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**DIRECTIVE OF THE GOVERNOR
17-11**

November 3, 2017

To: Washington State Health Care Authority;
Department of Social and Health Services;
Department of Health;
Office of Financial Management; and
Other Washington State Executive and Small-Cabinet Agencies as needed

From: Jay Inslee, Governor

Subject: Formation of a Health Sub-Cabinet to integrate physical and behavioral health and address mental health and the opioid use crisis

Background

State law requires Washington to fully integrate Medicaid purchasing for physical health, mental health, and substance use disorder treatment by January 1, 2020. But the responsibility for oversight, purchasing, and management of Washington State's community behavioral health system as well as the responsibility for licensing and certification of behavioral health providers and facilities are split among various state agencies. Consequently, I requested legislation to better align state agency programs. The legislation also provided regional interlocal county government authorities an important role in the transition. While the request legislation did not pass, it received broad support, and I will request the Legislature to reconsider it in 2018 and continue important agency planning efforts in the interim.

We have made progress to improve the state psychiatric hospitals and reform the mental and behavioral health systems. We are working to ensure our state psychiatric hospitals are resourced to provide the medical and psychiatric services that individuals with significant behavioral health problems require, and we have begun major reforms to our mental health civil involuntary system to treat people in their communities. Yet, we have more to accomplish.

Last year, I issued [Executive Order 16-09](#) to address the opioid use public health crisis and implement one of the nation's most comprehensive state opioid response plans. Our state agencies and many external partners have many initiatives underway, yet we must do more.

Health Sub-Cabinet

To address the overall health of Washingtonians, I am establishing a cabinet-level leadership structure to further develop and implement our strategic plans to better enable the administration to act more quickly and respond to changes and needed reforms. To that end, I direct the formation of a health sub-cabinet (sub-cabinet), with an immediate focus on behavioral health.

I direct the Director of the Health Care Authority, Secretary of Social and Health Services, and Secretary of the Department of Health to participate. Other agencies, including the Departments of Commerce and Corrections, shall participate in the sub-cabinet as necessary to coordinate related housing and criminal justice issues; and other non-executive agencies shall be invited as needed, including the Office of the Insurance Commissioner and the Health Benefit Exchange, to discuss related health care insurance issues. My policy and budget staff shall also participate, and other representatives from the agencies may be invited as needed. I, or my designee, will chair the sub-cabinet, and a member of my policy office will facilitate the meetings. The sub-cabinet shall select a project manager to ensure scheduling, agenda development and cross-agency coordination toward an outcomes-driven plan, and also to ensure regular progress that realizes our vision of a Healthier Washington. The sub-cabinet shall meet regularly to consider key interrelated issues and activities among state agencies, with a specific focus on behavioral health integration, mental health system reforms and opioid use response; the sub-cabinet shall report progress directly to me at or following each meeting. It shall exchange information on a regular basis with the broader state Health Leadership Team pursuant to [Executive Order 13-05](#).

Initial tasks of the sub-cabinet include:

a. Developing a strategic plan

The sub-cabinet shall develop a comprehensive strategic plan and action steps to consider all interrelated health care issues, especially those related to behavioral health, including state hospital reforms and the opioid response. Planning must involve reforms for the state hospitals and include collaborative work among the sub-cabinet agencies with community stakeholders and Tribal governments to effectively develop community resources and connections between the state hospital and community health systems. The sub-cabinet shall continue to develop statewide measures comparable across regions as integration proceeds. The sub-cabinet must establish timeframes to implement the strategic plan.

b. Advancing behavioral health integration

The sub-cabinet, through the already established project structure that the administration has for this integration work, shall proceed with planning for the implementation of behavioral health integration, including consideration of the business processes, data, systems and staff necessary to achieve full integration. This planning shall include the transition of community behavioral health purchasing authority and staff from DSHS to HCA and the transfer of certain behavioral health regulatory and licensure functions and staff from DSHS to DOH. Community based mental health service programs shall move from DSHS to HCA on July 1, 2018, upon receiving legislative authority. The sub-cabinet shall manage staff and resources to achieve integration as quickly as possible while continuing the critical work of serving clients throughout the behavioral health system, including state hospitals. The sub-cabinet shall work with my policy, budget, and agency staff to support and amend legislation (HB 1388/SB 5259) previously proposed by my request, including the development of any

supplemental budget needed to support behavioral health agency integration, mental health funding, assistance to regions seeking to become the behavioral health administrative service organization, opioid response, and any State Plan Amendments or Waivers.

The sub-cabinet shall establish a strategy and action plan to connect behavioral health integration and state psychiatric hospital reforms to ensure that the plan supports the work with regional authorities and providers to ensure continuity of client services throughout the service continuum of care, including physical and behavioral health and care necessitated through involuntary treatment programs. These support structures necessitate collaboration among cabinet agencies, county and regional leadership, managed health care systems, physical and behavioral health care providers, Tribes, and consumer representatives to ensure a dedicated focus on services to the clients who are the center of Washington's health delivery and support system.

c. Forming an interlocal leadership structure

For successful behavioral health integration, HCA, DSHS and DOH shall work with county and regional authorities and providers to ensure ongoing client services in the full continuum of care, including, but not limited to, implementation of the following terms and processes as explicitly agreed to by key parties during the 2017 legislative session:

- (1) Upon the request of a county authority or authorities within a regional service area, the state shall collaborate with counties to create an interlocal leadership structure that includes participation from counties and the managed health care systems serving that regional service area. The interlocal leadership structure must include representation from physical and behavioral health care providers, Tribes, and other entities serving the regional service area as necessary.
- (2) The interlocal leadership structure regional organization must be chaired by the counties and jointly administered by HCA, managed health care systems, and counties. It must design and implement the fully integrated managed care model for that regional service area to assure clients are at the center of care delivery and support integrated delivery of physical and behavioral health care at the provider level.
- (3) The interlocal leadership structure may address, but is not limited to addressing, the following topics:
 - (a) Aligning contracting, administrative functions, and other processes to minimize administrative burden at the provider level to achieve outcomes;
 - (b) Monitoring implementation of fully integrated managed care in the regional service area, including design of an early warning system to monitor ongoing success to achieve better outcomes and to make adjustments to the system as necessary;
 - (c) Developing regional coordination processes for capital infrastructure requests, local capacity building, and other community investments;

- (d) Identifying, using, and building on measures and data consistent with, but not limited to, RCW 70.320.030 and 41.05.690, for tracking and maintaining regional accountability for delivery system performance; and
 - (e) Discussing whether the managed health care systems awarded the contract by HCA for a regional service area should subcontract with a county-based administrative service organization or other local organization, which may include and determine, in partnership with that organization, which value-add services will best support a bidirectional system of care.
- (4) The interlocal leadership structure must involve DSHS with regard to decisions impacting or potentially impacting the state hospitals.
 - (5) To ensure an optimal transition, regional service areas that enter as mid-adopters (before January 2020) must be allowed a transition period of up to one year during which the interlocal leadership structure develops and implements a local plan, including measurable milestones, to transition to fully integrated managed care. The transition plan may include provisions for the counties' organization to maintain existing contracts during some or all of the transition period if the managed care design begins during 2017 to 2018, with the mid-adopter transition year occurring in 2019.
 - (6) Nothing in this portion of the directive may be used to compel contracts between a provider, integrated managed health care system, or administrative service organization. Counties in a region, HCA and the region's managed health care systems may mutually agree to different interlocal leadership structure.
 - (7) The interlocal leadership structure expires December 1, 2021, unless the interlocal leadership group decides locally to extend it.

This directive shall take effect immediately.