RCW 74.09.497 Authority review of payment codes available to health plans and providers related to primary care and behavioral health—Requirements—Principles considered—Matrices—Reporting. ***(Effective until January 1, 2025.)*** (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. [2017 c 226 s 2.]

Contingent effective date—2017 c 226 s 2: "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 July 23, 2017." [2017 c 226 s 10.] Engrossed Substitute House Bill No. 1340 was not signed into law by July 23, 2017.

Sustainable solutions for the integration of behavioral and physical health—2017 c 226: "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." [2017 c 226 s 1.]

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***Reviser's note:** The term "advanced registered nurse practitioner" was changed to "advanced practice registered nurse" by 2024 c 239 s 1, effective June 30, 2027.

Effective date—2024 c 62 ss 1-8, 10-18, 20-26, 28, and 30-32: See note following RCW 18.71A.010.

Intent—2024 c 62: See note following RCW 18.71A.020.

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