HOUSE BILL REPORT
HB 1713

As Reported by House Committee On:
Early Learning & Human Services
Appropriations

Title: An act relating to implementing recommendations from the children's mental health work group.

Brief Description: Implementing recommendations from the children's mental health work group.

Sponsors: Representatives Senn, Dent, Kagi and Kilduff.

Brief History:

Committee Activity:

Early Learning & Human Services: 2/1/17, 2/7/17 [DPS];
Appropriations: 2/20/17, 2/21/17, 2/22/17 [DP2S(w/o sub ELHS)].

Brief Summary of Second Substitute Bill

- Requires the Health Care Authority to coordinate mental health resources for Medicaid-eligible children, maintain an adequate provider network, and require provider payment for depression screenings for youth ages 12-18 and maternal depression screenings for mothers of children ages 0-1.
- Requires behavioral health organizations to reimburse providers for providing mental health services through telemedicine.
- Requires the Department of Early Learning to establish a child care consultation program for children who present behavioral concerns or symptoms of trauma.
- Requires the Office of the Superintendent of Public Instruction to produce a case study of an Educational Service District that is successfully delivering and coordinating children's mental health activities and services.

HOUSE COMMITTEE ON EARLY LEARNING & HUMAN SERVICES

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 13 members: Representatives Kagi, Chair; Senn, Vice Chair; Dent, Ranking

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This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Minority Member; McDonald, Assistant Ranking Minority Member; Frame, Goodman, Griffey, Kilduff, Klippert, Lovick, McCaslin, Muri and Ortiz-Self.

Staff: Dawn Eychaner (786-7135).

Background:

The 2016 Legislature established the Children's Mental Health Work Group (Work Group) to identify barriers to accessing mental health services for children and families, and to advise the Legislature on statewide mental health services for this population. The Work Group published its final report and recommendations in December 2016.

Medicaid Managed Care for Children.
The Health Care Authority (HCA) administers Apple Health, the state-federal Medicaid program that provides health care for eligible low-income individuals. Apple Health for Kids is available at low or no cost for children whose families meet income eligibility criteria. Benefits for children and youth up to age 21 who are enrolled through Apple Health managed care organizations (MCOs) include the Early and Periodic Screening Diagnosis and Treatment Program, which covers regularly scheduled health screening (well-child visits) to evaluate a child's growth, development, and general physical and mental health.

When purchasing managed care for Medicaid participants, the HCA must ensure that managed care organizations demonstrate the ability to supply an adequate provider network. Federal regulations and state law require managed care organizations to maintain a network of appropriate providers sufficient to provide adequate access to all services covered under the contract.

Behavioral Health Organizations.
The Department of Social and Health Services (DSHS) contracts with behavioral health organizations (BHOs) for the provision of community-based mental health and substance use disorder treatment. The BHOs contract with mental health and substance use disorder treatment programs to provide services to Medicaid enrollees who have a medical need and meet Access to Care Standards established by the DSHS.

Access to Care Standards are guidelines published by the DSHS for BHOs and their contracted mental health providers to use when determining eligibility for mental health services for individuals being served through the state public mental health system.

By January 1, 2020, behavioral health services must be fully integrated into managed care organizations that provide mental health services, substance use disorder services, and medical care services to Medicaid clients.

Telemedicine.
Telemedicine is the use of electronic communications to provide health care services to a patient at a distance. Electronic communication through audio-visual equipment allows real-time interaction between a patient and provider. Health plans offered by health carriers and Medicaid managed care organizations must reimburse health care providers for eligible

health care services provided through telemedicine. In addition, originating sites other than a person's home may charge a facility fee for infrastructure and preparation of the patient.

Mental Health in K-12 Schools.
In October 2016 the Joint Legislative Audit Review Committee (JLARC) completed an inventory of mental health services available to students through schools, school districts, and educational service districts. The JLARC reported that of the approximately 55,000 children ages 5-17 who received Medicaid-funded mental health services in 2015, approximately 10,000 students received those services in their schools. The remainder of students who received Medicaid-funded mental health services were served through MCOs or BHOs.

Child Care Consultation Pilot.
In 2008 the Department of Early Learning (DEL) conducted a childcare consultation pilot project and project evaluation. The pilot linked childcare providers with resources to support the care of infants and young children with behavioral concerns. Services included targeted consultation and training on social and emotional supports for providers.

Mental Health Workforce.
The Workforce Training and Education Coordinating Board (Workforce Board) advises the Governor and Legislature on workforce development policy. The Workforce Board convenes and provides staff support to the Health Workforce Council (Council). The Council researches factors affecting shortages in the healthcare professions and recommends strategies to ensure an adequate supply of health care personnel.

The Accreditation Council for Graduate Medical Education accredits medical education and residency programs and associated sponsoring institutions. Examples of psychiatry residency programs in Washington include the Providence Psychiatry Residency located at the Spokane Teaching Health Clinic on the Washington State University (WSU) Spokane campus, and the University of Washington (UW) Child and Adolescent Psychiatry Residency Program based at Seattle Children's Hospital.

Summary of Substitute Bill:

Medicaid Managed Care for Children.
Until June 30, 2020, the HCA must oversee the coordination of mental health resources and services for Medicaid-eligible children, including resources through tribal organizations, regardless of whether the referral occurred through primary care, school-based services, or another practitioner. The HCA must require each MCO and BHO to develop adequate capacity to facilitate children's mental health treatment services by:

- ensuring individuals secure and complete appointments;
- tracking individual utilization of services;
- coordinating with primary care providers on individual treatment plans and medication management;
- providing information to plan members and primary care providers about the behavioral health resource line; and

- maintaining an accurate list of providers contracted to provide mental health services to children and youth. The list must contain current information about provider availability and be made available to plan members and primary care providers.

The HCA must report on the number of children's mental health providers available in the previous year and the overall percentage of providers who were actively accepting new patients in its annual report to the Legislature on the status of access to behavioral health services for children.

Depression Screenings.
Beginning January 1, 2018, the HCA must require provider payment for depression screening for:
- maternal depression for mothers of children ages 0-5; and
- children ages 12-18. Screenings may be provided by primary care providers, public health nurses, and other providers in a clinical setting.

Telemedicine.
Beginning January 1, 2018, BHOs contracting with the DSHS must reimburse providers for behavioral health services provided through telemedicine. The DSHS must consult with the HCA to adopt rules to implement this requirement.

Mental Health Leads in Educational Service Districts.
Each Educational Service District (ESD) must establish a lead staff person for mental health. The Office of Superintendent of Public Instruction (OSPI) must employ a children's mental health services coordinator to provide support for the ESD leads. The OSPI must designate one ESD as a "lighthouse" to provide technical assistance to the other ESDs, including technical assistance with Medicaid billing for schools and school districts.

Childcare Provider Consultation.
The DEL must establish an early childhood mental health training and consultation program focused on trauma-informed care for child care providers participating in the Early Achievers quality rating system.

Mental Health Workforce.
The Workforce Board must conduct a workforce survey for clinicians qualified to provide children's mental health services and report the results to the Legislature by December 1, 2018. The Workforce Board must collect survey and administrative data related to the race and ethnicity of providers, languages spoken by providers, the ages of patients served, provider use of screening tools and assessments that are culturally relevant and linguistically valid and appropriate, and the amount of culturally relevant training that providers receive.

The WSU and the UW must each offer one 24-month residency position to a resident specializing in child and adolescent psychology. The WSU residency must be located in Eastern Washington, and the UW residency must be located in Western Washington.

Substitute Bill Compared to Original Bill:

Tribal organizations are included as entities for which the HCA must oversee the coordination of children's mental health treatment resources and services. The BHOs must develop adequate capacity to facilitate children's mental health treatment services by undertaking specified activities. Provider payment for depression screening is required for children ages 12-18 and may be provided by primary care providers, public health nurses, and other providers in a clinical setting. The HCA must require provider payment for maternal depression screening for mothers of children ages 0-5 beginning January 1, 2018, and subject to the availability of funds.

The child care consultation program administered by the DEL is changed to focus on trauma-informed care and to be made available to participants in the Early Achievers program. The ESDs must facilitate partnerships with community mental health agencies and other providers. The workforce survey conducted by the Workforce Board must collect survey and administrative data related to the race and ethnicity of providers, languages spoken by providers, the ages of patients served, provider use of screening tools and assessments that are culturally relevant and linguistically valid and appropriate, and the amount of culturally relevant training that providers receive. The DSHS must consult with the HCA when adopting rules related to reimbursement for behavioral health services provided through telemedicine. The requirement for the DSHS to determine the annual cost of operating the Partnership Access Line (PAL) and collecting proportional cost shares from health carriers is removed.

Appropriation: None.

Fiscal Note: Requested on February 9, 2017.

Effective Date of Substitute Bill: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for section 11, relating to provider reimbursement for behavioral health services provided through telemedicine, which takes effect January 1, 2018.

Staff Summary of Public Testimony:

(In support) This bill is at the nexus of two important issues this legislative session: education and mental health. Symptoms of mental illness and depression can manifest at a young age. Without depression screenings, children and young adults may suffer for years without treatment. Outpatients often come to the emergency room because they were unable to access mental health services in their community. Increased access for behavioral health support for childhood providers is needed, and many other states have implemented this type of consultation program with great success. The collaboration between ESDs and the OSPI is appreciated. Every day students suffer from unmet mental health needs and are not diagnosed. This bill will provide infrastructure needed to implement comprehensive mental health services throughout school districts in our state. The language around "culturally appropriate practices" in the bill is unclear. We need to ensure that youth of different ethnic backgrounds can receive the help that is appropriate for them. Several elements in this bill will help address the acute behavioral health workforce shortage. Telemedicine is a cost-

effective way to provide services to people in rural areas. There is an extreme shortage of children's mental health providers in Eastern Washington, and training providers in that region will help retain the workforce. More residencies are needed for child psychiatrists in the state. Please add clarification for the roles of MCOs and BHOs regarding network adequacy and to specify additional criteria for the workforce survey data. Schools cannot meet their mission of helping children learn without these mental health supports and services. The PAL provisions will provide stable funding for that program.

(Opposed) Children's mental health needs should not lead to psychiatric labels and drugging. More children receive medication than behavioral treatment for attention deficit hyperactivity disorder. The bill should be amended to require every program providing children's mental health services to track the administration of psychotropic drugs. Additional controls are needed to create accountability and oversight connected to individual health outcomes.

Persons Testifying: (In support) Representative Senn, prime sponsor; Roseann Martinez, Children's Home Society of Washington; Mary Richards; Elizabeth Meade, Washington Chapter American Academy of Pediatrics; Allison Krutsinger, Child Care Aware of Washington; Erin Riffe and Michael Hickman, Capital Region Educational Service District 113; Mary Stone-Smith, Catholic Community; Nickolaus Lewis, Lummi Nation; Chiara Solomon, Lummi Indian Business Council; Mike Hatchett, Washington Council for Behavioral Health; Ken Roberts, Washington State University; Tanya Keeble and Nicole Burkette, Providence Psychiatry Residency Spokane; Erica Hallock, Empire Health Foundation; Sean Graham, Washington State Medical Association; Andrea Tull Davis, Coordinated Care; Tatsuko Go Hollo, Children's Alliance; Joel Ryan, Washington State Association of Headstart & Early Childhood Education and Assistance Program; Melanie Smith, Wellspring Family Services; Greg Williamson, Department of Early Learning; Mona Johnson, Office of Superintendent of Public Instruction; Seth Dawson, National Alliance on Mental Illness; and Ian Goodhew, University of Washington Medicine.

(Opposed) Steven Pearce, Citizens Commission on Human Rights Seattle.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Early Learning & Human Services. Signed by 19 members: Representatives Ormsby, Chair; Robinson, Vice Chair; Bergquist, Cody, Fitzgibbon, Haler, Hansen, Hudgins, Jinkins, Kagi, Lytton, Pettigrew, Pollet, Sawyer, Senn, Springer, Stanford, Sullivan and Tharinger.

Minority Report: Do not pass. Signed by 13 members: Representatives Chandler, Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Stokesbary, Assistant Ranking Minority Member; Buys, Caldier, Condotta, Harris, Manweller, Schmick, Taylor, Vick, Volz and Wilcox.

Minority Report: Without recommendation. Signed by 1 member: Representative Nealey.

Staff: Catrina Lucero (786-7192).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Early Learning & Human Services:

The Health Care Authority (HCA) must reimburse providers for maternal depression screening for mothers of children ages birth to 1-year-old rather than children ages birth to 5 years old. Language is added to clarify that depression screenings for youth ages 12-18 occur on an annual basis. The requirements for managed health care and behavioral health organizations to ensure that an individual has completed a mental health appointment and to track the individual's utilization of services are removed. The HCA must report on languages spoken by children's mental health providers as part of the annual report on available providers.

Educational Service Districts (ESDs) are no longer required to employ a mental health lead. The requirement for the Office of the Superintendent of Public Instruction (OSPI) to designate one ESD as a "lighthouse" to provide technical assistance to other ESDs is also removed. Instead, OSPI must produce a case study of an ESD that is successfully delivering and coordinating children's mental health activities and services. The case study and recommendations for replicating the model are due to the Governor and Legislature by December 1, 2018.

The Department of Early Learning (DEL) is no longer required to develop an Early Childhood Mental Health Training and Consultation Program. The DEL must establish a Child Care Consultation Program to link child care providers with evidence-based, trauma-informed, and best-practice resources regarding caring for infants and young children who present behavioral concerns or symptoms of trauma. The DEL may contract with an entity with expertise in child development and early learning to provide the program.

The Workforce Training and Education Coordinating Board is no longer required to collect and report on workforce survey and administrative data for children's mental health clinicians. The 24-month child and adolescent psychiatry residency at the University of Washington is removed.

A null and void clauses is added, making the bill null and void unless funded in the budget.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

Effective Date of Second Substitute Bill: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for section 7, relating to provider reimbursement for behavioral health services provided through telemedicine, which takes effect January 1, 2018.

Staff Summary of Public Testimony:

(In support) We need a more integrated and effective system of care for children and youth so that we can intervene early and prevent serious life consequences. Care coordination is an important component. About 4 percent of children on Medicaid get treatment through outpatient behavioral health services. The prevalence of mental health issues among children on Medicaid is about 20 percent. Eighty percent of children with mental health issues are not receiving the care they need. The Seattle Children's Hospital emergency department often sees children in mental health crisis. There are days when five to 10 of the 50 beds available in the emergency department are occupied by mental health patients. The emergency department is an expensive setting. If these children had had access to care earlier, their stay in the emergency department may have been preventable. Early diagnosis and evidence-based treatments are critical. These children often end up getting treatment in more costly settings. Where students do their residencies is often where they end up staying to practice. There is a dearth of pediatric psychiatrists. This legislation addresses this by funding two child psychology residency positions.

(Opposed) The cost of including depression screening may also trigger additional screening costs. If the Health Care Authority is required to pay providers each time a screen is done this could have a significant budget impact. The cost of including universal mental health screening should be balanced against actual need. Screening for depression-related disorders in children only has a moderate benefit. Children with behavioral issues readily identify themselves without screening. Health care providers are already required to have some knowledge of suicide prevention and be alert to what children are saying and doing.

Persons Testifying: (In support) Kristen Houser; Kathryn Kolan, Washington State Medical Association; and Amanda Jacobsen, Washington Chapter American Academy of Pediatrics.

(Opposed) Kelly Richardson, Citizens Commission on Human Rights.

Persons Signed In To Testify But Not Testifying: None.