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WASHINGTON COUNCIL
FOR BEHAVIORAL HEALTH

Status of Key Bills
As of April 10, 2023

HB 1021 – Aligning social worker licensing requirements. (Thai) [HB 5354 – Dhingra] [DEAD but added to HB 1724]

- Reduces the supervision requirements for advanced social worker licensure to from 3200 hours to 3000 hours.
- Reduces the supervision requirements for independent clinical social work licensure from 4000 hours to 3000 hours over two years instead of three years.
- ***Council staff signed in PRO in House Postsecondary Education & Workforce.***

As referred to House Rules.

HB 1041 – Authorizing the prescriptive authority of psychologists. (Bateman/Macri) [DEAD]

- Allows psychologists to prescribe psychotropic medications after completing a clinical prescribing fellowship and passing a competency exam.
- Provides a definition of a "clinical prescribing fellowship": an intensive and closely supervised experience in prescribing psychology with a minimum of 100 patients for no less than 500 hours; fellowship is the final stage of practical training, which takes place after the completion of the didactic curriculum, at the postdoctoral level, and after becoming a licensed psychologist.

As heard in House Health Care & Wellness.

SHB 1069 – Adopting the mental health counselor compact. (Leavitt)

- Adopts/establishes an interstate compact in Washington for licensed mental health counselors.
- Changes, for individuals with counseling degrees, the licensing requirements for the Washington-issued mental health counselor credential to reflect the requirements the Compact.
- Retains the ability of persons with degrees in related disciplines to become licensed MHCs; and
- Clarifies that persons who do not have counseling degrees are not qualified to exercise the Compact privilege unless their academic programs meet the Compact standards.

As passed out of the House (93 yeas; 0 nays); as passed out of the Senate (49 yeas; 0 nays).

E2SHB 1134 – Implementing the 988 behavioral health crisis response and suicide prevention system. (Orwall)

- Amends terminology of "crisis call center hub" to "designated 988 contact hubs."
- Extends statutory due dates by two years for establishing Hub standards to July 1, 2025.
- Extends statutory due dates by two years for designating the Hubs to July 1, 2026.
- Defines a "community-based crisis team" as a team that is part of an emergency medical services agency, fire service agency, public health agency, medical facility, or city or county, other than a law

enforcement agency, that provides the on-site community interventions of a mobile rapid response crisis team.

- Establishes an endorsement for mobile rapid response crisis teams and community-based crisis teams that meet standards related to staffing, transportation, and training.
    - Includes establishment grants, performance payments, and enhanced performance payments for endorsed teams;
    - Allows mobile rapid response crisis teams and community-based crisis teams with an endorsement to receive a performance payment in the form of an enhanced case rate;
    - Allows mobile rapid response crisis teams and community-based crisis teams with an endorsement and that also meet response time and en route time standards to receive, subject to funding, a supplemental performance payment in the form of a higher enhanced case rate;
    - Directs HCA to design the payments in a manner that maximizes the ability to receive federal matching funds;
    - Clarifies that the use of the telecom tax includes the establishment grants, performance payments, and supplemental performance payments;
    - Directs HCA to contract with the Medicaid managed care rate actuary to conduct an analysis and develop options for payment mechanisms and levels for the rate enhancements in a way that allows for maximum leverage of Medicaid federal match;
    - Directs HCA to submit a report to the Governor and the appropriate committees of the Legislature by December 1, 2023, with a summary of the actuarial analysis, payment mechanism options, payment rate level options, and related cost estimates;
    - Allows alternative endorsement standards until January 1, 2030 to apply to a community-based crisis team that is comprised solely of an emergency medical services organization and is located in a county in Eastern Washington with a population of less than 60,000 residents;
    - Exempts such a team from staffing requirements if the personnel on the team have met training requirements applicable to emergency medical service and fire service personnel and they operate under a memorandum of understanding with a behavioral health agency to receive consultation while responding to a call; and
    - Requires HCA to review the EMS organization teams and report to the Governor and the health policy committees of the Legislature by December 1, 2028, regarding the ability of the teams to provide a timely and appropriate responses to persons experiencing a behavioral health crisis.
- Appropriates 10% of annual receipts from the telecom tax to the endorsement grant programs, up to 30% of which is dedicated to teams affiliated with a tribe.
- Requires BHAs to display the 988 crisis hotline number in common areas and include the number as a calling option on any phone message for persons calling the agency after business hours.
- Requires protocols between the Hubs and 911 call centers be developed.
- Allows DOH to fund partnerships between 988 call centers and 988 hubs with 911 call centers to increase the coordination and transfer of behavioral health calls that are better addressed by the 988 system.

- Requires protocols related to dispatching mobile rapid response crisis teams and community based crisis teams be developed.
- Requires the creation of data-sharing agreements with BHASOs to provide 988 crisis hotline caller data and reports and that the information be further shared with HCA and DOH, including dispatch time, arrival time, and disposition of the outreach for those calls referred for outreach.
- Requires data-sharing agreements with 988 contact hubs to comply with federal and state laws regarding the privacy of personal health information.
- Directs DOH to require designated 988 contact hubs to train employees on agricultural cultural competencies for suicide prevention and to provide appropriate assessments, intervention, and resources to members of the agricultural community, but not to screen persons contacting 988 to determine whether they are members of the agricultural community or transfer them away from 988 if they are currently in crisis and in need of emotional support.
- Requires DOH and HCA to include the Hubs in the decision-making process for selecting any technology platforms that will be used to operate the system.
- Removes the requirement that the new crisis call center platform be interoperable across crisis and emergency response systems throughout the state.
- Adds a 988 geolocation subcommittee to the CRIS Committee to examine issues related to identifying individuals needing active rescue or immediate in-person intervention.
- Instructs UW to collaborate with the Harborview Behavioral Health Institute (BHI) to plan for regional collaboration among behavioral health providers and assigns the task of developing an assessment of training needs, mapping of crisis response providers, and comprehensive review of behavioral health training to BHI.
- Requires HCA and the BHASOs to have convening authority and final report responsibility for the project to plan for regional collaboration among behavioral health providers and first responders, standardize practices and protocols, develop a needs assessment for training, and develop recommendations for establishing crisis workforce and resilience training; must be done in collaboration with UW, the Washington Council for Behavioral Health, and the Statewide 988 Coordinator.
- Requires the BH-ASOs to convene an annual crisis continuum of care forum with participation from partners in regional service areas to identify and develop collaborative regional-based solutions, funded by HCA.
- Provides liability protections related to 988 dispatching responsibilities and transfer of calls between 911 and 988.
- ***Council staff testified PRO in House Health Care & Wellness but with concerns; submitted written testimony, and continues to meet weekly with the prime sponsor about amendments.***
- ***Council staff testified PRO in House Appropriations.***
- ***Council staff testified PRO in Senate Health & Long-Term Care.***
- ***Council staff signed in PRO in Senate Ways & Means.***

As passed out of the House (95 yeas; 0 nays); as passed out of the Senate (49 yeas; 0 nays).

SHB 1242 – Creating a behavioral health work group to study the root causes of rising behavioral health issues in Washington communities. (Dent/Davis) [DEAD]

- Establishes the Joint Legislative Executive Committee on Behavioral Health (Committee).
- Requires the Committee to conduct numerous activities, including:
    - Establishing a profile of Washington's current and future population and behavioral health needs, as well as an inventory of existing and future services and needs;
    - Evaluating the current behavioral health care oversight and management of services and systems by state agencies;
    - Assessing the capacity shortages, gaps, and barriers in receiving or accessing behavioral health services;
    - Evaluating the effectiveness of the integrated care initiative on access to timely and appropriate behavioral health services for individuals with acute behavioral health needs; reductions in hospitalization and institutionalization; improvements in community-based cases; and support for an effective and adequate network of community-based care providers for individuals with acute behavioral health needs;
    - Exploring the role the education, criminal justice, and affordable and supportive housing and homeless response systems have in identification and treatment of behavioral health issues;
    - Evaluating workforce issues; and
    - Developing a strategy to prepare for future demographic trends and building the necessary capacity to meet the demands. The work of the Committee must be informed by the past and existing work of behavioral health work groups.

As heard in House Appropriations.

E2SHB 1515 – Concerning contracting and procurement requirements for behavioral health services in medical assistance programs. (Macri)

- One-Sentence Summary: Requires new network adequacy requirements be established and provides specific requirements for HCA to follow during any procurement process.
- At least six months prior to reprocurement of the MCO contracts:
    - And no later than January 1, 2025, HCA must adopt statewide network adequacy standards for MCO behavioral health provider networks that are assessed on a regional basis, which ensure access to appropriate and timely behavioral health services and address all behavioral health services covered in contract; and
    - HCA must identify options that minimize provider administrative burdens, including the potential to limit the number of MCOs that operate in a regional service area.
- Requires HCA to establish a process for annual review of the network adequacy standards that allows for participation by counties and behavioral health providers, and a structure for monitoring compliance with these network adequacy standards.
- Requires MCOs participating in the procurement process have an established track record for contracting for the full continuum of behavioral healthcare services
- Adds additional factors that must be given significant weight in any procurement process:
    - Ability to provide for crisis service needs of Medicaid enrollees;

- Extent to which an MCO's approach to contracting simplifies billing and contracting burdens;
- Demonstrated commitment to use alternative pricing and payment structures with providers or provider networks, including VBP efforts and capacity-based funding models;
- Demonstrated commitment to establish, continue, or expand arrangements with provider networks that leverage additional funding sources to enhance integrated care and that meet the conditions of the integrated managed care contract and NCQA accreditation standards.

- Prohibits HCA from limiting or restricting a delegation arrangement that an MCO and provider network have agreed upon, provided that the arrangement meets the requirements of the integrated managed care contract and NCQA accreditation standards.
- Authorizes MCOs and HCA to evaluate whether or not to establish or support future delegation arrangements with other provider networks.
- Requires HCA to seek approval to amend the State Medicaid Plan to support direct payments to agencies to support 24/7 crisis system capacity.
- ***Council staff testified PRO in House Health Care & Wellness.***
- ***Council staff signed in PRO in House Appropriations.***
- ***Council staff testified PRO in Senate Health & Long-Term Care.***
- ***Council staff testified PRO in Senate Ways & Means.***

As passed out of the House (96 yeas; 0 nays); as passed out of the Senate (49 yeas; 0 nays).

HB 1583 – Creating the profession of certified peer specialists. (Eslick/Davis) [SB 5555 – Randall/Dhingra] [DEAD]

- Establishes certified peer specialists and certified peer specialist trainees as new health professions to be certified by DOH.
- Directs HCA to develop and offer an 80-hour education course for persons seeking to become certified as a peer specialist or peer specialist trainee.
- Requires by July 1, 2027, that all approved supervisors be certified peer counselors.
- Requires BHAs to reduce caseloads for approved supervisor as determined by the certified peer counselor advisory committee.
- Establishes standards and training for approved supervisors of certified peer specialist trainees.
- Establishes training requirements for certified peer specialists practicing as peer crisis responders.
- ***Council staff testified OTHER in House Health Care & Wellness.***

As scheduled in House Appropriations.

2SHB 1724 – Increasing the trained behavioral health workforce. (Bateman/Macri)

- Requires DOH, in consultation with the Workforce Training Board and the Examining Board of Psychology (EBP), to examine licensure requirements for psychologists, SUDPs, advanced social workers, independent clinical social workers, MHCs, and MFTs.
- Requires DOH to identify changes to statutes and rules that would remove barriers to entering and remaining in the workforce and streamline and shorten the credentialing process.
- Requires DOH to consider the following topics:

    - the availability of peer-reviewed research and other evidence indicating the necessity of specific licensure requirements for ensuring that behavioral health professionals are prepared to practice with reasonable skill and safety;
    - changes that would facilitate licensure of qualified out-of-state and international applicants to promote reciprocity, including the adoption of compacts;
    - changes that would promote greater consistency across licensure requirements for advanced social workers, independent clinical social workers, MHCs, and MFTs and allow for prior professional experience within relevant fields to be counted towards supervised experience requirements;
    - technical assistance programs, such as navigators or dedicated customer service lines, to facilitate the completion of licensing applications;
    - the creation of an associate-level license for psychologists;
    - **whether agency affiliated counselors should be allowed to practice in FQHCs**; and
    - any rules that pose excessive administrative requirements for application or renewal or place a disproportionate burden on applicants from disadvantaged communities.
- Creates a program to facilitate placement of behavioral health associates with clinical supervision, including a database of license holders with the required qualifications who are willing to serve as approved supervisors and agencies or facilities that offer supervision services, subject to funding.
- Creates a stipend program for out-of-pocket costs incurred by behavioral health associates completing supervised experience requirements; requires DOH to consider defraying out-of-pocket expenses associated with unpaid internships that are part of an applicant's educational program, subject to funding.
- Removes practice setting limitations for probationary licenses.
- Includes reduced supervision hours for social workers from HB 1021.
- Establishes a certification pathway for a person who has a bachelor's degree, has counseling-specific coursework as determined by DOH, and has at least five years of experience in direct treatment of persons with a mental disorder gained under the supervision of a licensed clinical supervisor.
    - Allows a certified AAC to act as an MHP in providing assessment and diagnosis of mental health disorders within the context of employment by an agency and under the supervision of a licensed clinical supervisor, but excludes them from providing clinical supervision or practicing as a designated crisis responder or co-occurring disorder specialist.
- Creates an AAC license available to applicants who have an advanced degree, counseling-specific coursework as determined by DOH, and at least two years of experience in direct treatment of persons with a mental disorder gained under the supervision of a licensed clinical supervisor.
    - Allows a licensed AAC to practice independently as an MHP, including practice as a designated crisis responder or co-occurring disorder specialist if other requirements are met.
- ***Although the AAC proposal did not come from the Council, staff worked with DOH and HCA to improve the amendment language and ensure it protects our current workforce.***
- ***Council staff signed in PRO in Senate Ways & Means.***

As passed out of the House (95 yeas; 0 nays); as passed to Senate Rules for second reading.

2SSB 5120 – Establishing 23-hour crisis relief centers in Washington state. (Dhingra)

- Establishes a five-year pilot project for 23-hour crisis relief centers (CRCs) serving adults, which are intended to divert individuals from emergency departments and jail.
- Requires DOH to authorize up to five 23-hour crisis relief centers that meet state minimum standards to participate in a pilot program between January 1, 2024, and January 1, 2029. The participating 23-hour crisis relief centers shall be located in different geographic areas of the state with varying levels of population density.
- DOH shall create guidelines for participation in the pilot program, in consultation with HCA, by January 1, 2024. The guidelines at a minimum must include the following requirements:
    - Prohibits a CRC from requiring medical clearance for individuals dropped off by all first responders as defined in the bill.
    - Requires a CRC to be structured to have a no-refusal policy for individuals dropped off by law enforcement, unless the facility is at capacity.
    - Requires a CRC to be structured to accept all other admissions 90% of the time and track instances of refusal and the reason for that refusal, making this data available to DOH.
    - Requires DOH to develop standards for the number of recliner chairs that may be authorized in a participating 23-hour CRC and the appropriate variance for temporarily exceeding that number in order to provide the no-refusal policy for law enforcement.
    - Requires CRCs to provide access to a prescriber and be able to dispense medications
    - Allows the 23-hour CRC to detain for a sufficient amount of time (i.e., 12 hours) a person whom it believes meets ITA criteria of grave disability or imminent likelihood of serious harm to wait for a DCR evaluation.
    - Provides another exception to the 23 hour and 59 minute time limit for patients who are making an imminent transition to an established aftercare plan
    - Requires DOH to develop standards for determining medical stability before an emergency medical services drop-off at a CRC.
- Requires DOH to specify physical environment standards for the construction review process that are responsive to the unique characteristics of the types of interventions used to provide care for all levels of acuity in facilities operating under the 23-hour CRC pilot project model.
- Requires DOH, DSHS, and HCA to establish guidelines that prohibit discharges or transfers to a CRC pilot site from nursing homes, assisted living facilities, enhanced services facilities, soldier's and veterans' homes, and adult family homes; requires these agencies to develop similar guidelines for hospitals that do not have a formal relationship with a CRC pilot site.
- Requires DOH to conduct an assessment of the 23-hour CRC pilot program with information related to: the number of clients served; the extent to which clients entered as self-referrals, were brought in by a first responder, or were referred through the 988 system; the physical health needs of the clients upon arrival; the average length of stay of the clients; and the subsequent destination of the clients following their stay at the participating 23-hour crisis relief center
- Requires DOH to submit a report to the governor and each chamber of the legislature by December 1, 2029, with findings from the assessment and recommendations on whether the 23-hour CRC should be made permanent, statewide implementation, and any changes to the operational standards for the 23-hour CRC to better meet the needs of the clients.

- Allows a police officer who has reasonable cause to believe an individual has committed a crime to take the individual to a CRC pilot site in lieu of arresting the individual.
- Requires DOH to develop the guidelines for the CRC pilot program in consultation with various stakeholders, including the WA Council.
- Adds 23-hour CRCs participating in the pilot program to list of facilities for which real-time bed availability will need to be available.
- Eliminates crisis triage facilities as a facility type in Washington and requires DOH to convert all crisis triage facility licenses to crisis stabilization unit licenses.
- ***Council staff testified PRO in Senate Health & Long-Term Care but with concerns, submitted written testimony, and offered several amendments, most of which were included in the sub.***

As passed out of the Senate (47 yeas; 0 nays); as passed out of the House (97 yeas; 0 nays).

SB 5130 – Concerning assisted outpatient treatment. (Frame/Dhingra)

- Reduces the burden of proof for an assisted outpatient treatment (AOT) petition from clear, cogent, and convincing evidence to a preponderance of the evidence.
- Allows a behavioral health case manager to file the supporting declaration for an AOT petition, and reduces requirements for supporting declarations filed by MHPs and SUDPs.
- Updates the process for revocation of a less restrictive alternative treatment order for children to match the process for adults.

As passed out of the Senate (49 yeas; 0 nays); as passed to House Rules for second reading.

SSB 5189 – Establishing behavioral health support specialists. (Trudeau) [HB 1348 – Callan]

- Establishes the behavioral health support specialist credential under Title 18.
- Defines "Behavioral health support specialist" as person certified to deliver brief, evidence-based interventions with a scope of practice that includes behavioral health under the supervision of a Washington state credentialed provider who has the ability to assess, diagnose, and treat identifiable mental and behavioral health conditions as part of their scope of practice; does not have within their scope of practice the ability to make diagnoses but does track and monitor treatment response and outcomes using measurement-based care.
- Allows BHSS credential applicants to complete a registered apprenticeship approved by the Washington State Apprenticeship and Training Council in combination with an approved bachelor's degree or post-baccalaureate certificate.
- Requires DOH to collaborate with UW Department of Psychiatry and Behavioral Sciences and consult with other stakeholders to develop rules to implement this credential by January 1, 2025.
- Requires HCA to take any necessary steps to ensure that the services of behavioral health support specialists are covered under the state medicaid program by January 1, 2025.
- Directs carriers to provide access to services provided by behavioral health support specialists in a manner sufficient to meet network access standards by July 1, 2025.
- ***Council staff testified OTHER with concerns in Senate Health & Long-Term Care; our offered amendments were not included in the sub.***

As passed out of the Senate (47 yeas; 0 nays); as passed out of the House (98 yeas; 0 nays).

SB 5228 – Providing occupational therapy services for persons with behavioral health disorders. (Dhingra)

- Requires HCA to expand coverage in the state Medicaid program by June 30, 2024 to ensure BHAs are reimbursed by the MCOs for medically necessary occupational therapy needs of their clients.
- ***Council staff signed in PRO in Senate Health & Long-Term Care.***
- ***Council staff signed in PRO in Senate Ways & Means.***
- ***Council staff signed in PRO in House Healthcare & Wellness.***
- ***Council staff signed in PRO in House Appropriations.***

As passed out of the Senate (48 yeas; 0 nays); as passed out of the House (97 yeas; 0 nays).

SSB 5271 – Protecting patients in facilities regulated by the department of health by establishing uniform enforcement tools. (Cleveland; DOH request legislation) [HB 1424 – Thai] [DEAD]

- Extends the enforcement tools enacted in 2020 and 2021 for psychiatric and acute care hospitals to all facilities the department regulates.
- Adds immediate enforcement tools, such as stop placement, limited stop placement, limited stop service, and reasonable conditions, to address violations that constitute immediate jeopardy, including when a facility refuses to comply with an investigation.
- Defines immediate jeopardy as a situation in which the facility has placed patients in its care at risk for serious injury, serious impairment, or death.
- Adds intermediate tools to address repeat violations to bring facilities into compliance with regulations. These tools, including reasonable conditions and civil fines, are intended to be used after the department's initial informal process of issuing a statement of deficiencies and a facilities' plan of correction fail to ensure the violation does not occur again.
- Ensures the authority to issue cease and desist orders and injunctions for unlicensed operation.

As passed out of Senate Ways & Means; placed on second reading.

SSB 5300 – Concerning continuity of coverage for prescription drugs prescribed for the treatment of behavioral health conditions. (Dhingra)

- Prohibits health carriers from requiring substitution of a prescribed nonpreferred drug with a preferred drug or increasing an enrollee's cost sharing obligation when the prescription is for a refill of an antipsychotic, antidepressant, or antiepileptic drug, or any other drug prescribed to treat a serious mental illness.
- Prohibits all state purchased health care programs from requiring substitution of a nonpreferred drug with a preferred drug when the prescription is for a refill of an antipsychotic, antidepressant, or antiepileptic drug, or any other drug prescribed to treat a serious mental illness.
- ***Council staff signed in PRO in Senate Health & Long-Term Care.***
- ***Council staff signed in PRO in Senate Ways & Means.***
- ***Council staff signed in PRO in House Health Care & Wellness.***
- ***Council staff signed in PRO in House Appropriations.***

As passed out of the Senate (46 yeas; 0 nays); as passed out of the House (98 yeas; 0 nays).

ESB 5352 – Concerning vehicular pursuits. (Lovick) [HB 1363 – Rule]

- Lowers the evidentiary threshold required for engaging in a vehicular pursuit by allowing an officer to conduct the vehicular pursuit if the officer has reasonable suspicion that a person in the vehicle has committed or is committing specified criminal offenses.
- Limits vehicular pursuits to situations where the subject of the pursuit poses a serious risk of harm to others.
- Modifies certain vehicular pursuit requirements related to supervisory oversight and establishes new requirements related to direct communication with specified entities, development of a plan to end the vehicular pursuit, and the pursuing officer's training and certifications.
- Requires a pursuing officer in a jurisdiction with fewer than 15, rather than 10, commissioned officers to request the on-call supervisor be notified of the pursuit.
- Provides that the emergency vehicle operator training required for pursuing officers must include training on performing the risk assessment analysis of whether a person being pursued poses a serious risk of harm to others and the safety risks of failing to apprehend or identify the person are considered greater than the safety risks of the pursuit.

As passed out of the Senate (26 yeas; 23 nays); as passed out of the House (57 yeas; 40 nays).

SB 5422 – Providing access to behavioral health services to children using licensed clinicians colocated within the school. (Wilson, J.) [DEAD]

- Requires an MCO to provide reimbursement for medically necessary behavioral health services provided within a school *by a licensed or certified behavioral health agency* to a student within that school who is enrolled in the medicaid program, regardless of whether the behavioral health agency is within the network of the MCO, ***unless*** the MCO provides equivalent services colocated within the school which are available to the child using in-network providers.

As referred to Senate Health & Long-term Care.

E2SSB 5440 – Providing timely competency evaluations and restoration services to persons suffering from behavioral health disorders. (Dhingra; Governor-request legislation)

- Makes a number of changes to provisions governing competency evaluation and competency restoration procedures and requirements.
- Expands the duties of forensic navigators, and requires appointment of a forensic navigator for a defendant charged with a nonfelony who has had two or more competency evaluations in 24 months on separate charges.
- Requires jails to allow clinical intervention specialists access to persons referred for competency evaluation or restoration services, and specifies the duties of clinical intervention specialists.
- Prohibits jails or juvenile detention facilities from discontinuing or substituting a person's medications for a serious mental health disorder if the person is medically stable on the drug, with limited exceptions.
- Requires DSHS to develop a program for persons who have been found incompetent to stand trial based on an intellectual or developmental disability or dementia, subject to funding.
- Requires HCA to take steps to increase compensation of staff in outpatient competency restoration programs, subject to funding.

- Requires DSHS to engage in certain data collection and to identify locations that may be commissioned or renovated for use in treating persons committed for competency evaluation or restoration or civil conversion, or following acquittal by reason of insanity.

As passed out of the Senate (44 yeas; 5 nays); as passed out of the House (64 yeas; 34 nays).

SSB 5481 – Concerning the uniform telemedicine act. (Cleveland; Uniform Law Commission request legislation) [DEAD]

- Allows the provision of telemedicine services for providers licensed by this state or those providing telemedicine services in consultation with a provider who has a practitioner-patient relationship with the patient or in the form of a specialty assessment, diagnosis, or recommendation for treatment.
- Directs the Telemedicine Collaborative to review a proposal to allow out-of-state providers to register to provide telemedicine services to patients in this state.
- Extends the expiration date of the telemedicine collaborative July 1, 2025.

As passed out of Senate Health & Long-Term Care; referred to Senate Rules.

SB 5497 – Concerning Medicaid expenditures. (Wilson, L.; Rolfes)

- Directs HCA to provide reasonable oversight of all Medicaid program integrity activities required by federal regulation.
- Requires HCA to establish and maintain effective internal control over any state agency that receives Medicaid funding in compliance with federal regulation.
- Requires HCA to update managed care contracts to include appropriate program integrity requirements.

As passed out of the Senate (45 yeas; 3 nays); as passed out of the House (97 yeas; 0 nays).

SSB 5499 – Concerning the multistate nurse licensure compact. (Mullet)

- Enters Washington into the Nurse Licensure Compact.
- Requires hospitals, establishments, ambulatory surgical facilities, nursing homes, assisted living facilities, hospice care centers, adult family homes, and nursing pools, subject to enforcement by DOH, to report to the board of nursing within 30 days of employment all nurses holding a multistate license issued by a state other than Washington and provide an attestation that those employees have completed the demographic data surveys required by the board of nursing and suicide assessment, treatment, and management training as a condition of employment.

As passed out of the Senate (40 yeas; 8 nays); as passed out of the House (94 yeas; 4 nays).

SB 5540 – Concerning medicaid managed health care system reprocurement. (Cleveland/Rivers) [DEAD]

- One-Sentence Summary: Requires HCA to request authorization and funding from the legislature **before** it may reprocure state contracts with Medicaid MCOs.
- Within one month prior to any legislative session during which HCA will be requesting this authorization and funding, HCA must submit to the legislature a detailed reprocurement plan that must include at least the following items:

- Specific objectives to be served by the reprocurement, and an evaluation of any alternatives to the reprocurement that could serve these same objectives.
- Value of any changes to the design or structure of the Medicaid program that could be made through the reprocurement, such as increasing or decreasing the number MCOs operating in the state or within substate regions or moving additional Medicaid services from fee-for-service to managed care.
- Key contractual provisions to be maintained, deleted, or added through the reprocurement process related to cost, quality, and access to incent the long-term efficiency and effectiveness of the Medicaid program.
- The anticipated impact of the reprocurement on Medicaid enrollees; participating health care providers, including potential rate changes, payment and contractual disruptions, and any costs associated with the reprocurement for which providers will not be reimbursed; health equity; and Medicaid costs.
- Proposed timeline for implementing the plan.

- In developing the reprocurement plan, HCA must solicit and consider input from Indian tribes and stakeholders, including physical and behavioral health care providers, Medicaid enrollees, community-based organizations, the Washington state office of equity, and other state agencies. HCA must also survey other states to help determine the impact of and current best practices regarding Medicaid reprocurement.

As referred to Senate Health & Long-Term Care.

E2SSB 5536 – Concerning controlled substances, counterfeit substances, and legend drug possession and treatment. (Robinson)

- Increases the penalty for knowing possession of a controlled substance or counterfeit substance to a gross misdemeanor.
- Creates a pretrial diversion program for individuals charged with possession.
- Requires courts to impose minimum jail sanctions on defendants convicted of possession who refuse SUD treatment or who willfully abandon treatment or consistently fail to comply with treatment.
- Requires courts to vacate convictions of possession for defendants who successfully complete required SUD treatment and file proof with the court.
- Enacts recommendations of the Substance Use and Recovery Services Advisory Committee expanding SUD treatment and harm reduction programs and related services.

As passed out of the Senate (28 yeas; 21 nays); as passed out of the House (54 yeas; 41 nays).

2SSB 5555 – Creating the profession of certified peer specialists. (Randall/Dhingra) [SB 1583 – Eslick/Davis]

- Establishes certified peer specialists and certified peer specialist trainees as new health professions to be certified by DOH.
- Directs HCA to develop and offer an 80-hour education course for persons seeking to become certified as a peer specialist or peer specialist trainee.
- Requires by July 1, 2027, that all approved supervisors be certified peer counselors.

- Requires BHAs to reduce caseloads for approved supervisor as determined by the certified peer counselor advisory committee.
- Establishes standards and training for approved supervisors of certified peer specialist trainees.
- Establishes training requirements for certified peer specialists practicing as peer crisis responders.
- Directs the advisory board to provide advice and guidance on the feasibility and design of a two-phase certification program.
- Directs the advisory board to make recommendations on strategies to eliminate financial barriers to licensing.
- Requires OIC to ensure that every health insurance carrier is providing access to peer specialists in compliance with network access standards.
- ***Council staff testified OTHER in Senate Health & Long-Term Care. (Thanks, Kim!)***
- ***Council staff testified OTHER in House Health Care & Wellness.***

As passed out of the Senate (27 yeas; 19 nays); as passed to House Rules for second reading.

SB 5585 – Allowing licensed and certified behavioral health agencies to designate certain individuals as mental health professionals. (Braun) [DEAD]

- Allows a behavioral health agency to designate a person employed by the agency as a mental health professional if the person holds a bachelor's degree in counseling or one of the social sciences and has at least five years of experience in direct treatment of persons with a mental disorder, gained under the supervision of a mental health professional recognized by the Department of Health or attested to by the behavioral health agency.

As referred to Senate Health & Long-Term Care.

SB 5660 – Establishing a mental health advance directive effective implementation work group; creating a new section; and providing an expiration date. (Boehnke/Dhingra) [DEAD]

- Directs HCA to convene a Mental Health Advance Directive Effective Implementation Work Group with two subgroups to develop recommendations.
    - Directs the Document Storage Subgroup to recommend methods for MHAD creation, storage, and sharing, including a path to creation of a statewide MHAD repository; next steps towards piloting or implementation; approaches to interoperability; and protection of privacy.
    - Directs the Training for Document Creation and Utilization Subgroup to create training modules to support utilization of MHADs by persons with lived experience, families, agencies, and providers, including development of training toolkits and program testing and data collection relating to the toolkits in two pilot locations in Western and Eastern Washington.
- Directs HCA to include representatives from 17 constituencies in the work group and states that the work group must be representative of the diversity of individuals who use MHADs and behavioral health services.
- Directs the work group to report its findings to the Governor and relevant committees of the Legislature by December 1, 2023.
- ***Council staff signed in PRO in Senate Health & Long-term Care.***

As referred to Senate Ways & Means.