Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Behavioral and Primary Health Regulatory Alignment Task Force

Engrossed Third Substitute House Bill 1713, Sec. 534 (2016)

November 8, 2016

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Washington State Department of Social & Health Services
Transforming lives

Washington State Health Care Authority

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BACKGROUND

Engrossed Third Substitute House Bill (E3SHB) 1713 (Chapter 29, Laws of 2016) charged the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) to convene a task force to "align regulations between behavioral health and primary health care settings and simplify regulations for behavioral health care providers."

The legislation specifies that "brief integrated health services must not, in general, take longer to document than to provide." Additionally, regulations "should emphasize the desired outcome rather than how they should be achieved."

The task force must include a representative cross-section of behavioral health organizations and behavioral health providers. To ensure full understanding of the issues, the task force included representation from:

- Behavioral health agencies
- Behavioral health organizations
- Behavioral health providers and advocates
- The Department of Health (DOH)
- Fully integrated managed care plans from Southwest Washington
- Hospitals

The legislation requires the following action by state agencies:

- DSHS must collaborate with DOH, HCA, and other appropriate agencies to reduce unneeded costs and burdens to health plans and providers associated with excessive audits, licensing, and contracting. DSHS shall consider combining audit functions, sharing audit information, and treating an organization's multiple sites as a single entity.
- DSHS shall review its practices to determine whether it complies with the statutory mandate to deem certain accreditation as equivalent to licensure. The agency's practices must comport with standard practices and incentivize voluntary accreditation.

The task force must also consider how to provide notice to parents when a minor requests chemical dependency treatment. The notice must comply with federal privacy laws and be in the best interests of the minor and their family. E3SHB 1713 requires DSHS to prepare a report to relevant legislative committees by December 1, 2016.

The task force is required to provide a status report to relevant legislative committees by December 15, 2016 on behavioral health alignment. The task force may also make recommendations, if any, concerning the required agency actions identified above.

The task force meetings were well attended. Members met twice to identify issues that hinder behavioral health alignment and opportunities for improvement, and discuss the changes needed, including those involving state agencies. Additionally, members met a third time to collaborate on the legislative reports. The task force also discussed ways to provide notice to parents when minors request substance abuse treatment.

ISSUES

During the June 16, 2016, meeting, members shared many opportunities to improve behavioral health regulations. The main areas identified included improvements to: regulations, licensing, reporting, and audits; standardization and definitions for alignment; service integration; and information sharing between agencies and organizations. A list of the topics compiled by the task force is included in Appendix B.

At the July 28, 2016, task force meeting, members discussed how to provide notice to parents of minors who request chemical dependency treatment. The notice must comply with federal privacy laws and be in the best interests of the minor and their family. Members received an overview of federal and state laws, which is summarized in a separate legislative report from DSHS.

During this meeting, the task force also reviewed a chart listing members' top ideas for behavioral health integration and how to implement these changes. Members identified the following items as priorities:

Deeming.

RCW 71.24.035(5)(c)(i) provides the following:

> The secretary shall provide for deeming of compliance with state minimum standards for those entities accredited by recognized behavioral health accrediting bodies recognized and having a current agreement with the department.

It is DSHS' practice to have organizations meet all rule and accrediting body requirements for licensure instead of just one set of requirements.

Task force members expressed concern about DSHS' process for licensing organizations with multiple sites. Currently, if an organization opens a new location, licensing requires more than one visit to each new location. Members also suggested that, generally, organizations with multiple sites should be treated as a single entity, as discussed in the next section of this report.

Streamline Audits.

Task force members commented on the frequency and redundancy of audits, which are time consuming and labor-intensive for facility staff. Providers may receive audits from external quality review organizations, behavioral health organizations, DSHS and DOH. One provider noted its organization received four separate audits within a six-month window.

Because providers are audited by multiple agencies, the findings are conflicting, resulting in costly staff training and more time spent on documentation. Auditors from different agencies review the same materials but use different interpretations and policies, which is confusing to the entity being audited. The task force felt that it was not necessary to conduct a full review of personnel records in every audit. Members suggested that the auditors review a sample of the records or perhaps only the files of those employees hired since the last review. Additionally, the task force would like to see organizations with multiple sites treated as a single entity, and reductions in the number of audits conducted at different locations.

Billing Practices.

Some task force members shared concerns about billing practices and noted that there needs to be a more robust billing structure in place for mental health services. One challenge is the "same day" billing prohibition, which limits the ability to provide effective integrated care. When providers treat substance use disorder under a fee-for-service model, they cannot bill for another treatment service on the same day at the same location. As a result, providers do not know how to bill for a client who receives multiple services at the same time. For example, if a patient has a primary care physician visit and a psychiatric advanced registered nurse practitioner (ARNP) visit on the same day, the ARNP is unable to bill and receive reimbursement under the standard billing code for that service.

Another challenge is the confusion about what can be billed in a federally qualified health center setting for psychologists, licensed mental health counselors, or licensed independent clinical social workers on the same day as a medical visit. Some members also indicated there is irregular reimbursement for behavioral health services in primary care.

The task force would like to see alignment of behavioral and primary health billing practices. Members suggested that the State clearly define billing codes similar to what is done in Oregon.

Agency Rules.

The task force noted several areas for improvement regarding agency rules. Providers find the rules that regulate mental health intake protocols are overly prescriptive. Additionally, multiple rules regulate different types of provider licenses, resulting in duplicate sets of rules for facilities to follow. Members identified concerns that the substance abuse disorder and mental health services are not fully codified in HCA's Title 182 WAC. Some of these rules are still codified in DSHS' Title 388 WAC as they relate to the Medicaid program. The task force also commented that the State should define "co-occurring services," which are not currently defined in the WACs.

Agency Workgroups.

The task force recognized a need for more communication about workgroups. Different agencies have workgroups on various subjects relating to behavioral health integration. Agencies, providers, and workgroups may not know what others are working on, and there may be duplication of efforts. Task force members would like to have a listing of all workgroups.

FINDINGS

During the final meeting on August 16, 2016, the task force focused on these five key issues that were identified in previous meetings. The task force also identified two additional areas for further consideration, Integrated Care and Performance Measures, which are included in the items below.

Deeming.

The task force asked the State to review its practices under RCW 71.24.035(5)(c)(i) to determine whether its practices comply with the statute.

Currently, DSHS has deeming agreements with the Joint Commission for Accreditation of Health Care Organizations (JCAHO), the Council on Accreditation (COA), and the Commission for Accreditation of Rehabilitation Facilities (CARF). DSHS has performed crosswalks between the standards of the accrediting bodies and the current rules and has identified significant gaps. For example, the accrediting bodies have no standards for individuals receiving court-ordered treatment under Less Restrictive Alternatives, and there is no state oversight as a result.

DSHS will deem accreditation as equivalent to meeting licensing standards and will not perform site visits or audits on agencies that are currently accredited. However, there is concern that the statute as currently written does not give DSHS authority to address the gaps between accrediting body standards and State standards. This is particularly concerning with regard to the treatment of individuals on Less Restrictive Alternative court orders, which is not addressed by any of the accrediting bodies.

- The task force recommends that DSHS ask that the Legislature to consider a change in statute to authorize specifically targeted audits of accredited agencies to review the services provided to court-ordered individuals.

Streamline Audits.

Task force members have asked the State to help eliminate redundant audits. They would like the State to conduct a single review annually at one facility site per provider. As part of this process, the task force has asked the State to review an organization with multiple locations as a single entity and no longer require organizations to submit a full application and policies and procedures each time the organization adds a site, unless the organization is adding services that have not been previously certified.

DSHS recognizes it is clearly a burden for providers to undergo redundant audits and a full personnel file review every review cycle. As part of this task force process, DSHS has already decided that it will: 1) begin to review the records of only those personnel who have been hired since the date of the last survey or review a sample of records; and 2) for those agencies with multiple sites, conduct clinical reviews at an organization's main location instead of performing a separate review at each site. DSHS has also formed an internal workgroup to review survey practices and identify additional opportunities to make the process more streamlined, outcome-driven, and quality focused.

DSHS will provide the results of audits to the respective behavioral health organizations (BHOs) to assist with their review process. The task force expressed concerns that, in some BHOs, reviews are essentially the same process as the one used by DSHS, which creates redundancy and confusion. DSHS will work with BHOs on establishing review processes and clear areas of authority. DSHS will also consider combining review activities with the BHOs where appropriate.

DSHS and DOH will form a workgroup to address redundancies in rules and audits that overlap. The goal of this workgroup is a coordinated process that will combine audit activities into a single site visit and ease the burden on providers.

Billing Practices.

The task force identified the need for behavioral health and primary care billing practices to be aligned, as there is confusion about billing for multiple services. The task force appears to believe that the billing system should be reflective of a fully integrated care system.

Because the behavioral health system and the clinical health system have been funded separately and developed mostly independently, Federal and State billing rules exist which do not allow for the billing of multiple types of service provider delivery on the same day. For example, primary care practices with a behavioral health specialist are not able to bill for a behavioral health visit on the same day a patient has a billed visit in primary care. This inability to generate revenue makes it a challenge for primary care practices to employ behavioral health specialists.

HCA has reached out for technical assistance on billing coding standardization through the Medicaid Innovation Accelerator Program. The agency plans to include specific questions about billing between behavioral and primary care, coding for co-occurring disorder treatment, and whether other states limit the types of providers who offer mental health treatment. In addition, members asked that the State clearly define codes similar to the process used in Oregon.

Agency Rules.

The task force would like to see the rules revised to focus on desired outcomes and integrate them into one set of rules. As the State continues to integrate behavioral and primary health, HCA and DSHS will look at ways to write clear rules that are not burdensome for providers. In the region of Southwest Washington for Medicaid, HCA developed rules in chapters 182-538A through 182-538C WAC as a first step in developing rules for integrated managed care.

The task force expressed concern that mental health and substance use disorder services are currently provided under two separate sets of rules, which makes services to individuals with both disorders difficult. DSHS is currently working on developing a single set of rules to serve individuals with co-occurring disorders, in addition to combining the involuntary treatment process, and will involve provider agencies and other stakeholders. DSHS expects to have a draft of these rules completed by December 31, 2016.

The task force also identified problems with how the rules are applied through the audit process. DSHS is working on revising the audit process to focus on outcomes rather than processes, as described above in the Streamline Audits section.

Integrated Care.

The task force recognizes that integrating primary and behavioral health care is a complex issue that will require further work across systems. The task force would like to see integrated care, not just integrated funding. Members want to integrate the delivery of substance abuse disorder and mental health services so that they are not fragmented.

HCA is working on integrating behavioral health services into Apple Health managed care contracts in support of integrating clinical and behavioral health care services across the larger health system. To inform the clinical model for integration, HCA will coordinate efforts with the Behavioral Health Integration workgroup of the Bree Collaborative and other interested stakeholders. HCA will work to define what integrated care means in the context of Washington's Medicaid program and will take the task force's concerns into consideration. The agency's goal is to provide guidance related to bi-directional integration in collaboration with stakeholders.

The task force was given a skeleton model of fully integrated managed care currently used in Southwest Washington for review. Members also received information about a three-day conference in Sea-Tac during November 2016 featuring leaders from other states speaking on integrated care models under development.

Agency Workgroups.

Task force members asked the State to provide information about existing behavioral health workgroups and opportunities for participation. In order to help avoid duplication of resources, HCA will compile a list of current workgroups and provide it to task force members. DSHS' Division of Behavioral Health and Recovery (DBHR) will make a list of current workgroups available on its website.

Performance Measures.

The task force recognizes the importance of having a set of performance measures for clinical integration. HCA and DSHS have begun work on performance expectations for purchasing integrated care through managed care organizations. HCA will provide the task force members with a spreadsheet of common core measures that includes behavioral health performance measures. The agency will solicit feedback from members to see if there are other behavioral health measures that should be added to the matrix.

CONCLUSION

Task force members appreciated the opportunity to meet and discuss important challenges facing behavioral health integration. The members identified a number of ways state agencies can collaborate with each other, task force members, and other organizations to consider improvements to behavioral health regulatory practices.

As indicated above, DSHS and HCA have already taken steps toward some of the opportunities identified by the task force, and the agencies plan to start working on the remaining items. Both agencies anticipate that once these improvements are implemented, they will help integrate behavioral and primary health, save time and resources, and allow providers to dedicate more time to client care.

Washington State Health Care Authority

Washington State Department of Social & Health Services
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Appendix A

Sponsors: **Anthony ("Tony") O'Leary, DSHS**
Annette Schuffenhauer, HCA

Behavioral and Physical Health Regulatory Alignment Task Force
June 16, 2016

----- Agenda -----

Main Outcomes:

When	What	Lead
8:30 – 8:50	**Welcome and Introductions** • Please Sign-In • Task Force Coordinating Team (Roles and Responsibilities) • Brief Introductions (All)	**Tony O'Leary**
8:50 – 9:00	**Opening Remarks**	**Dr. Charissa Fotinos**
9:00 – 9:30	**Overview of Task Force** • E3SHB 1713 §§ 533-534 • Logistics: - Meeting #1: Identifying the Opportunities and Issues - Meeting #2: Identifying Required Actions to Address the Issues - Meeting #3: Prioritizing Recommendations & Prepare for Report Development/Review	**Annette Schuffenhauer**
9:30 – 9:45	**Break**	**All**
9:45 – 10:50	**Identifying Issues and Opportunities:** • Aligning Regulations for Physical/Behavioral Health • Simplifying Regulations • Providing Notices to Parents When Minors Request Chemical Dependency Treatment (in compliance with privacy laws) • Others?	**Annette Schuffenhauer**
10:50 – 11:00	**Break**	**All**
11:00 – 11:20	**Continue Identifying Issues and Opportunities**	**Annette Schuffenhauer**
11:20 – 11:30	**Next Steps/Action Items**	**Annette Schuffenhauer**

OVERVIEW OF ENGROSSED THIRD SUBSTITUTE HOUSE BILL 1713

Background. Primary care and behavioral health providers have different regulatory, licensing, and certification requirements. Different providers may be regulated by the Department of Health (DOH), the Department of Social and Health Services (DSHS), or the Health Care Authority (HCA), based on whether an activity relates to contracting or licensing. In addition, licensees may be subject to audits conducted at both the federal and local levels.

Task Force. E3SHB 1713 requires DSHS and HCA to convene a task force to align regulations between behavioral health and primary health care settings and simplify the regulations for behavioral health providers. The task force must include a cross-section of behavioral health organizations and providers.

The bill directs the task force to consider the following regarding alignment:

- The alignment must support integration from the standpoint of standardizing practices and culture in a manner that, to the extent practical, reduces barriers to access. These barriers include paperwork reduction for providers and patients.
- In general, it must not take longer to document brief integrated behavioral health services than it does to provide the actual services.
- Regulations should emphasize the desired outcome rather than how it should be achieved.

The task force must also consider how to provide notice to parents when a minor requests chemical dependency treatment. The notice must be comply with federal privacy laws and be in the best interest of the minor and their family.

Agency Action. The bill requires additional action by state agencies:

- DSHS must collaborate with DOH, HCA, and other appropriate agencies to reduce unneeded costs and burdens to health plans and providers associated with excessive audits, licensing, and contracting. DSHS shall consider combining audit functions, sharing audit information, and treating an organization's multiple sites as a single entity.
- DSHS shall review its practices to determine whether it complies with the statutory mandate to deem certain accreditation as equivalent to licensure. The agency's practices must comport with standard practices and incentivize voluntary accreditation.

The task force may make recommendations to DSHS regarding these activities.

Legislative Reports. DSHS and HCA must submit a report to the Legislature by December 15, 2016, on the task force's recommendations concerning behavioral health alignment and its recommendations, if any, made regarding unnecessary costs and DSHS' accreditation practices.

DSHS must provide a report to the legislature by December 1, 2016, concerning the task force's progress regarding notification to parents when minors have requested chemical dependency treatment.

NEW SECTION. **Sec. 533.** A new section is added to chapter 71.24 RCW to read as follows:

(1) The department and the Washington state health care authority shall convene a task force including participation by a representative cross-section of behavioral health organizations and behavioral health providers to align regulations between behavioral health and primary health care settings and simplify regulations for behavioral health providers. The alignment must support clinical integration from the standpoint of standardizing practices and culture in a manner that to the extent practicable reduces barriers to access, including reducing the paperwork burden for patients and providers. Brief integrated behavioral health services must not, in general, take longer to document than to provide. Regulations should emphasize the desired outcome rather than how they should be achieved. The task force may also make recommendations to the department concerning subsections (2) and (3) of this section.

(2) The department shall collaborate with the department of health, the Washington state health care authority, and other appropriate government partners to reduce unneeded costs and burdens to health plans and providers associated with excessive audits, the licensing process, and contracting. In pursuit of this goal, the department shall consider steps such as cooperating across divisions and agencies to combine audit functions when multiple audits of an agency or site are scheduled, sharing audit information across divisions and agencies to reduce redundancy of audits, and treating organizations with multiple sites and programs as single entities instead of as multiple agencies.

(3) The department shall review its practices under RCW 71.24.035(5)(c)(i) to determine whether its practices comply with the statutory mandate to deem accreditation by recognized behavioral health accrediting bodies as equivalent to meeting licensure requirements, comport with standard practices used by other state divisions or agencies, and properly incentivize voluntary accreditation to the highest industry standards.

(4) The task force described in subsection (1) of this section must consider means to provide notice to parents when a minor requests chemical dependency treatment, which are consistent with federal privacy laws and consistent with the best interests of the minor and the minor's family. The department must provide a report to the relevant committees of the legislature by December 1, 2016.

NEW SECTION. **Sec. 534.** The department of social and health services and the Washington state health care authority shall report their progress under section 533 of this act to the relevant committees of the legislature by December 15, 2016.

Appendix B

Sponsors: **Anthony ("Tony") O'Leary, DSHS**
Annette Schuffenhauer, HCA

Behavioral and Physical Health Regulatory Alignment Task Force
Meeting #2

Thursday, July 28, 2016
12:30 to 3:30 p.m.

Health Care Authority
Cherry Street Plaza
626 8th Ave SE, Olympia, WA 98501

Conference Call Information
Toll Free Number: 1-888-407-5039
Participant PIN Code: 27592714 #

Agenda

Main Outcomes:

When	What	Lead
12:30 – 12:45	**Welcome and Introductions** • Please Sign-In • Brief Introductions	**Annette Schuffenhauer**
12:45 – 1:15	**Providing Notices to Parents When Minors Requesting SUD** (in compliance with privacy laws)	**Tony O'Leary**
1:15 – 1:45	**Review Opportunities, Issues, and Solutions Identified Through Homework Assignment** (see handout)	**Annette**
1:45 – 2:00	**Break**	**All**
2:00 – 3:20	**Discuss the Top Opportunities, Issues, and Solutions**	**Annette**
3:20 – 3:30	**Next Steps and Action Items** Meeting #3: August 16, 8:30 to 11:30	**Annette**

	Improvement Opportunity #1	Improvement Opportunity #2	Improvement Opportunity #3
Heather Fennell Compass Health	**Audits ~ redundancies, sample size, CAPs, etc.** **Solution:** Develop a small work team with DBHR, DOH and BHO staff to review WAC and contract requirements and agree upon which elements will be reviewed by each agency to eliminate redundancy. Develop standardized tools for each audit with interpretive guidelines. Develop sample size regulations. Determine frequency of audits based upon scores. Determine if there are peer or agency reviews that can happen to self- identify issues, develop action plan, etc. that will suffice some of the audit requirements. Develop a standard way of implementing corrective action plans. Review the option of doing DOH and DBHR reviews together for service areas licensed by both, such as E&T facilities, Residential facilities and Triage Centers.	**Licensing Regulations ~ cumbersome and inefficient** **Solution:** Develop a system by which you can license a service/facility with both DOH and DBHR at the same time ~ same application, one fee, and one facility review for new locations.	**Performance Measures** **Solution:** Develop a small work team with DBHR, DOH, BHO and Provider Agencies to review all current performance measures being required at all levels. Review performance measures developed in other states that have fully integrated models to determine performance expectations in an integrated model.
Brigitte Folz Director for Behavioral Health and Addictions Programs Harborview Medical Center	**CD and MH WACs are not integrated and do not encourage integration.** **Solution:** WACS need to be combined into the HCA WACs and align with the MCO contracts. WAC 388-865 and WAC 388-877	**Maze of incentives and non- aligned with big picture wellness goals**. **Solution:** Align incentives across the system. Currently we have Medicaid incentives coming from CMS on the medical side and in behavioral health (inpatient). Quality measure on the outpatient side needs to align with the ACNs and the CMS population.	**Confusing, time consuming and contradictory audits** **Solution:** Streamline audit system among, EQROs, BHOs, DSHS, ALTSA, DBHR and DOH.

	Improvement Opportunity #1	Improvement Opportunity #2	Improvement Opportunity #3
Betsy Kruse Deputy Director North Sound Mental Health Admin	**WAC / Regulations/ Licensing / Reporting Requirements** Review and consolidate requirements for DOH licensing of health professionals (MH and CD, etc.). Should meet the needs to ensure consumer safety but allow for adequate work force. Requirements should be the same for MCOs Different interpretations or actual rules/regulations inhibit ability to implement integration "pilots." **Solution:** Work together/partner at State level with BHO/Provider involvement across systems/departments/agencies to revise/rewrite rules to enable an integrated future delivery system. In the short term review the WAC's and their interpretation to see where they can be streamlined and still meet regulations. It seems to be incumbent on the State to get all parties (HCA, DBHR, ALTSA, etc) together at the table to develop a uniform system to audit organizations.	**Audits** Redundancies in audits (for example, audits by 4 different entities within 6 months): EQRO, BHO, and State BH. Audits of same or similar thing but with different expectations and policies, conflicting results, and agency subjectivity (DSHS and DOH). Different interpretations by different (or the same) agency. Different processes, contradictory missions. Self-determination versus protection. Time consuming, costly, and shifts attention away from client. DBHR interpretation of laws are out of alignment with what we believe the intent of the law (e.g. assessment process vs. form?) **Solution:** Work together/partner at State level with BHO/Provider involvement across systems/departments/agencies to revise/rewrite rules to enable an integrated future delivery system. In the short term review the WAC's and their interpretation to see where they can be streamlined and still meet regulations. It seems to be incumbent on the State to get all parties (HCA, DBHR, ALTSA, etc) together at the table to develop a uniform system to audit organizations.	**Services / Integration** Actual desire to address BH vs. wanting BH to "take care" of people with BH issues so PC doesn't have to deal with these people is still huge – stigma. **Solution:** This requires a huge culture shift. There has to be a very planned approach for this to succeed. Having worked for a large community hospital for 28 years I know the physicians and others want BH help but actually enrolling them in efforts to accomplish this is a huge task. They really do want BH to fix the patients/clients so they can go on with their work. They have many pressures to get their work done each day and if someone can help them with a difficult patient/client it's a great day. I provided integrated care in a home health setting for 30 plus years. We truly integrated care for older adults – many cases had psychosocial RN, medical RN, PT/OT/ MSW and Home Health Aid all wrapped up in an integrated team. It worked beautifully. MD's were grateful that we provide the assistance their patients/clients needed. I hear a lot of talk about bringing BH to the Primary Care Clinic. That works for some - mostly for persons who need short term assistance. It can be very useful linking persons to long term BH services focused on serving persons with chronic and seriously behavioral health concerns. We need to also provide Primary care services in the BH setting. Integrate both ways. Give patients/clients choice. The models in the two settings, BH/Medical Care are quite different and clients need to be given a choice as to where they receive their services. I can hardly imagine the communities will want to give over the BH services to MCO's in 5 years. I may be wrong but the communities are pretty invested in the system of care especially now with the integration of MH/SUD services. The issue BH brings is a community issue and it looks very different from the medical side of the house as they say. All I can say is TRAIN, TRAIN. Community networking. Evaluate other models of care and implement a system of Care that will serve the communities the clients live in. Can the MCO's do this?

<table>
<tr><th></th><th>Improvement Opportunity #1</th><th>Improvement Opportunity #2</th><th>Improvement Opportunity #3</th></tr>
<tr><td rowspan="2">Alice Lind
Manager, Grants and Program Development
Health Care Authority</td><td>Integrate care, not just funding.</td><td>Need to align performance expectations of PH and BH providers under ‘integrated” MCO contract for value-based purchasing - alignment for Fully Integrated Managed Care.</td><td>What does clinical integration look like? Performance measures on clinical integration?</td></tr>
<tr><td colspan="3">Solution:
Same solution for these inter-related issues:
HCA and DSHS form small workgroup to develop a set of performance expectations for purchasing integrated care through MCOs.
Test the draft set of performance expectations with this Task Force and other groups of stakeholders.
Include final approved set of expectations in procurement and contracts with FIMC managed care plans.</td></tr>
<tr><td>Joan Miller
Policy Analyst
Washington Council for Behavioral Health</td><td>Audits (Issues related to Multiple Agencies)
Treating BH agencies with many sites as separate agencies (DBHR) increases number of audits. Site reviews for licensing and certification are conducted for every contract, and virtually every review will check basics such as policies & procedures, internal controls, the presence of an independent audit, and insurance coverage, etc. Currently, DBHR requires a separate review for each location even though the same issues are being audited.

Solution:
Reduce duplication in licensing activities by treating organizations with several sites and programs as single entities with multiple sites rather than treating each site as a separate agency.

Affected Regulations:
DBHR would need to create a new WAC under Chapter 388- 865 to treat behavioral health agencies with many sites as one agency.</td><td>Standardization/Definitions/Alignment
(Issues related to Multiple Agencies)
How are we preparing for statewide elimination of BHOs in SW WA? While this Task Force looks for ways to streamline regulations, we need to keep an eye toward full integration in 2020, and how HCA, DBHR, and DOH will divvy up responsibilities. State-only funds have lots of strings attached that are completely new for MCOs but that behavioral health relies on to sustain team-based programs that are evidence- based.

Solution:
Determine whether “programmatic licensure” makes sense under FIMC, and if so, which state agency will certify these programs once DBHR moves to HCA. Examples of these types of programs include evidence-based practices such as PACT, WISe, Coordinated Specialty Care, and Supported Employment.

Affected Regulations:
A new WAC will likely need to be created depending on which agency is responsible for programmatic licensure.</td><td>Shortage of qualified people in the workplace. Primary care can’t hire CDP for treatment. (Federal Government Related Issues – Other)
Issue: Provider type credentialing has limitations about where certain providers may deliver services, resulting in a barrier to integrated clinical delivery. For example, primary care settings cannot bill for CD treatment, unless licensed for CD outpatient.

Solution:
Allow CDPs to bill in other settings (e.g., PCP offices; CMHAs).

Affected Regulations:
WAC Chapter 388-877B would likely need to be amended in several places to allow CDPs to bill in setting other than a DBHR- approved agency, specifically WAC 388-877B-0300(2)&(3).</td></tr>
</table>

Gregory Robinson Senior Policy Analyst Washington Council for Behavioral Health	**Redundancy in audits.** **Solution:** From my perspective we need some role clarification for regulatory agencies. Which elements should be reviewed by regulatory agencies as part of licensure and certification, and which elements should be part of contract compliance and performance review? When regulatory bodies overlap in their scope, it inevitably results in different expectations and increased costs. Regulatory oversight sometimes feels like budget justification for the staffing of regulatory agencies rather than an efficient use of public funds. DBHR and DOH need to better delineate their respective scope and not duplicate – for example if DOH wants to review and evaluate patient treatment plans, why do they require DBHR certification of the facility? Or they should rely on DBHR certification and skip the treatment plan reviews in their regulatory visits. Similarly BHOs and MCOs should limit their oversight to contract deliverables, and not compliance with WACs.	**Deeming – RCW 71.24.037(3) says** "The secretary shall provide for deeming of licensed service providers as meeting state standards…" yet WAC 388-877-0310 says "The Department may deem…" **Solution:** Our experience is that the DBHR does not appreciate deeming, and attempts to restrict the use of deeming whenever they can. We should be encouraging our agencies to become accredited – as national managed care entities do more of the provider contracting they will likely value accreditation more than certification by a state of Washington agency. Our rules should incentivize deeming through accreditation, which should lower the overall cost of the licensing and certification efforts, which would lower the cost of licenses.	**DBHR and HCA need to revise the Medicaid state plan** to specifically list co-occurring service modalities, and then modify the Service Encounter Reporting Instructions accordingly. **Solution:** Co-occurring services should be as included in the WACs as are mental health services or substance use disorder services. Sure there are workarounds, but those workarounds lead to coding discrepancies and a lack of, or corruption of, data about what the need for co-occurring services really is, and what the appropriate rates should be developed through actuarial analysis.

Brian E. Sandoval Primary Care Behavioral Health Manager Washington Association of Community and Migrant Health Centers (WACMHC)	**Creation of a more inclusive membership for task force and committee participation across the state, specifically as it relates to FQHCs.** FQHCs tend to be underrepresented in task forces and committees across the state despite providing a large proportion of behavioral health services. The task forces and committees across the state responsible for making decisions for behavioral health issues are disproportionally made of up individuals from BHOs themselves, state entities, or BHO participating entities. **Solution:** Adopt statewide standards for task force and committee participation regarding behavioral health issues. It is recommended that FQHC participation be at least 10% of the task force membership. **Regulations to be affected:** None currently. Collaborative for the Advancement of Telemedicine could be used as an example for identifying and mandating broad group membership. HCA, DOH, DBHR and others to participate in these shared standards.	**Decrease the complexity and duplication of data reporting for mental health, SUD, and residential SUD.** The integration of the Behavioral Health services (Mental Health, SUD and Residential SUD) led to ceased use of the TARGET (Treatment and Assessment Report Generation Tool) system that was maintained by the state. This system was a standardized way across WA to report data for SUD outpatient and Residential services. Recently, the data requirements were delegated to the BHOs. Currently providers are required to use the BHO data system for Mental Health, SUD and Residential. The BHO requires that the organization reports data using their local codes, not the state codes. Each BHO has created local codes to match the state codes. As a result, some organizations need to use at least 6 different local codes to identify the same state code. The problem of data transmission has been compounded by the integration of the residential treatment centers under the BHO. Since the residential treatment centers for SUD are state wide resources the provider is required to transmit the data using the BHO data system based on the client's place of residence**.** Currently, on any given day, organizations will have clients at a treatment center from 5 or 6 BHOs. Organizations' data staff has to manage up to 6 separate systems. There are also different forms, requirement and timelines for each BHO, so it is a very difficult or impossible task. Some BHOs have a system that can be easily accessed by the provider. Other BHOs have systems that are so complex that we are unable to bill dealing with the data difficulties. **SEE CONTINUED:**	**Lack of clarity related to billing requirements for integrating behavioral health and physical health** Same day billing rules limit the ability to provide effective "integrated" care. There is an increased need for psychiatric medication management in primary care setting and billing rules inhibit the ability to provide necessary services. For example, when patients come in for a PCP visit and a psych ARNP visit on the same day, the psych ARNP is unable to bill and get reimbursed for a code 99213. There is also lack of clarity related to what can and cannot be billed in an FQHC setting for psychologists, LMHCs, or LICSWs on the same day as a medical visit. **Solution:** Remove same-day billing restrictions for all disciplines in primary care and specialty settings. 2) Provide billing guidance document for "integrated" physical and behavioral health services. **Regulations to be affected**: Unable to locate WAC. Billing Rules need to be changed/clarified are specified in http://hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides

Brian E. Sandoval - continued		**CONTINUED:** **Solution:** Streamline the reporting requirements by requiring the state code, not the local BHO code. This will diminish the amount of data errors and improve efficiency of reporting. If possible, provide one system to report into (similar to TARGET) that the BHOs can access to avoid duplication and enhance efficiency. **Regulations to be affected:** To be brought to the 7/28 task force meeting.	
	Additional Issue: Lack of understanding for workforce development needs for integration **Detail:** As organizations attempt to begin or enhance efforts towards behavioral and physical health integration, there is limited direction about what type of workforce is needed to achieve "integration." This issue is founded upon a lack of definition for what behavioral integration is across the system of care (from primary care, to specialty care, to residential care). **Solution:** Develop state plan for defining clinical integration across the health care system. Then develop state plan to meet the defined behavioral health needs based on the definition. Currently the Bree Collaborative is working on the definition for behavioral health integration in primary care. However, there are no other workgroups tasked with working on clinical integration across systems (primary care, specialty care/SUD, residential, crisis). **Regulations to be affected:** Currently there is a lack of legislation for a responsible agency.		

	Improvement Opportunity #1	Improvement Opportunity #2	Improvement Opportunity #3
Nancy Tyson Executive Director, Health Professions and Facilities Department of Health In concert with: Brad Burnham, Julie Tomaro, and Tim Farrell	**RCW/WAC - Co-occuring Services.** State needs to define what "co-occurring services" means. **Solution:** RTF rule development in process. Co-occurring is being defined. Other (state and private) agencies are involved in the rule development to ensure coordination. Term co-occurring is use in MH/CD world where "co-morbidity" is used in physical/medical world but could include MH/CD. There appears to be confusion in some settings.	**Audits.** Redundancies in audits. **Solution:** ○ All staff behavioral health facility licensing and certification mtgs held quarterly with DOH and DBHR to discuss issues identified (to include inspections and complaint investigations). ○ RTF rule workshops are being held currently to update the DOH WAC. Other private and state agencies involved as well as individual constituents. ○ Develop a crosswalk. ○ Develop a MOU to clarify roles and responsibilities between DOH and DBHR. ○ Changes may need to be made in chapter 246-337, chapter 388-877A, and chapter 388-877B WAC.	**Clients' Rights.** Similar but not identical client rights between agencies. **Solution:** ○ DOH and DBHR each have distinct requirements for Resident Rights in facilities. DOH is willing to work with DBHR to coordinate and see if we can integrate/share language for clarity to benefit residents ○ Changes may need to be made in WAC 246-337-075, chapter 388-877A, and chapter 388-877B WAC

Rick Weaver President/Chief Executive Officer Comprehensive Health Care	**Overly prescriptive regulations**. This specifically refers to WAC 388-865. **Solution:** The WAC should be re-written to define desired outcomes and to eliminate the prescriptive how to language. For example require a treatment plan. Don't tell us how to do a treatment plan.	**Burdensome licensing requirements**. This is somewhat driven by WAC 388-865 but also by agency practice. There are three important fixes. **Solution:** First, follow state statute and deem those agencies who are accredited by recognized bodies. Deem means deem as meeting the requirements because you are accredited. It doesn't mean meet the WAC requirements and be accredited. If there are certain services that the agency believes shouldn't be deemed (I've heard ITA as being a concern), then propose legislation to exempt those services from deeming. Second, treat an agency as a single entity not as a collection of sites. Don't make each site file a license application and have a site survey. Have a single application for the entire organization and, if necessary, list the sites. Don't audit each and every site, every time. Sample. Third, use sampling methodology in licensing reviews. No other audit entity does 100% audit on staff and client files.	**Contract management.** **Solution:** Have a single contract file for each contractor. It's silly to have to complete a contractor intake form with the same information for each contract an organization has with the state. Many organizations have dozens of contracts and have to complete the burdensome paperwork over and over again with no coordination across agencies or even within agencies

E3SHB 1713, Section (4): *The task force described in subsection (1) of this section must consider means to provide notice to parents when a minor requests chemical dependency treatment, which are consistent with federal privacy laws and consistent with the best interests of the minor and the minor's family. The department must provide a report to the relevant committees of the legislature by December 1, 2016.*

The federal privacy laws referenced in the bill are found in 42 CFR, Part 2.

42 CFR Part 2, Subpart B - General Provisions addresses consent for treatment and disclosure of information to minors. However, the definition of a "minor" appears to be at the discretion of the State:

§ 2.14 Minor patients.

(a) Definition of minor. As used in these regulations the term "minor" means a person who has not attained the age of majority ***specified in the applicable State law***, or if no age of majority is specified in the applicable State law, the age of eighteen years.

(b) State law not requiring parental consent to treatment. ***If a minor patient acting alone has the legal capacity under the applicable State law to apply for and obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations may be given only by the minor patient.*** This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a State or local law requiring the program to furnish the service irrespective of ability to pay.

(c) State law requiring parental consent to treatment.

(1) Where State law requires consent of a parent, guardian, or other person for a minor to obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations must be given by both the minor and his or her parent, guardian, or other person authorized under State law to act in the minor's behalf.

(2) Where State law requires parental consent to treatment the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with subpart C of these regulations or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the program director under paragraph (d) of this section.

(d) Minor applicant for services lacks capacity for rational choice. Facts relevant to reducing a threat to the life or physical well being of the applicant or any other individual may be disclosed to the parent, guardian, or other person authorized under State law to act in the minor's behalf if the program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under subpart C of these regulations to his or her parent, guardian, or other person authorized under State law to act in the minor's behalf, and

(2) The applicant's situation poses a substantial threat to the life or physical well being of the applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf.

Washington State law allows persons thirteen years of age or older to consent to treatment without parental authorization:

RCW 70.96A.095 Age of consent - Outpatient treatment of minors for chemical dependency.

Any person thirteen years of age or older may give consent for himself or herself to the furnishing of outpatient treatment by a chemical dependency treatment program certified by the department. Parental authorization is required for any treatment of a minor under the age of thirteen.

42 CFR Part 2, Subpart D - Disclosures Without Patient Consent outlines circumstances by which information can be disclosed without a patient's consent:

- §2.51 Medical emergencies;
- §2.52 Research activities; and
- §2.53 Audit and evaluation activities.

However, none of these circumstances would allow notification to parents without the minor patient's consent.

The federal requirements appear to be clear that notice to parents when a minor requests chemical dependency treatment can only be given with the minor's consent. The Legislature could provide a means to provide notice to parents when a minor requests chemical dependency treatment which is consistent with federal privacy laws by changing the age of consent as defined in RCW 70.96A.095 from thirteen to eighteen.

Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Appendix C

Sponsors: **Anthony ("Tony") O'Leary, DSHS**
Annette Schuffenhauer, HCA

Behavioral and Physical Health Regulatory Alignment Task Force

Tuesday, August 16, 2016
8:30 to 11:30 a.m.

Health Care Authority
Cherry Street Plaza
626 8th Ave SE, Olympia, WA 98501

Conference Call Information
Toll Free Number: 1-888-407-5039
Participant PIN Code: 27592714 #

Agenda

When	What	Lead
8:30 – 8:45	**Welcome and Introductions** • Please Sign-In • Brief Introductions	Annette Schuffenhauer
8:45 – 9:15	**Review Draft Report: Providing Notices to Parents When Minors Requesting SUD**	Tony O'Leary
9:15 – 9:30	**Alignment of Billing Practices**	Annette and Tony
9:30 – 9:45	**WAC Revisions**	Annette and Tony
9:45 – 10:00	**Define Integrated Care**	Annette and Tony
10:00 – 10:15	**Break**	Annette and Tony
10:15 – 10:30	**Coordination of Agency Workgroups**	Annette and Tony
10:30 – 10:45	**Performance Measures**	Annette and Tony
10:45 – 11:00	**Deeming**	Annette and Tony
11:00 – 11:15	**Streamline Audits**	Annette and Tony
11:15 – 11:30	**Next Steps**	Annette

Behavioral and Physical Health Regulatory Alignment Task Force Top Issues, Opportunities, and Status as Identified at July 29, 2016 Meeting

Topic		Status	Comments
1.	**Alignment of Billing Practices** – The task force identified that behavioral health and primary care billing practices need to be aligned, as there is confusion about billing for multiple services. Members asked that the State clearly define codes, similar to the process used in Oregon.	HCA has reached out for technical assistance on billing coding standardization through the Medicaid Innovation Accelerator Program. The agency plans to include specific questions about billing between behavioral and primary care, coding for co-occurring disorder treatment, and whether other states limit the types of providers who offer mental health treatment.	
2.	**WAC Revisions** – The task force would like to see the WACS revised to focus on desired outcomes and integrate them into one set of rules.	As the State continues to integrate behavioral and primary health, HCA and DSHS will look at ways to write clear rules that are not burdensome for providers but still meet the requirements of federal and state statutes	
3.	Integrated Care – The task force would like to see integrated care not just integrated funding. Members want to integrate the delivery of substance abuse disorder and mental health services so that they are not fragmented.	HCA will work to define what integrated care means in the context of Washington's Medicaid program. The agency's goal is to provide guidance related to bi-directional integration in collaboration with stakeholders.	
4.	Coordinating of Agency Workgroups – Task force members asked the state to provide information about existing behavioral health workgroups and opportunities for participation.	In order to help avoid duplication of resources, HCA will compile a list of current workgroups and provide it to task force members; DSHS will post a listing of all current workgroups on its website.	
5.	**Performance Measures** – Some task force members asked about having performance measures for clinical integration. It was suggested that HCA and DSHS form a small workgroup to prepare a set of performance expectations for purchasing integrated care through MCOs.	HCA will explore the feasibility of forming a workgroup with DSHS to develop performance measures.	
6.	**Deeming** – The task force asked the State to look at deeming agencies accredited by	DSHS recognizes that providers would like improvements in the area of deeming; however, there is concern that the deeming	

	recognized bodies as equivalent to meeting licensure requirements. A few members believed such a change would not require legislation, but DSHS would need to revise its rules.	process requested by the task force may be problematic, as there are significant gaps between state statutes, rules, and standards used by the accrediting bodies. For example, the accrediting bodies have no standards for individuals receiving court-ordered treatment under Less Restrictive Alternatives, and there is no state oversight as a result.	
7.	**Streamline Audits** – Task force members have asked the State to help eliminate redundant audits. They would like the State to conduct a single review annually at one facility site per provider. As part of the process, the task forces has asked the State to review an organization with multiple location as a single entity.	DSHS recognizes it is clearly a burden for providers to undergo redundant audits and a full personnel file review every year. DSHS has formed an internal workgroup to review survey practices, and identify opportunities to make the process more streamlined, outcome-driven, and quality focused. As part of this process, DSHS will consider: 1) reviewing the records of only those personnel who have been hired since the date of the last survey; and 2) conducting clinical reviews at an organization's main location instead of performing a separate review at each site. DSHS and DOH plan to form a workgroup to address audits that overlap.	

Appendix D

Behavioral and Physical Health Alignment Task Force
Meetings held on June 16, July 28, and August 16
List of Invitees

Richard Stride, Cascade Mental Health
Robin Cronin, Catholic Family and Child Services
Rick Weaver, Comprehensive Healthcare
Gregory Robinson, The Washington Council
Libby Hein, Community Health Services
Will Rice, Catholic Community Services
Marc Bollinger, Great Rivers Behavioral Health Organization
Nancy Tyson, Department of Health
Jeron Ravin, Washington Association of Community and Migrant Health Centers
Brian Sandoval, Yakima Valley Farm Workers Clinic / Washington Association of Community and Migrant Health Centers
Joe Avalos, Thurston-Mason Behavioral Health Organization
Kevin Black, Senate Human Services, Mental Health and Housing Committee
Gary Romjue, Catholic Community Services
Betsy Kruse, North Sound Behavioral Health Organization
Timothy Farrell, Department of Health
Todd Broderius, Great Rivers Behavioral Health Organization
Scott Sims, Columbia Treatment Services
Julie Tomaro, Department of Health
Brad Burnham, Department of Health
Dan Floyd, King County Disease Control and Health Statistic
Pam Brown, West End Outreach Services
Joan Miller, Washington Council for Behavioral Health
Richard Stride, Cascade Mental Health Care
Max Whipple, Belair Clinic
Adam Marquis, Jefferson Mental Health Services
Craig Pridemore, Columbia River Mental Health Services
Brigitte Folz, Harborview Behavioral Health
Timothy Hoekstra, Columbia Valley Community Health
Mary Stone Smith, Catholic Community Services
Darla Boothman, Grant County Integrated Services
Heather Fennell, Compassion Health
Jennifer Kreidler-Moss, Peninsula Community Health

Tre Normoyle, Valley View Health Center
Peggy Papsdorf, Pioneer Human Services
Linda Grant, Evergreen Manor
Scott Munson, Sundown M Ranch
Carl Kester, Lakeside Milam Recovery
Jason Bean-Mortinson, Thurston-Mason Behavioral Health Organization
Sylvia Gil, Community Health Network of Washington
Terri Card, Greater Lakes Mental Healthcare
Connie Mom-Chhing, Community Health Plan of Washington
Sandy Ellingboe, Multicare Behavioral Health
Annette Schuffenhauer, Health Care Authority
Tony O'Leary, Department of Social and Health Services
Melinda Froud, Health Care Authority
Charissa Fotinos, MD, Health Care Authority
Alice Lind, Health Care Authority
Debbie Morrill, Health Care Authority