HOUSE BILL REPORT
SSB 5779

As Passed House - Amended:
April 10, 2017

Title: An act relating to behavioral health integration in primary care.

Brief Description: Concerning behavioral health integration in primary care.

Sponsors: Senate Committee on Human Services, Mental Health & Housing (originally sponsored by Senators Brown and O'Ban).

Brief History:
Committee Activity:
Health Care & Wellness: 3/21/17, 3/22/17 [DP];
Appropriations: 4/1/17, 4/4/17 [DPA].
Floor Activity:
Passed House - Amended: 4/10/17, 94-3.

Brief Summary of Substitute Bill
(As Amended by House)

- Requires the Health Care Authority (Authority) to review behavioral health and primary care payment codes, adjust payment rules to facilitate integration of behavioral health and primary care, and establish a methodology and rate that provides increased reimbursement to providers for behavioral health services provided in primary care settings.
- Requires the Authority and the Department of Social and Health Services to establish a performance measure related to integration of behavioral health services in primary care settings.
- Requires the Authority to oversee the coordination of mental health services for Medicaid-eligible children and ensure that managed care organizations and behavioral health organizations maintain adequate capacity to facilitate children's mental health treatment services.
- Repeals a practice setting restriction on the use of the titles "certified chemical dependency professional" and "certified chemical dependency professional trainee."

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.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 16 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Harris, Jinkins, MacEwen, Maycumber, Riccelli, Robinson, Slatter, Stonier and Tharinger.

Staff: Alexa Silver (786-7190).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended. Signed by 30 members: Representatives Ormsby, Chair; Robinson, Vice Chair; Chandler, Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Stokesbary, Assistant Ranking Minority Member; Bergquist, Buys, Cody, Fitzgibbon, Haler, Hansen, Harris, Hudgins, Jinkins, Kagi, Lytton, Manweller, Nealey, Pettigrew, Pollet, Sawyer, Schmick, Senn, Springer, Stanford, Sullivan, Tharinger, Vick, Volz and Wilcox.

Minority Report: Do not pass. Signed by 2 members: Representatives Condotta and Taylor.

Staff: Catrina Lucero (786-7192).

Background:

Administration of Medical Assistance and Community Behavioral Health Services.
The Health Care Authority (Authority) administers the Medicaid program, which is a state-federal program that pays for health care for low-income state residents who meet certain eligibility criteria. The Authority primarily administers the Medicaid program through contracts with managed care organizations. The managed care organizations provide a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services.

Since April 1, 2016, the Department of Social and Health Services (DSHS) has contracted with behavioral health organizations to oversee the delivery of mental health and substance use disorder services for adults and children. A behavioral health organization may be a county, group of counties, or a nonprofit entity. Behavioral health organizations are paid by the state on a capitation basis, and funding is adjusted based on caseload. Behavioral health organizations contract with local providers to provide an array of mental health and chemical dependency services, monitor the activities of local providers, and oversee the distribution of funds under the state managed care plan.

Legislation enacted in 2014 directed all behavioral health services to be integrated into Medicaid managed care organizations by April 2020. The Authority's contracts with managed care organizations must include established consistent processes to incentivize integration of behavioral health services in the primary care setting, promoting care that is integrated, collaborative, co-located, and preventive. In one regional service area in

Southwest Washington, behavioral health services have already been integrated into the contracts of Medicaid managed care organizations.

Managed care organizations compete for the award of contracts based on several elements, including the ability to supply an adequate provider network. The Authority and the DSHS are required to submit an annual report to the Legislature on the status of access to behavioral health services for children. The report must include, for example, the percentage of children served by behavioral health organizations.

Performance Measures.
The Performance Measures Coordinating Committee (Committee), which was directed by statute to recommend standard statewide measures of health performance, approved an initial set of measures in December 2014. State agencies are required to use the measure set to inform and determine benchmarks for purchasing decisions. The Authority and the Committee have established a public process to periodically evaluate and make changes to the measure set.

The Authority and the DSHS are also required to adopt performance measures to determine whether service contracting entities (such as managed care organizations and behavioral health organizations) are achieving specified outcomes for clients. The Authority and the DSHS must include the performance measures in contracts with service coordination organizations.

Certified Chemical Dependency Professionals.
The Department of Health certifies chemical dependency professionals, who are health care providers who employ chemical dependency counseling to assist persons to develop and maintain abstinence from alcohol and other drugs. To become certified, a person must meet specific education, examination, and experience requirements.

A person may not use the title "certified chemical dependency professional" or "certified chemical dependency professional trainee" when treating patients in settings other than DSHS-approved substance use disorder treatment programs, unless the person also holds a license as an advanced registered nurse practitioner, a marriage and family therapist, a mental health counselor, an advanced social worker or independent clinical social health worker, a psychologist, or an allopathic or osteopathic physician or physician assistant.

Summary of Amended Bill:

Primary Care and Behavioral Health Payment Codes.
By August 1, 2017, the Health Care Authority (Authority) must complete a review of payment codes related to primary care and behavioral health. The review must involve stakeholders and include adjustments to payment rules if needed to facilitate bidirectional integration. In addition, the review must include consideration of the following principles to the extent allowed by federal law:

- Payment rules must allow professionals to operate within their full scope of practice.
- Payment rules should allow medically necessary behavioral health and primary care services for covered patients to be provided in any setting.

- 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, collaborative care, and whole-person care in behavioral health.
- Payment rules should be designed liberally to encourage innovation and ease future transition to more integrated models of care and payment.
- 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 his or her scope of practice.
- 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 his or her scope of practice.
- Payment rules that 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 used only when consistent with national coding conventions and consonant with accepted best practices.

Concurrent with the review, 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 behavorial health agencies. The Authority must: clearly explain applicable rules to increase providers' awareness, standardize billing practices, and reduce common and avoidable billing errors; disseminate this information to maximally reach all relevant plans and providers; and update the provider billing guide for consistency. Once this work has been completed, the Authority must inform the Governor and the Legislature of the steps taken and the results achieved.

"Bidirectional integration" is defined as integrating behavioral health services into primary care settings and integrating primary care services into behavioral health settings. "Primary care behavioral health" is defined as a health care integration model in which behavioral health care is co-located, collaborative, and integrated within a primary care setting. "Whole-person care in behavioral health" is defined as a model in which primary care services are integrated into a behavioral health setting either through colocation or community-based care management.

Provider Reimbursement.

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

Performance Measures.

The Authority and the Department of Social and Health Services (DSHS) must establish a performance measure to be integrated into the statewide common measure set that tracks effective integration practices of behavioral health services in primary care settings.

Mental Health Treatment for Children.

For children who are eligible for medical assistance and have been identified as requiring mental health treatment, the Authority must oversee the coordination of resources and services through the managed health care system and tribal organizations. The Authority must ensure the child receives treatment and appropriate care based on his or her assessed needs, regardless of whether the referral occurred through primary care, school-based services, or another practitioner. These requirements expire on June 30, 2020.

In addition, until June 30, 2020, the Authority must require managed health care systems and behavioral health organizations to develop and maintain adequate capacity to facilitate child mental health treatment services in the community or transfers to a behavioral health organizations. Managed health care systems and behavioral health organizations must: (1) follow up with individuals to ensure an appointment has been secured; (2) coordinate with and report back to primary care providers regarding 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 about providers' availability and must be available to health plan members and primary care providers.

The Authority's report on access of behavioral health services for children must include the number of children's mental health providers available in the previous year, the languages spoken by those providers, and the percentage of children's mental health providers who were actively accepting new patients.

Certified Chemical Dependency Professionals.
The prohibition on the use of the titles "certified chemical dependency professional" and "certified chemical dependency professional trainee" in settings other than DSHS-approved substance use disorder treatment programs is repealed.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for section 2, which takes effect if ESHB 1340 does not take effect, and section 3, which takes effect if ESHB 1340 takes effect.

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) The impetus for this bill was a series of community conversations about suicide prevention. Many children need mental health services but have a hard time accessing them. At most, one in four children enrolled in Medicaid who need behavioral health support are receiving services through the plans. It is difficult to navigate the system, and it takes time to get an appointment. Patients must get a referral from a primary care doctor, and someone else prescribes medication through a separate referral process. One of the biggest problems for behavioral health care is follow-through on subsequent appointments.

The Children's Mental Health Work Group recommended looking into including behavioral health specialists in primary care settings to improve access to care. This model makes a behavioral health specialist available to identify issues and provide some services and potential referrals when children come into a primary care setting. The system is more effective when an assessment is done in a medical office when the family is already there. Many childhood psychological problems present as medical issues, and this model allows the doctor to suggest speaking with a counselor. Inexpensive interventions at the primary care level can make a significant difference to depression and anxiety issues. Funding should be provided to support this integrated model of care.

There have been significant challenges for billing and reimbursement for clinics that have integrated behavioral health in primary care. In some clinics that have adopted this model, a medical staff person identifies behavioral health symptoms and the patient is sent down the hall to speak with a behavioral health specialist. Bills for behavioral health and physical health visits that occur on the same day are rejected, which inhibits the standard of care of providing all services in one day. The billing guides for different areas of care are confusing and conflict with each other. Education of practitioners is important.

(Opposed) None.

(Other) Integrating behavioral health into primary care improves patient outcomes and increases access to behavioral health care. Because behavioral health and primary care were historically siloed, there are issues around assuring that billing and coding support new integrated models of care. The Health Care Authority is working with stakeholders to clarify and simplify the practice and educate stakeholders on the use of existing billing codes. Performance measurement is important to improve integration.

Washington has adopted a policy calling for bi-directional integration of behavioral and physical health. People with serious mental illness and substance use disorder often have co-occurring medical conditions and are unable to access primary care. They experience significant disparities in terms of life expectancy. A community behavioral health agency is often the only health care provider for this population, but there has been little attention paid to integrating primary care into these settings. This bill should be extended to licensed behavioral health agencies seeking to bring primary care into behavioral health settings to ensure support for this model of integrated care.

Staff Summary of Public Testimony (Appropriations):

(In support) Changes to billing and reimbursement rules would streamline access to care. Behavioral and physical health care have historically been handled by different providers and reimbursement methodologies. There are multiple, and sometimes conflicting, sets of provider guidelines related to billing and reimbursement. The current reimbursement rules do not allow for same day billing. Allowing a client be treated by a physical health care professional and a behavioral health care professional in the same day and location is critical as the state moves toward a more integrated model. Many people access services through counseling. Allowing for bidirectional integration would allow these individuals to be treated for their physical health care needs as well in an integrated setting. Integrating physical and behavioral health care for children promotes early identification of health issues

and improves access to care. The Children's Mental Health Workgroup identified billing and reimbursement rules as one of the current barriers to integrated health care.

(Opposed) None.

Persons Testifying (Health Care & Wellness): (In support) Senator Brown, prime sponsor; Laurie Lippold, Partners for Our Children; Katherine Runyon, American Academy of Pediatrics; Len McComb, Community Health Network of Washington; Brian Sandoval, Yakima Valley Farm Worker's Clinic; and Kristin Houser, King County Behavioral Health Advisory Board.

(Other) Ann Christian, Washington Council for Behavioral Health; Dan Lessler, Health Care Authority; and Lindsey Grad, Service Employees International Union Healthcare 1199.

Persons Testifying (Appropriations): Seth Dawson, National Alliance on Mental Illness Washington; Len McComb, Community Health Network of Washington; Alicia Ferris, Community Youth Services; and Laurie Lippold, Partners for Our Children.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.