

Impact of Supplemental State Operating and Capital Budgets in King County
Major Issues Affecting the Community Behavioral Health System
Reflects Final 2018 Supplemental Operating and Capital Budgets

5/11/2018

Operating	Supplemental SFY19 Amount	Details and Impact
BHO Enhancements	+\$23.1M state funds +\$69.3M total includes Medicaid rate increase +\$18.0M in KC	Funding is provided to behavioral health organizations for community behavioral health service enhancements, distributed to regions by population. 20% of the state general fund amount is directed to non-Medicaid funding, with the remainder going to increase Medicaid rates. A plan is required from each region to: reduce the use of long-term commitment beds via community alternatives; expedite state hospital discharges; recruit/retain staff in community facilities; divert people from the criminal justice system; and improve recovery-oriented services including clubhouse expansion.
Workforce Proviso (Medicaid Rate Assumptions)	Included Positive impact in KC TBD	This proviso directs actuaries to reevaluate the adequacy of community behavioral health Medicaid rates by comparing to wages in government agencies and hospitals, and updating traffic assumptions. Once rates are updated accordingly, this will increase Medicaid funding for community behavioral health services.
Opening Medicaid State Plan	+\$956K state funds + broad proviso Positive impact in KC TBD	Directs the state to seek an amendment to include SUD peer services in the Medicaid state plan, and to coordinate with BHOs to explore further opportunities to add additional items to the state plan, and also will begin training/certification of peer specialists. Once approved by CMS, a Medicaid plan amendment could improve health outcomes and contribute to future increases in Medicaid rates.
IMD Federal Rule Partial Backfill	\$15.5M state backfill funds +\$3.1M in KC in SFY18 KC impact TBD in SFY19	Backfill funds are provided, primarily in the SUD service category, based on a continued assumption of success in securing a partial waiver. This represents the full amount of backfill that DSHS has said is needed, though BHOs generally believe it provides partial funding only. The anticipated funding level for SFY19 falls well short of the amount provided for SFY18. Unless a waiver is secured, funding will likely be insufficient to cover SFY19 IMD costs.
Non-Medicaid/Crisis Services Reserve	+\$14.5M one-time state funds Possible +\$4.4M in KC	Funding is provided to create a reserve for non-Medicaid services and to stabilize the crisis service system, along with a mandate to spend down or return all reserves before the fully integrated managed care transition. KC has been anticipating and planning for the reserve spenddown.
Opioid Treatment and Overdose Prevention	+\$3.5M state funds +\$14.4M total Possible +\$1.4M in KC	Funds 4 regional hub and spoke centers for medication assisted treatment (MAT); opioid overdose reversal medication distribution; a MAT capacity tracking tool; prescription drug take-back; tribal opioid reduction grants; and a buprenorphine MAT rate increase. It is hoped that 1 hub and spoke center may be sited in KC. MAT capacity tracking and prescription drug take-back would create state versions of KC activities.
Assisted Outpatient Treatment (AOT)	+\$727K state funds +1.7M total Possible +\$520K in KC	Provides limited funding for expanded eligibility for AOT via Senate Bill 6491 to include SUD and people with just 1 prior involuntary commitment. This modest funding level is based on a very low estimate of AOT caseload, and a long, gradual phase-in of AOT services.
Trueblood Fines	+\$46.4M state funds Possible +\$3.6M in KC	Provides for court-mandated fines and other legal costs associated with the <i>Trueblood</i> lawsuit addressing access to competency evaluation and restoration services. A portion of this funding is typically granted out to regions for services to the <i>Trueblood</i> class. King County has had success in securing <i>Trueblood</i> -related grant funds for community-based diversion services.
Capital	Supplemental SFY19 Amount	Details and Impact
Behavioral Health Community Capacity	+\$25.3M state funds At least +\$3M, up to possible +\$8.2M, in KC	\$2M is added for one additional non-IMD secure detoxification facility (bringing the biennial total up to \$4M for two facilities); \$1.3M is added for crisis diversion and stabilization facilities (bringing the biennial total up to \$12.7M); \$2.7M is added to develop alternative long-term commitment beds outside the state hospital (bringing the biennial total up to \$12.7M); \$5M is added for non-IMD facility/service capacity for certain children and youth; \$2M is provided for community behavioral health capacity grants generally; and \$3M is provided for Evergreen Treatment Services' building purchase, contingent on matching funds. Funds will go out as grants to community hospitals or community entities, and will be administered by Commerce.

This summary focuses on major budget items that are new for state fiscal year 2019. Changes expected to have a minor impact are not included. All estimates, especially but not limited to local King County impacts, could continue to be updated as additional information emerges.

Behavioral Health Community Capacity Funding Opportunities Relevant to King County in 2017-19 State Capital Budget (SSB 6090/ESSB 6095) *updated 3/8/2018*

All funding opportunities will be administered by Commerce. Except for Housing Trust Fund, all applications must be coordinated with a BHO or successor FIMC organization.

Category	Amount	Eligible Organizations	Details	ESSB 6095 Section
Behavioral Health Supportive Housing	\$24.4M <i>statewide</i>	<ul style="list-style-type: none"> Community-based nonprofits Housing authorities Tribes 	<ul style="list-style-type: none"> \$24.4M for housing projects providing supportive housing and case management services to persons with chronic mental illness 	<i>Sec. 1002</i>
Psychiatric Residential Treatment Beds	\$6.6M <i>statewide</i>	<ul style="list-style-type: none"> Community providers 	<ul style="list-style-type: none"> Grants to community providers to create non-IMD psychiatric residential treatment beds to serve people being diverted from or transitioned from state hospitals Must submit proposal to, and contract with, BHO or successor FIMC organization for operating costs 	<i>Sec. 1007</i>
Detoxification Facilities	\$6.0M <i>statewide</i>	<ul style="list-style-type: none"> Community hospitals Other community entities 	<ul style="list-style-type: none"> \$4.0M for at least 2 non-IMD secure detoxification facilities \$2.0M for at least 1 non-IMD acute (voluntary) detoxification facility 	<i>Sec. 1007</i>
Crisis Diversion or Stabilization Facilities	\$12.7M <i>statewide</i>	<ul style="list-style-type: none"> Community hospitals Other community entities 	<ul style="list-style-type: none"> Grants for non-IMD crisis diversion or stabilization facilities At least 2 facilities in King County 1 facility in Pierce County (\$3.2M earmarked for Pierce) 	<i>Sec. 1007</i>
Long-Term Civil Commitment Beds (State Hospital Alternatives)	\$12.7M <i>statewide</i>	<ul style="list-style-type: none"> Community hospitals Freestanding E&Ts 	<ul style="list-style-type: none"> Grants to community hospitals or freestanding E&Ts to create non-IMD beds for people on long-term civil commitments transitioning from or diverted from state hospitals Must contract with DSHS for operating costs 	<i>Sec. 1007</i>
Services and Capacity for Children and Youth	\$5.0M <i>statewide</i>	<ul style="list-style-type: none"> Community hospitals Other community entities 	<ul style="list-style-type: none"> Grants to increase behavioral health services and capacity for children/minor youth, including but not limited to: <ul style="list-style-type: none"> SUD treatment Services for sexual assault and traumatic stress, anxiety, or depression Interventions for children exhibiting aggressive or depressive behaviors Consideration of programs with outreach and treatment for youth dealing with mental health or social isolation 	<i>Sec. 1007</i>
General Community Behavioral Health Capacity	\$2.0M <i>statewide</i>	<ul style="list-style-type: none"> Community hospitals Other community entities 	<ul style="list-style-type: none"> Competitive grants; funding priority unspecified Consideration of programs with outreach and treatment for youth dealing with mental health or social isolation 	<i>Sec. 1007</i>
Earmarks for Specific King County Projects	\$5.5M <i>in King County</i>	<ul style="list-style-type: none"> Valley Cities SeaMar Evergreen Treatment Services 	<ul style="list-style-type: none"> \$2.0M Valley Cities Recovery Place (Beacon Hill) \$500K SeaMar Geriatric Diversion (South Park) \$3.0M for Evergreen Treatment Services building purchase, contingent on matching funds 	<i>Sec. 1007</i>

- *IMD = Institution for Mental Disease. BHO = Behavioral Health Organization. FIMC = Fully Integrated Managed Care. E&T = Evaluation and Treatment Facility. MH = Mental Health. SUD = Substance Use Disorders.*
- *Section 1007 also includes \$4.6M for 2 enhanced services facilities (ESFs). ESFs are a Home and Community Services (HCS) program for long-term placement of geriatric or traumatic brain injury patients. As ESFs are intended to serve HCS-identified clients with intensive behavioral support needs, and not BHO clients, King County will not have direct involvement. New ESFs could have positive impact on state/local hospital capacity.*
- *Section 1022 directs OFM to work with Commerce, HCA, DSHS, DOH, and BHOs to establish a statewide plan to assess/prioritize facility needs and gaps in the behavioral health continuum of care, to inform future grant allocations, due to legislative fiscal committees 12/31/18. The plan must address community hospital inpatient psychiatric beds, E&Ts, ESFs, triage facilities, crisis stabilization facilities for short-term detention, crisis walk-in clinics, residential treatment facilities, and supportive housing. The plan must include prioritization of facility type by geographic region; systematic method to distribute resources across geographic regions so that all communities' local continuums are being strengthened; and assessment of feasibility of establishing state-operated, community-based mental health hospitals. Once completed on 12/31/18, this statewide plan could potentially inform project selection for the above funding opportunities.*

2018 Behavioral Health Policy Legislation Results for King County BHRD Partners – 3/8/18, as passed legislature

At the time of this update, legislation shown below was still pending Governor's signature. Questions? Contact Chris Verschuyl: chris.verschuyl@kingcounty.gov.

Bill Number	Brief Title	Details
ESHB 1047 (Peterson)	Creating a system for safe and secure collection and disposal of unwanted medications	Creates statewide drug take-back program(s) that could be operated by drug manufacturers or independent drug take-back organizations, including a collection system; a handling and disposal system; security of patient information on drug packaging; and promotion. Permits pharmacies, hospitals, clinics, and law enforcement to serve as collectors. Counties' grandfathered programs, such as King County's, may operate for 12 months after a DOH-approved program begins operating before local laws are preempted. Program sunsets 1/1/2029.
2ESHB 1388 (Cody)	Changing designation of state behavioral health authority from DSHS to HCA and transferring powers, functions, and duties to HCA and DOH	Transfers responsibilities for the oversight/purchasing of behavioral health services from DSHS to HCA, except for the operation of the state hospitals. Transfers certification responsibilities from DSHS to DOH. Includes interlocal leadership structure section that provide counties a key role in shaping the transition to fully integrated managed care (FIMC) alongside HCA and the managed care organizations (MCOs).
SHB 1524 (Kloba)	Increasing success in therapeutic courts	Would expand the criminal justice treatment account (CJTA) definition of "treatment" to all programmatic elements of therapeutic courts, including but not limited to recovery supports. Previous prohibitions on the use of CJTA for housing, vocational training, and mental health counseling are removed. CJTA's definition of "treatment support" is also made permissive. Neither treatment nor recovery supports may be subject to medical necessity authorizations.
E2SHB 2779 (Senn)	Improving access to mental health services for children and youth	Improving access to mental health services for children and youth by renewing the Children's MH Workgroup established in 2016, expands its membership, and provides multiple new mandates including policy changes and reporting requirements. Permits BHOs to reimburse for partial hospitalization, and mandates BHO reimbursement for supervising people working toward MH professional licenses.
SSB 5553 (Pedersen)	Preventing suicide by permitting the voluntary waiver of firearm rights	Creates a process by which a person can voluntarily waiver firearm rights, and prohibiting the transfer of firearms to such persons. Voluntary firearm waivers are entered into federal databases.
SSB 6124 (Dhingra)	Clarifying that court hearings under the Involuntary Treatment Act may be conducted by video	Adds a definition of "hearing" for all civil involuntary treatment proceedings under RCW 71.05 that allows for individuals to participate in hearings either in person or by video, or by any equivalent technology. Requires all parties to participate in the hearing in person rather than by video if determined by the court. Permits witnesses to appear via other means including telephonically.
ESSB 6491 (O'Ban)	Increasing the availability of assisted outpatient behavioral health treatment	Broadens assisted outpatient treatment (AOT) eligibility. Requires only 1 prior commitment, removes requirement to be unable to remain safely in community, and expands AOT to substance abuse, not just mental health. Eliminates intermediate evaluation, meaning DMHP evaluation can lead directly to 90-day AOT commitment. Applies higher initial detention standard to revocation of AOT less restrictive orders, but leaves current revocation standard in place for all other LR's. Medication management is made an optional service rather than mandatory. Requires notification to care coordinator when a person is not in compliance with treatment conditions.