HOUSE BILL REPORT
SSB 5779

As Reported by House Committee On:
Health Care & Wellness

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].

Brief Summary of Substitute Bill

- Requires the Health Care Authority (Authority) to complete a review of behavioral health payment codes and adjust payment rules to facilitate integration of behavioral health with primary care.
- Requires the Authority to increase reimbursement rates for behavioral health services provided in primary care settings, subject to appropriation.
- 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.
- Repeals a practice setting restriction on the use of the titles "certified chemical dependency professional" and "certified chemical dependency professional trainee."

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).

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.

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.

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 Bill:

Behavioral Health Payment Codes.
By August 1, 2017, the Health Care Authority (Authority) must complete a review of payment codes related to behavioral health. The review must: involve stakeholders; include adjustments to payment rules if needed to facilitate integration of behavioral health with primary care; and 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 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 and collaborative care.
- 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 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 a matrix listing behavioral health-related codes available for provider payment through medical assistance programs and clearly explain applicable rules to increase providers' awareness, standardize billing practices, and reduce common and avoidable billing errors. The Authority must disseminate this information to maximally reach all relevant plans and providers and must 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.

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. "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.

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.

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 for Senate Bill 5779. A new fiscal note was requested on March 20, 2017.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(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.

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