being available to an individual. We articulate these principles in the report with the concept:

“Giving the right service, in the right place, for the right amount of time.”

Utilization Management Tools

Four instruments were identified as potentially suitable to use as a standardized tool for determining medical necessity for hospital admission and continued length of stay review. They represent best practices in that they have known psychometric properties. This is not a comprehensive list, but rather an introduction to a limited number of commercial and public domain products available. Commercial products include InterQual¹⁸ and Milliman Care Guidelines.¹⁹ Public domain products include Level of Care Utilization System (LOCUS) (Adult Psychiatric and Addiction Services, 2000)²⁰ and Brief Medical Necessity Scale.²¹

Review of Utilization Management in Washington State

The state MHD manages two state hospitals that provide inpatient psychiatric services for adults: Western State Hospital (WSH) and Eastern State Hospital (ESH). Additionally, the MHD manages the Child Study and Treatment Center (CSTC) for children who require inpatient level of care. MHD has a contractual relationship with 13 Regional Support Networks (RSNs) to manage community outpatient services as well as provide utilization oversight of the psychiatric beds in community hospitals. Key informants from each of these entities were interviewed or surveyed to provide information about current UM practices. In

¹⁸ A sample of their product may be viewed at the following website: <http://www.interqual.com>.

¹⁹ Milliman: <http://www.milliman.com>. Washington State Milliman Consultant: vance.clipson@milliman.com.

²⁰ Sowers, W., George, C., & Thompson, K. (1999). Level of care utilization system for psychiatric and addiction services (LOCUS): A preliminary assessment of reliability and validity. *Community Ment Health J*, 35, 545-563. A sample of their product may be viewed at the following website: <http://www.comm.psych.pitt.edu/finds/LOCUS2000.pdf>.

²¹ Roy-Byrne, P., Russo, J., Rabin, L., Fuller, K., Jaffe, C., Ries, R., et al. (1998). A brief medical necessity scale for mental disorders: Reliability, validity, and clinical utility. *J Behav Health Serv Res*, 25, 412-424.

addition, descriptive data on patients currently served at state hospitals were compiled from databases maintained by the MHD through the Health and Recovery Services Administration (HRSA) of the state Department of Social and Health Services (DSHS).

Comparisons with Other States

As part of this study, we contracted with the TriWest Group to compare Washington State with Arizona, Colorado, New Mexico and Pennsylvania in the areas of: organization of the states' managed care systems, organization of involuntary treatment systems, and approaches to UM in community and state hospitals. Their detailed findings and recommendations are in Section VI of this report and in Appendix J. In brief, the comparison states review revealed several key themes:

- Unlike comparison states, the RSNs in Washington State do not directly contract with inpatient providers. Because of this, Washington's RSNs have fewer tools to manage inpatient utilization and expenditures.
- Washington State's current policy of holding RSNs accountable for all involuntarily admitted individuals, regardless of Medicaid status, challenges effective UM practices at the RSN level and is a system not found in other comparison states. Additionally, unlike other states reviewed here, Washington's ITA does not provide for outpatient court-ordered care.
- Unlike Washington, a number of comparison states have customized and comprehensive medical necessity criteria in place as guidelines for accessing inpatient care. None have been scientifically tested for validity or reliability so their actual utility is unclear.
- Like Washington State, comparison states do not have standardized UM procedures in place at their state hospitals.

Summary Key Findings

Lack of Consistency

- Results of key informant interviews revealed a lack of consistency in carrying out UM functions throughout the state.
- Multiple key informants identified the need for centralized UM leadership.
- Key informants representing community hospitals and RSNs expressed the need for a reliable and valid instrument for UM functions.
- UM data reporting methods are not consistent.

Need for More Data

- Multiple key informants report having questions that could be addressed if data were available.
- Analyses of administrative data raised questions about why some individuals have unusually long stays at state hospitals and why 27% of discharges from state hospitals are readmitted within one year of discharge, yet data to answer these questions were not available.

Barriers to Timely State Hospital Discharges

- Discharge barriers occur at all levels which prevent or slow discharge to the community, such as lack of placements for specialized populations, lack of structured residential placement, and lack of housing and services for unfunded consumers.
- RSNs are not penalized for consumers that remain in state facilities unless they exceed their allotted bed census—this may act as a disincentive for RSNs to develop community services.
- Discharge barriers are not being tracked and reported in a systematic way.

Recommendations-

Standardization of UM Processes, Data, and Leadership

- 1) Standardize UM criteria for pre-authorization and length of stay review. HRSA/MHD is launching a new initiative to standardize the processes, clinical elements, and forms, which the RSNs use for authorization and concurrent review. This will go into effect on August 1, 2007. Additionally, RSN authority to conduct utilization review (UR) is being reasserted and standardized across the state (WAC 3880-550-2600). We recommend that the standardization be extended to include objective criteria and this data be systematically collected.
- 2) Whatever instrument(s) are selected, it is essential that they provide data that can be maintained and analyzed by the MHD. For this to occur, the raw data must be freely available to the MHD.
- 3) Uniformly track data on discharge barriers across the state hospitals. A suggested list of key discharge variables for tracking and reporting to the MHD is offered in Appendix J.
- 4) The MHD is poised to develop a new data system interface with Provider One. This should be used to collect standardized data on initial admission authorizations, continued stay reviews, and discharge barriers for both community and state hospitals.
- 5) Statewide medical expertise is essential to a successful UM program. Consideration should be given by the MHD to hiring a Director of Inpatient Care Management or a Chief Medical Officer versed in public behavioral health UM.

Close Resource Gaps, Resolve Data Inconsistencies

- 6) The ability to effectively manage inpatient hospital length of stay will continue to be challenging. Serious study of each RSN's hospital diversion and discharge options must be conducted in order to forecast needed areas of development. The 2002, 2004, and 2005 Public Consulting Group, Inc.

(PCG) studies²² are still relevant and can be used as an immediate source of identified needs.

- 7) Conduct a root cause analysis of why, at times, there are discordant data reports between the MHD and some RSNs.

Enhance Management Processes for State Hospital Admissions and Discharges

- 8) A Dispute Resolution and Consumer Appeals panel should be established at each state hospital. Panel membership should include consumers and reflect recovery principles, as well as include RSN and hospital staff.
- 9) A new model that better aligns incentives for the development of community based options needs to be developed. Many of the resource options for long-term hospitalized patients are not under the control of the RSNs, such as adult family homes and skilled nursing facilities. For patients who do not meet the diagnostic criteria for MHD/RSN enrollment, other divisions of DSHS should share fiscal responsibility for continued hospital stay.
- 10) RSNs should take a more assertive role in reviewing each individual being considered for admission to the state hospitals on 90 or 180-day court orders.

Conduct Further Study

- 11) We recommend further study of the subset of state hospital patients whose extended stays account for a disproportionate number of bed days as it could inform efforts directed at reducing long lengths of stay.
- 12) We also recommend further study of individuals who are re-admitted to state hospitals or who enter community hospitals in the year following discharge from a state hospital. This is especially the case for individuals who are readmitted to inpatient hospital care multiple times in a one-year period. Further study could be done by analyzing information integrated from multiple databases and/or through a well-constructed annual chart review of those with re-hospitalizations. In either case, we recommend that readmissions be closely tracked and that this information be used to inform planning efforts to improve service to such individuals.

²² Brown, T., & Brimmer, K. (2002). Projecting the need for inpatient and residential behavioral health services for adults served by the Mental Health Division: Public Consulting Group, Inc.; State of Washington, Department of Social and Health Services, Mental Health Division.

Brown, T., & Brimmer, K. (2004). Capacity and demand study for inpatient psychiatric hospital and community residential beds: Adults & children: Public Consulting Group, Inc.; State of Washington, Department of Social and Health Services, Mental Health Division.

PALS community placement assessment. (2005). Public Consulting Group, Inc.; State of Washington, Department of Social and Health Services, Mental Health Division.

Appendix 5:

**Comprehensive Matrix of STI Consultant
Recommendations**

System Transformation Initiative Report Recommendations	Req. \$	Policy Change
<i>Focus Area 1 - Improving Access/Promoting Best Practices</i>		
1.1 Do not propose any changes regarding the structure of Rehabilitative Services within Washington’s Medicaid State Plan under the current federal climate. <i>(MHD Priority)</i>	No	No
1.2 Develop statewide standards for continuing care and discharge under the Access to Care Standards in order to shift the utilization management focus of RSNs from front-end restrictions for all enrollees to proactive care management of services for enrollees with intensive, ongoing needs. <i>(MHD Priority)</i>	No	Yes
1.3 Prior to the next Medicaid waiver submission, conduct a full actuarial analysis of the financial impact of revising GAF (Global Assessment of Functioning) and C-GAS (Children's Global Assessment Scale) minimums for routine outpatient care and if financially feasible, raise the minimum functional levels to allow earlier intervention.	Yes	Yes
1.4 Prioritize the following 3 evidence based and promising practices for Statewide Implementation <i>(MHD Priority)</i> <ul style="list-style-type: none"> ➤ Peer support services provided directly by Consumer and Family Run Organizations ➤ Integrated Dual Disorder Treatment for persons with co-occurring mental health and substance use disorders ➤ Collaborative Care Models for integrating medical and mental health treatment for populations most effectively served by clinicians located in primary care settings 	Yes	Yes
1.5 Revise Current RSN Contract Requirements for “State wideness” and Provide Definitive Guidance to RSNs on Implementation.	N/A	N/A
1.6 Develop encounter coding protocols to allow MHD and RSNs to track the provision of other best practices	N/A	N/A
1.7 For any best practices promoted statewide and paid for under Medicaid, conduct a formal actuarial analysis of costs prior to implementation and conduct additional analysis at the end of each year to determine if RSNs have developed the funded services. For any RSN that has not provided the level of targeted best practices that was funded, the difference between the documented costs incurred for targeted best practice services provided and the amount allocated should be paid back to MHD and the federal portion paid back to CMS.	N/A	N/A

System Transformation Initiative Report Recommendations	Req. \$	Policy Change
1.8 Include in the priority EBPs: Wraparound Service Coordination for children with severe emotional disturbances and their families who are served by multiple state agencies and Multidimensional Treatment Foster Care (MTFC) for children needing intensive out-of-home services, but able to receive care safely in a family-based setting	N/A	N/A
1.9 Develop Centers of Excellence to support the implementation of those best practices prioritized for statewide implementation.	N/A	N/A
<i>Focus Area 2 - Increasing Access to Permanent Supportive Housing</i>		
2.1 1 Directly support the development of 760 additional PSH units by: <ul style="list-style-type: none"> ➤ Exploring options for securing rent subsidies funding for 35% of units that can't be funded through existing sources (260 units) ➤ Exploring options for securing funding for operating subsidies (e.g. landlord incentives, risk mitigation funds) needed to encourage, support and sustain private landlords who rent to consumers ➤ Determining whether additional funding for PSH case management and crisis services can be met through current RSN allocations or require additional funding (MHD Priority)	Yes	No
2.2 Promote the creation of PSH at the RSN and local level by providing best practice information on models, partnerships and financing and by funding technical assistance to build capacity (MHD Priority)	Yes	Yes
2.3 Ensure the Prepaid Inpatient Health Plan (PIHP) benefit package includes flexible modality for services in home settings with rate sufficient to cover costs. (MHD Priority)	Yes	Yes
2.4 Suggest standard to identify number of crisis respite beds needed and identify funding if needed. (MHD Priority)	Yes	Yes
2.5 Develop a closer working relationship with the Washington State Department of Community, Trade & Economic Development (CTED) and consider opportunities to explore coordinated housing/services projects. (MHD Priority)	Yes	Yes
2.6 Explore the use of the Charitable, Educational, Penal, and Reformatory Institutions Trust fund to support the creation of more PSH for mental health consumers	N/A	N/A
2.7 Review the physical building conditions and services in all supervised living beds funded for mental health consumers statewide and ask RSNs to establish long-term plans for all units. Those plans could include plans to maintain “as is”, rehab, convert to ARTF, or replace with PSH.	N/A	N/A

System Transformation Initiative Report Recommendations	Req. \$	Policy Change
2.8 Develop a closer working relationship with CTED’s Housing Division by <ul style="list-style-type: none"> ➤ adding MHD housing staff to key housing advisory committees; Coordinate technical assistance and pilot project funding for PSH; ➤ adding MHD consultation into the CTED funding decisions on projects with units for people with mental illnesses; ➤ investigating opportunities to more effectively tap state 2060 Operating and Maintenance funds; and ➤ investigating options to allow people leaving state hospitals, without housing options, to be eligible for homeless housing units. 	N/A	N/A
2.9 Collect data at RSN/provider level and publish an annual statewide report on the housing status and tenure of all consumers served in the public mental health system.	N/A	N/A
<i>Focus Area 3 - Continued Study of the Involuntary Treatment Act</i>		
3.1 There should be no changes to the definition of “mental disorder” or “grave disability” at this time as there is a significant divide among stakeholders on these issues. <i>(MHD Priority)</i>	No	No
3.2 Narrowing the criteria for civil commitment should only occur after enhanced community services and resources are in place. These services must respond to the medical, psychological and psycho-social condition(s) that underlay the actions that prompt involuntary consideration and should not be limited by fund source. This is consistent with the direction given by the majority of stakeholders. <i>(MHD Priority)</i>	Yes	No
3.3 Parent initiated treatment should be studied in the context of the implementation of HB 1088 with an emphasis on assuring appropriate parental involvement. <i>(MHD Priority)</i>	No	TBD
3.4 Conduct additional study in other ITA areas (e.g. forensic conversions, involuntary medications, and advanced directives in involuntary settings). <i>(MHD Priority)</i>	Yes	TBD
3.5 The statutory definition of “mental disorder” could be narrowed to include only certain mental illnesses or to exclude specific conditions, such as developmental disabilities, traumatic brain injury, or dementia.		
3.6 The statutory definition of “grave disability” could be narrowed to: <ul style="list-style-type: none"> ➤ Permit civil commitment only when the person is unable to make their own informed judgment about treatment. ➤ Include a requirement that the person’s deterioration is likely to result in the person becoming a danger to themselves or others. ➤ Include a requirement that the person’s deterioration is likely to result in the person requiring hospitalization. 		

System Transformation Initiative Report Recommendations	Req. \$	Policy Change
<i>Focus Area 4 - Utilization Management/Making Best Use of a Limited Resource</i>		
4.1 Establish a statewide standardized UM protocol for both acute and extended (i.e., state hospital) inpatient admissions and continuing stays drawing from an analysis of raw data from selected UM instrument(s). (MHD Priority)	Yes	Yes
4.2 Track uniform data on discharge barriers across the state hospitals. (MHD Priority)	No	No
4.3 Consider hiring a Director of Inpatient Care Management or a Chief Medical Officer within the MHD versed in public behavioral health UM to provide the required medical expertise. (MHD Priority)	Yes	No
4.4 Complete a study of each RSN's hospital diversion and discharge options in order to forecast needed areas of development. (MHD Priority)	Yes	No
4.5 Conduct a root cause analysis of why, at times, there are discordant data reports between the MHD and some RSNs. (MHD Priority)	No	No
4.6 Establish a dispute resolution and consumer appeals panel at each state hospital. Panel membership should include consumers, RSN and hospital staff and reflect recovery principles. (MHD Priority)	No	No
4.7 Review the financial incentives underlying involuntary treatment payments and align payments with the systems most appropriately responsible for ongoing care. (MHD Priority)	Yes	TBD
4.8 The new MHD data system interface with Provider One should be used to collect standardized data on initial admission authorizations, continued stay reviews, and discharge barriers for both community and state hospitals.	N/A	N/A
4.9 RSNs should take a more assertive role in reviewing each individual being considered for admission to the state hospitals on 90 or 180-day court orders	N/A	N/A
4.10 Develop processes, procedures and other mechanisms that result in the RSNs assuming the authority to contract directly with hospitals for the provision of acute inpatient care on a regular and ongoing basis.	N/A	N/A
4.11 Areas for further study: ➤ the subset of state hospital patients whose extended stays account for a disproportionate number of bed days ➤ individuals who are re-admitted to state hospitals or who enter community hospitals in the year following discharge from a state hospital.	N/A	N/A
<i>Additional Recommendations and Options Pertaining to Tribal Governments</i>		

System Transformation Initiative Report Recommendations	Req. \$	Policy Change
5.1 Develop a handbook to guide RSNs in their interactions with Tribal governments and Tribal providers.	No	Yes
5.2 Develop a clear policy for the involvement of Indian Health Service and 638 facility providers in 1915-B waiver networks including consideration of mechanisms for direct contracting with Tribes.	TBD	Yes
5.3 Convene a work group to develop recommendations on how to incorporate Tribal traditional healing practices within the public mental health benefit.	No	Yes
5.4 Incorporate specific provisions for the inclusion of Tribes in any systematic efforts to promote best practices.	TBD	No
5.5 Continue facilitation of statewide forums such as the Tribal Mental Health Work Group and ensure the participation of senior staff in these forums.	No	No
5.6 Explore options for allowing Tribes to detain individuals independent of RSN approval by giving Tribes and Tribal Courts the ability to appoint Tribal DMHPs with authority to order involuntary treatment independently.	TBD	Yes
5.7 Explore options for requiring RSNs to accept referrals for 72-hour detentions from Tribes, rather than, in the words of one focus group participant, “wasting resources” by engaging a DMHP to conduct an additional assessment.	TBD	Yes
5.8 Increase the resources available to Tribal governments for housing and services for mental health clients including access to support services and landlord risk mitigation funds.	Yes	TBD
5.9 Increase the coordination and collaboration between Tribal governments and local and state government.	No	TBD
5.10 While the consultants for the Utilization Management Study have not made formal recommendations specific to the Tribes, there has been significant input through the STI process and the MHD Tribal Mental Health Workgroup to provide access to voluntary inpatient beds for the tribes without having to go through RSN inpatient authorization processes.	TBD	Yes