SSB 5779 - H COMM AMD
By Committee on Appropriations

ADOPTED 04/10/2017

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** Health transformation in Washington state requires a multifaceted approach to implement sustainable solutions for the integration of behavioral and physical health. Effective integration requires a holistic approach and cannot be limited to one strategy or model. Bidirectional integration of primary care and behavioral health is a foundational strategy to reduce health disparities and provide better care coordination for patients regardless of where they choose to receive care.

An important component to health care integration supported both by research and experience in Washington is primary care behavioral health, a model in which behavioral health providers, sometimes called behavioral health consultants, are fully integrated in primary care. The primary care behavioral health model originated more than two decades ago, has become standard practice nationally in patient centered medical homes, and has been endorsed as a viable integration strategy by Washington's Dr. Robert J. Bree Collaborative.

Primary care settings are a gateway for many individuals with behavioral health and primary care needs. An estimated one in four primary care patients have an identifiable behavioral health need and as many as seventy percent of primary care visits are impacted by a psychosocial component. A behavioral health consultant engages primary care patients and their caregivers on the same day as a medical visit, often in the same exam room. This warm hand-off approach fosters coordinated whole-person care, increases access to behavioral health services, and reduces stigma and cultural barriers in a cost-effective manner. Patients are provided evidence-based brief interventions and skills training, with more severe needs being effectively engaged, assessed, and referred to appropriate specialized care.

While the benefits of primary care behavioral health are not restricted to children, the primary care behavioral health model also provides a unique opportunity to engage children who have a strong relationship with primary care, identify problems early, and assure healthy development. Investment in primary care behavioral health creates opportunities for prevention and early detection that pay dividends throughout the life cycle.

The legislature also recognizes that for individuals with more complex behavioral health disorders, there are tremendous barriers to accessing primary care. Whole-person care in behavioral health is an evidence-based model for integrating primary care into behavioral health settings where these patients already receive care. Health disparities among people with behavioral health disorders have been well-documented for decades. People with serious mental illness or substance use disorders continue to experience multiple chronic health conditions and dramatically reduced life expectancy while also constituting one of the highest-cost and highest-risk populations. Two-thirds of premature deaths are due to preventable or treatable medical conditions such as cardiovascular, pulmonary, and infectious diseases, and forty-four percent of all cigarettes consumed nationally are smoked by people with serious mental illness.

The whole-person care in behavioral health model allows behavioral health providers to take responsibility for managing the full array of physical health needs, providing routine basic health screening, and ensuring integrated primary care by actively coordinating with or providing on-site primary care services.

Providers in Washington need guidance on how to effectively implement bidirectional integration models in a manner that is also financially sustainable. Payment methodologies must be scrutinized to remove nonessential restrictions and limitations that restrict the scope of practice of behavioral health professionals, impede same-day billing for behavioral health and primary care services, abet billing errors, and stymie innovation that supports wellness and health integration.

NEW SECTION. **Sec. 2.** A new section is added to chapter 74.09 RCW to read as follows:

(1) By August 1, 2017, the authority must complete a review of payment codes available to health plans and providers related to primary care and behavioral health. The review must include

adjustments to payment rules if needed to facilitate bidirectional integration. The review must involve stakeholders and include consideration of the following principles to the extent allowed by federal law:

(a) Payment rules must allow professionals to operate within the full scope of their practice;

(b) Payment rules should allow medically necessary behavioral health services for covered patients to be provided in any setting;

(c) Payment rules should allow medically necessary primary care services for covered patients to be provided in any setting;

(d) Payment rules and provider communications related to payment should facilitate integration of physical and behavioral health services through multifaceted models, including primary care behavioral health, whole-person care in behavioral health, collaborative care, and other models;

(e) Payment rules should be designed liberally to encourage innovation and ease future transitions to more integrated models of payment and more integrated models of care;

(f) Payment rules should allow health and behavior codes to be reimbursed for all patients in primary care settings as provided by any licensed behavioral health professional operating within their scope of practice, including but not limited to psychiatrists, psychologists, psychiatric advanced registered nurse professionals, physician assistants working with a supervising psychiatrist, psychiatric nurses, mental health counselors, social workers, chemical dependency professionals, chemical dependency professional trainees, marriage and family therapists, and mental health counselor associates under the supervision of a licensed clinician;

(g) Payment rules should allow health and behavior codes to be reimbursed for all patients in behavioral health settings as provided by any licensed health care provider within the provider's scope of practice;

(h) Payment rules which limit same-day billing for providers using the same provider number, require prior authorization for low-level or routine behavioral health care, or prohibit payment when the patient is not present should be implemented only when consistent with national coding conventions and consonant with accepted best practices in the field.

(2) Concurrent with the review described in subsection (1) of this section, the authority must create matrices listing the

following codes available for provider payment through medical assistance programs: All behavioral health-related codes; and all physical health-related codes available for payment when provided in licensed behavioral health agencies. The authority must clearly explain applicable payment rules in order to increase awareness among providers, standardize billing practices, and reduce common and avoidable billing errors. The authority must disseminate this information in a manner calculated to maximally reach all relevant plans and providers. The authority must update the provider billing guide to maintain consistency of information.

(3) The authority must inform the governor and relevant committees of the legislature by letter of the steps taken pursuant to this section and results achieved once the work has been completed.

NEW SECTION. **Sec. 3.** A new section is added to chapter 74.09 RCW to read as follows:

(1) By August 1, 2017, the authority must complete a review of payment codes available to health plans and providers related to primary care and behavioral health. The review must include adjustments to payment rules if needed to facilitate bidirectional integration. The review must involve stakeholders and include consideration of the following principles to the extent allowed by federal law:

(a) Payment rules must allow professionals to operate within the full scope of their practice;

(b) Payment rules should allow medically necessary behavioral health services for covered patients to be provided in any setting;

(c) Payment rules should allow medically necessary primary care services for covered patients to be provided in any setting;

(d) Payment rules and provider communications related to payment should facilitate integration of physical and behavioral health services through multifaceted models, including primary care behavioral health, whole-person care in behavioral health, collaborative care, and other models;

(e) Payment rules should be designed liberally to encourage innovation and ease future transitions to more integrated models of payment and more integrated models of care;

(f) Payment rules should allow health and behavior codes to be reimbursed for all patients in primary care settings as provided by

any licensed behavioral health professional operating within their scope of practice, including but not limited to psychiatrists, psychologists, psychiatric advanced registered nurse professionals, physician assistants working with a supervising psychiatrist, psychiatric nurses, mental health counselors, social workers, substance use disorder professionals, substance use disorder professional trainees, marriage and family therapists, and mental health counselor associates under the supervision of a licensed clinician;

(g) Payment rules should allow health and behavior codes to be reimbursed for all patients in behavioral health settings as provided by any licensed health care provider within the provider's scope of practice;

(h) Payment rules which limit same-day billing for providers using the same provider number, require prior authorization for low-level or routine behavioral health care, or prohibit payment when the patient is not present should be implemented only when consistent with national coding conventions and consonant with accepted best practices in the field.

(2) Concurrent with the review described in subsection (1) of this section, the authority must create matrices listing the following codes available for provider payment through medical assistance programs: All behavioral health-related codes; and all physical health-related codes available for payment when provided in licensed behavioral health agencies. The authority must clearly explain applicable payment rules in order to increase awareness among providers, standardize billing practices, and reduce common and avoidable billing errors. The authority must disseminate this information in a manner calculated to maximally reach all relevant plans and providers. The authority must update the provider billing guide to maintain consistency of information.

(3) The authority must inform the governor and relevant committees of the legislature by letter of the steps taken pursuant to this section and results achieved once the work has been completed.

NEW SECTION. **Sec. 4.** A new section is added to chapter 74.09 RCW to read as follows:

(1) For children who are eligible for medical assistance and who have been identified as requiring mental health treatment, the

authority must oversee the coordination of resources and services through (a) the managed health care system as defined in RCW 74.09.325 and (b) tribal organizations providing health care services. The authority must ensure the child receives treatment and appropriate care based on their assessed needs, regardless of whether the referral occurred through primary care, school-based services, or another practitioner.

(2) The authority must require each managed health care system as defined in RCW 74.09.325 and each behavioral health organization to develop and maintain adequate capacity to facilitate child mental health treatment services in the community or transfers to a behavioral health organization, depending on the level of required care. Managed health care systems and behavioral health organizations must:

(a) Follow up with individuals to ensure an appointment has been secured;

(b) Coordinate with and report back to primary care provider offices on individual treatment plans and medication management, in accordance with patient confidentiality laws;

(c) Provide information to health plan members and primary care providers about the behavioral health resource line available twenty-four hours a day, seven days a week; and

(d) Maintain an accurate list of providers contracted to provide mental health services to children and youth. The list must contain current information regarding the providers' availability to provide services. The current list must be made available to health plan members and primary care providers.

(3) This section expires June 30, 2020.

Sec. 5. RCW 74.09.010 and 2013 2nd sp.s. c 10 s 8 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Authority" means the Washington state health care authority.

(2) <u>"Bidirectional integration" means integrating behavioral health services into primary care settings and integrating primary care services into behavioral health settings.</u>

<u>(3)</u> "Children's health program" means the health care services program provided to children under eighteen years of age and in households with incomes at or below the federal poverty level as

annually defined by the federal department of health and human services as adjusted for family size, and who are not otherwise eligible for medical assistance or the limited casualty program for the medically needy.

((~~(3)~~)) (4) "Chronic care management" means the health care management within a health home of persons identified with, or at high risk for, one or more chronic conditions. Effective chronic care management:

(a) Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;

(b) Employs evidence-based clinical practices;

(c) Coordinates care across health care settings and providers, including tracking referrals;

(d) Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and

(e) Uses appropriate community resources to support individual patients and families in managing chronic conditions.

((~~(4)~~)) (5) "Chronic condition" means a prolonged condition and includes, but is not limited to:

(a) A mental health condition;

(b) A substance use disorder;

(c) Asthma;

(d) Diabetes;

(e) Heart disease; and

(f) Being overweight, as evidenced by a body mass index over twenty-five.

((~~(5)~~)) (6) "County" means the board of county commissioners, county council, county executive, or tribal jurisdiction, or its designee.

((~~(6)~~)) (7) "Department" means the department of social and health services.

((~~(7)~~)) (8) "Department of health" means the Washington state department of health created pursuant to RCW 43.70.020.

((~~(8)~~)) (9) "Director" means the director of the Washington state health care authority.

((~~(9)~~)) (10) "Full benefit dual eligible beneficiary" means an individual who, for any month: Has coverage for the month under a medicare prescription drug plan or medicare advantage plan with part D coverage; and is determined eligible by the state for full medicaid

benefits for the month under any eligibility category in the state's medicaid plan or a section 1115 demonstration waiver that provides pharmacy benefits.

((~~(10)~~)) (11) "Health home" or "primary care health home" means coordinated health care provided by a licensed primary care provider coordinating all medical care services, and a multidisciplinary health care team comprised of clinical and nonclinical staff. The term "coordinating all medical care services" shall not be construed to require prior authorization by a primary care provider in order for a patient to receive treatment for covered services by an optometrist licensed under chapter 18.53 RCW. Primary care health home services shall include those services defined as health home services in 42 U.S.C. Sec. 1396w-4 and, in addition, may include, but are not limited to:

(a) Comprehensive care management including, but not limited to, chronic care treatment and management;

(b) Extended hours of service;

(c) Multiple ways for patients to communicate with the team, including electronically and by phone;

(d) Education of patients on self-care, prevention, and health promotion, including the use of patient decision aids;

(e) Coordinating and assuring smooth transitions and follow-up from inpatient to other settings;

(f) Individual and family support including authorized representatives;

(g) The use of information technology to link services, track tests, generate patient registries, and provide clinical data; and

(h) Ongoing performance reporting and quality improvement.

((~~(11)~~)) (12) "Internal management" means the administration of medical assistance, medical care services, the children's health program, and the limited casualty program.

((~~(12)~~)) (13) "Limited casualty program" means the medical care program provided to medically needy persons as defined under Title XIX of the federal social security act, and to medically indigent persons who are without income or resources sufficient to secure necessary medical services.

((~~(13)~~)) (14) "Medical assistance" means the federal aid medical care program provided to categorically needy persons as defined under Title XIX of the federal social security act.

((~~(14)~~)) (15) "Medical care services" means the limited scope of care financed by state funds and provided to persons who are not eligible for medicaid under RCW 74.09.510 and who are eligible for the aged, blind, or disabled assistance program authorized in RCW 74.62.030 or the essential needs and housing support program pursuant to RCW 74.04.805.

((~~(15)~~)) (16) "Multidisciplinary health care team" means an interdisciplinary team of health professionals which may include, but is not limited to, medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers including substance use disorder prevention and treatment providers, doctors of chiropractic, physical therapists, licensed complementary and alternative medicine practitioners, home care and other long-term care providers, and physicians' assistants.

((~~(16)~~)) (17) "Nursing home" means nursing home as defined in RCW 18.51.010.

((~~(17)~~)) (18) "Poverty" means the federal poverty level determined annually by the United States department of health and human services, or successor agency.

((~~(18)~~)) (19) "Primary care behavioral health" means a health care integration model in which behavioral health care is colocated, collaborative, and integrated within a primary care setting.

(20) "Primary care provider" means a general practice physician, family practitioner, internist, pediatrician, ((~~osteopath~~)) osteopathic physician, naturopath, physician assistant, osteopathic physician assistant, and advanced registered nurse practitioner licensed under Title 18 RCW.

((~~(19)~~)) (21) "Secretary" means the secretary of social and health services.

(22) "Whole-person care in behavioral health" means a health care integration model in which primary care services are integrated into a behavioral health setting either through colocation or community-based care management.

Sec. 6. RCW 74.09.495 and 2016 c 96 s 3 are each amended to read as follows:

To better assure and understand issues related to network adequacy and access to services, the authority and the department shall report to the appropriate committees of the legislature by December 1, 2017, and annually thereafter, on the status of access to

behavioral health services for children birth through age seventeen using data collected pursuant to RCW 70.320.050.

(1) At a minimum, the report must include the following components broken down by age, gender, and race and ethnicity:

((~~(1)~~)) (a) The percentage of discharges for patients ages six through seventeen who had a visit to the emergency room with a primary diagnosis of mental health or alcohol or other drug dependence during the measuring year and who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within thirty days of discharge;

((~~(2)~~)) (b) The percentage of health plan members with an identified mental health need who received mental health services during the reporting period; and

((~~(3)~~)) (c) The percentage of children served by behavioral health organizations, including the types of services provided.

(2) The report must also include the number of children's mental health providers available in the previous year, the languages spoken by those providers, and the overall percentage of children's mental health providers who were actively accepting new patients.

NEW SECTION. **Sec. 7.** A new section is added to chapter 74.09 RCW to read as follows:

Subject to the availability of amounts appropriated for this specific purpose, in order to increase the availability of behavioral health services and incentivize adoption of the primary care behavioral health model, the authority must establish a methodology and rate which provides increased reimbursement to providers for behavioral health services provided to patients in primary care settings.

Sec. 8. RCW 70.320.020 and 2014 c 225 s 107 are each amended to read as follows:

(1) The authority and the department shall base contract performance measures developed under RCW 70.320.030 on the following outcomes when contracting with service contracting entities: Improvements in client health status and wellness; increases in client participation in meaningful activities; reductions in client involvement with criminal justice systems; reductions in avoidable costs in hospitals, emergency rooms, crisis services, and jails and

prisons; increases in stable housing in the community; improvements in client satisfaction with quality of life; and reductions in population-level health disparities.

(2) The performance measures must demonstrate the manner in which the following principles are achieved within each of the outcomes under subsection (1) of this section:

(a) Maximization of the use of evidence-based practices will be given priority over the use of research-based and promising practices, and research-based practices will be given priority over the use of promising practices. The agencies will develop strategies to identify programs that are effective with ethnically diverse clients and to consult with tribal governments, experts within ethnically diverse communities and community organizations that serve diverse communities;

(b) The maximization of the client's independence, recovery, and employment;

(c) The maximization of the client's participation in treatment decisions; and

(d) The collaboration between consumer-based support programs in providing services to the client.

(3) In developing performance measures under RCW 70.320.030, the authority and the department shall consider expected outcomes relevant to the general populations that each agency serves. The authority and the department may adapt the outcomes to account for the unique needs and characteristics of discrete subcategories of populations receiving services, including ethnically diverse communities.

(4) The authority and the department shall coordinate the establishment of the expected outcomes and the performance measures between each agency as well as each program to identify expected outcomes and performance measures that are common to the clients enrolled in multiple programs and to eliminate conflicting standards among the agencies and programs.

(5)(a) The authority and the department shall establish timelines and mechanisms for service contracting entities to report data related to performance measures and outcomes, including phased implementation of public reporting of outcome and performance measures in a form that allows for comparison of performance measures and levels of improvement between geographic regions of Washington.

(b) The authority and the department may not release any public reports of client outcomes unless the data ((~~have [has]~~)) has been deidentified and aggregated in such a way that the identity of individual clients cannot be determined through directly identifiable data or the combination of multiple data elements.

(6) The authority and department must establish a performance measure to be integrated into the statewide common measure set which tracks effective integration practices of behavioral health services in primary care settings.

NEW SECTION. **Sec. 9.** RCW 18.205.040 (Use of title) and 2014 c 225 s 108, 2008 c 135 s 17, & 1998 c 243 s 4 are each repealed.

NEW SECTION. **Sec. 10.** Section 2 of this act takes effect only if Engrossed Substitute House Bill No. 1340 (including any later amendments or substitutes) is not signed into law by the governor by the effective date of this section.

NEW SECTION. **Sec. 11.** Section 3 of this act takes effect only if Engrossed Substitute House Bill No. 1340 (including any later amendments or substitutes) is signed into law by the governor by the effective date of this section."

Correct the title.

EFFECT: Requires the review of payment codes by the Health Care Authority (HCA) to include review of primary care codes, and requires adjustments to payment rules to facilitate bidirectional integration. Provides that payment rules should allow medically necessary primary care services to be provided in any setting and should allow health and behavior codes to be reimbursed in behavioral health settings as provided by any licensed health care provider acting within his or her scope of practice. Requires the HCA to develop a matrix of all physical health related codes available for provider payment when provided in licensed behavioral health agencies. Requires the HCA and the Department of Social and Health Services to establish a performance measure that tracks effective integration practices of primary care services in behavioral health settings. States legislative findings related to bidirectional integration, whole-person care in behavioral health, and access to primary care for individuals with complex behavioral health disorders. Defines "bidirectional integration" as integrating behavioral health services into primary care settings and integrating primary care services into behavioral health settings. Defines "whole-person care in behavioral health" as a health care integration model in which primary care services are integrated into a behavioral health setting either through colocation or community-based care management.

Requires the HCA, until June 30, 2020, to oversee the coordination of mental health resources and services for Medicaid-eligible children, including resources through tribal organizations, to ensure children receive treatment and appropriate care based on their assessed needs, regardless of whether the referral occurred through primary care, school-based services, or another practitioner. Requires the HCA to require each managed care organization and behavioral health organization to develop and maintain adequate capacity to facilitate children's mental health treatment services in the community or transfers to a behavioral health organization. Requires managed care organizations and behavioral health organizations to: (1) Follow up with individuals to ensure that an appointment has been secured; (2) coordinate with and report back to the primary care provider on individual treatment plans and medication management; (3) provide information to health plan members and primary care providers about the behavioral health resource line; and (4) maintain an accurate list of providers contracted to provide mental health services to children and youth, which must contain current information regarding providers' availability and must be made available to health plan members and primary care providers.

Requires the HCA to report to the Legislature on the number of children's mental health providers available in the previous year, the languages spoken by those providers, and the overall percentage who were actively accepting new patients.

References "substance use disorder professionals" and "substance use disorder professional trainees" (instead of "chemical dependency professionals" and "chemical dependency professional trainees") if ESHB 1340 is enacted.

Removes the provision naming the act the Youth Behavioral Health Protection Act.

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