HB1272 HD1

Measure Title: RELATING TO IMPROVING ACCESS TO PSYCHIATRIC CARE FOR MEDICAID PATIENTS.

Report Title: Medicaid; Telehealth; Psychiatric Services

Description: Specifies that coverage for telehealth under the State's medicaid managed care and fee-for-service programs includes psychiatric services provided through a coordinated care manager who is present in a primary health care provider's office through telehealth. (HB1272 HD1)

Current Referral: HMS/CPH, WAM

Introducer(s): EVANS, BELATTI, BROWER, CREAGAN, DECOITE, KOBAYASHI, C. LEE, MCDERMOTT, MCKELVEY, MIZUNO, MORIKAWA, ONISHI, SAN BUENAVENTURA, SOUKI, TODD, YAMANE

DAVID Y. IGE
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PANKAJ BHANOT
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DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

March 20, 2017

TO: The Honorable Senator Josh Green, Chair
Senate Committee on Human Services

The Honorable Senator Rosalyn H. Baker, Chair
Senate Committee on Commerce, Consumer Protection & Health

FROM: Pankaj Bhanot, Director

SUBJECT: **HB 1272 HD 1 - RELATING TO IMPROVING ACCESS TO PSYCHIATRIC CARE FOR MEDICAID PATIENTS**

Hearing: March 20, 2017, 2:50 p.m.
Conference Room 016, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) offers comments.

PURPOSE: The purpose of the bill is to specify that coverage for telehealth under the State's Medicaid managed care and fee-for-service programs includes psychiatric services provided through a coordinated care manager who is present in a primary care provider's office through telehealth.

DHS is in agreement that continued improvements in the provision of behavioral health care, including psychiatric services, are needed, and that the collaborative care model is one such model that has been successful elsewhere in the country. Although the bill is making changes to the telehealth statutes related to Medicaid, it in essence is adding a new benefit or service, the collaborative care model, to be covered by Medicaid. However, at this point, the collaborative care model is not implemented in Hawaii for the Medicaid population, although it is being piloted by a major health insurer for its Medicare population.

There are several specific aspects of the collaborative care model unrelated to telehealth that are not available or are not covered that this bill does not address. For example, provider to provider consultations, which the collaborative care model includes, are not covered by the federal Medicaid program. Additionally, the bill presumes that there would be behavioral health care managers located in provider's offices, which today there are not.

Finally, the "coordinated care manager" would be providing case management services for a much broader population than what our current Medicaid program authorizes, and thus, those services would not be covered by telehealth or any other mode of service delivery.

For these reasons, Med-QUEST would need additional time to: request permission via the 1115 waiver from the federal regulating agency, Centers for Medicare and Medicaid Services, to implement a new benefit or service than what is currently covered; to broaden to additional providers to provide the new service or benefits; and to expand to allow reimbursements for telehealth for the specific type of provider to provider consultations envisioned using the collaborative care model. Without the permissions, reimbursements would be comprised of state general funds only.

Finally, analysis would be needed regarding the overall costs versus savings to implement this new collaborative care model in order to determine if an additional appropriation would be needed. For these reasons, we respectfully suggest that the pilot project be completed, perhaps with an inclusion of a sunset provision, so that we can learn how to implement such a program here on a broader scale, and understand the relative costs and potential savings, before mandating coverage under Medicaid.

Thank you for the opportunity to testify on this bill.

DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
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Testimony in SUPPORT of HB1272 HD1
RELATING TO IMPROVING ACCESS TO PSYCHIATRIC CARE FOR MEDICAID PATIENTS.

SENATOR JOSH GREEN, CHAIR
SENATE COMMITTEE ON HUMAN SERVICES

SENATOR ROSALYN BAKER, CHAIR
SENATE COMMITTEE ON COMMERCE, CONSMER PROTECTION, AND HEALTH
Hearing Date: March 20, 2017 Room Number: 016

Fiscal Implications: None for the Department of Health.

Department Testimony: The Department of Health supports the intent of HB1272 HD1, but defers to the Department of Human Services on how enactment of this measure may affect current operations, including federal matching funds.

The adoption of telehealth as a community standard of care in Hawaii is a major strategic priority for the Department of Health that will improve health care access and health outcomes, resulting in more cost-effective care. The collaborative care model in particular is an opportunity for Hawaii to enhance mental health services in an intergrated primary care setting, which is far more optimal than the often fragmented care experienced by patients.

Offered Amendments: N/A.

THE QUEEN'S HEALTH SYSTEMS

To: The Honorable Josh Green, Chair
The Honorable Stanley Chang, Vice Chair
Members, Committee on Human Services

The Honorable Rosalyn H. Baker, Chair
The Honorable Clarence K. Nishihara, Vice Chair
Members, Committee on Commerce, Consumer Protection, and Health

From: Paula Yoshioka, Senior Vice President, The Queen's Health Systems
Date: March 17, 2017
Hrg: Senate Committees on Human Services and Commerce, Consumer Protection, and Health Joint Hearing; Monday, March 20, 2017 at 2:50PM in Room 016

Re: **Support for HB 1272, HD1, Relating to Improving Access to Psychiatric Care for Medicaid Patients**

My name is Paula Yoshioka, and I am a Senior Vice President at The Queen's Health Systems (QHS). QHS would like to express our **support** for HB 1272, HD1, Relating to Improving Access to Psychiatric Care for Medicaid Patients. This bill specifies that coverage for telehealth under the State's Medicaid managed care and fee-for-service programs includes psychiatric services provided through a behavioral health care manager who is present in a primary health care provider's office through telehealth.

The Queen's Clinically Integrated Physician Network (QCIPN) is working with our psychiatrist colleagues to develop a mental health integration (MHI) model for our primary care physicians (PCPs) to improve the care of patients with behavioral health needs using the Collaborative Care model initially developed at the University of Washington.

The Centers for Medicare and Medicaid (CMS) have adopted and promoted this model nationwide. CMS developed billing codes to allow PCP's to get reimbursement for adopting this model of care for Medicare fee-for-service patients in their practice. This bill uses the new Medicare billing structure as a basis for Medicaid reimbursement in the Collaborative Care model.

The QCIPN initial MHI pilot will be with the Queen's Health Care Centers (QHCC) PCP practices and Queen Emma Clinic this year. The pilot will also include PCP practices on the Big Island and we hope to eventually include Maui and Molokai. In QEC 80 percent of patients are covered by Medicaid so reimbursement for MHI will be a big step in the right direction to getting more access to care for the behavioral health needs of our most vulnerable patients.

I commend the legislature for introducing this much needed measure and ask that you support to support this bill. Thank you for your time and attention to this important issue.

An Independent Licensee of the Blue Cross and Blue Shield Association

March 20, 2017

The Honorable Josh Green, Chair
The Honorable Stanley Chang, Vice Chair
Senate Committee on Human Services

The Honorable Rosalyn H. Baker, Chair
The Honorable Clarence Nishihara, Vice Chair
Senate Committee on Commerce, Consumer Protection, and Health

Re: HB1272, HD1 – Relating to Improving Access to Psychiatric Care for Medicaid Patients

Dear Chair Green, Chair Baker, Vice Chair Chang, Vice Chair Nishihara, and Committee Members:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 1272, HD1 which would specify that coverage for telehealth under the State's Medicaid managed care and fee-for-service programs includes psychiatric services provided through a coordinated care manager who is present in a primary health care provider's office through telehealth. HMSA offers the following comments on HB 1272, HD1.

HB 1272, HD1 seeks to comport with federal CMS guidelines, as referenced in Section 1 of the bill. The CMS psychiatric collaborative care model typically is administered by a primary care team consisting of a primary care provider (PCP) and a behavioral health care manager, working in collaboration with a psychiatric consultant, such as a psychiatrist. Care is directed by the primary care team, and the psychiatric consultant provides regular consultations. The corresponding codes incorporate the services of all members of the collaborative care team as incident-to services of the PCP.

We appreciate the previous Committees' adoption of proposed amendments to address some of our concerns. However, in Section 2 we have concerns with the inclusion of "licensed counselor" in the definition of "behavioral health care manager." It is unclear who the "licensed counselor" would include and whether DCCA would have licensing control/oversight over this group. In addition, the Committee may want to consider including language that ensures that the care manager may only provide psychotherapy when it is in the scope of their license and expertise. We would also note that "psychiatric consultant" is not defined within the same section of the Bill.

Thank you for allowing us to provide testimony on HB1272, HD1.

Sincerely,

Mark K. Oto
Director, Government Relations

To: The Honorable Senators of the committees of Commerce, Consumer Protection, and Health; Human Services; and Ways and Means
From: Hawaii Association of Professional Nurses (HAPN)
Subject: HB1272 HD1 – RELATING TO IMPROVING ACCESS TO PSYCHIATRIC CARE FOR MEDICAID PATIENTS
Hearing: Monday, March 20, 2017, 2:50 P.M.
Conference Room 016

Aloha Senator Josh Green, Chair, Senator Stanley Chang, Vice Chair and members of the Senate Committee on Human Services, Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair and members of the Senate Committee on Commerce, Consumer Protection and Health. Thank you for the opportunity to submit testimony on HB1272 HD1, in **strong opposition** as the bill is writte. HB1272HD1 specifies coverage for telehealth under the State's Medicaid managed care and fee-for-service programs including psychiatric services provided through a coordinated care manager who is present in a primary health care provider's office through telehealth. HAPN has deep concern under the definition of "Psychiatric consultation service" as this House bill leaves out the ability of Advance Practice Registered Nurses (APRN) to provide these consultation services. The companion Senate bill included APRNs in the definition of "Health care provider" – those individuals who would be able to provide consultation services. HAPN prefers the Senate version, SB1155 SD1.

HAPN is in strong opposition of this bill for several reasons. This bill does not include the requirement of a Psychiatric Mental Health Evaluation, a process that is a mainstay and of significant importance in the work of a psychiatric mental health provider. That evaluation necessitates a face to face interview. Therefore, this bill would encourage the initiation of psychotropic medication without proper evaluation by trained psychiatric mental health providers. Those favoring this bill have made note that APRNs would be excellent "Behavioral health care managers" within the primary health care provider's office, however in that role, would not be functioning to their full capability. Generalist registered nurses, on the other hand, have been trained to provide excellent coordination of care, a model that has been used in many insurance companies, as case managers. Psychiatric APRNs, by statute, are able to provide direct care, service, prescription, and medication/symptom monitoring, and should therefore be included in the definition of consultant.

While elements of this bill have merit and some relief of increased behavioral health care needs in the primary health care provider's clinic, this is a strong deviation from the proper, well thought out care that all patients deserve. Rather than the expert consultant doing the prescribing, this bill requires the primary health care provider to prescribe medication that they may not be familiar with and may not know the signs/symptoms of medication adverse effects.

In summary, psychiatric APRNs already provide consultation to patients, families, communities and agencies both private and public and should be included in the definition of consultant.

Thank you for the opportunity to share the perspective of HAPN with your committee. Thank you for your enduring support of the nursing profession and the patients who benefit from our services in the Aloha State.

Respectfully,

Wailua Brandman APRN FAANP, Chair, HAPN Legislative Committee
255-4442

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FROM:
HAWAII MEDICAL ASSOCIATION
Dr. Chris Flanders, Executive Director
Lauren Zirbel, Community and Government Relations

COMMITTEE ON HUMAN SERVICES
Senator Josh Green, Chair
Senator Stanley Chang, Vice Chair

COMMITTEE ON COMMERCE, CONSUMER PROTECTION, AND HEALTH
Senator Rosalyn H. Baker, Chair
Senator Clarence K. Nishihara, Vice Chair

NOTICE OF HEARING

DATE: Monday, March 20, 2017
TIME: 2:50 P.M.
PLACE: Conference Room 016

RE: HB 1271, HD 1
Position: Support

On behalf of the physician and medical student members of the Hawaii Medical Association, we are writing regarding our ongoing commitment to reform of the health care system.

This legislation will ensure that Hawaii's Medicaid managed care programs, which currently do not cover collaborative care, will cover collaborative care. Hawaii Medicaid currently only covers Physician to Patient contact, not collaborative care between a psychiatrist and a family physician or behavioral care manager.

Studies show that the collaborative care model will result in the following:

1) Better outcomes: not only for psych but also for internal medicine
2) Better satisfaction
3) Reduced cost 6:1 ROI

Studies are so promising that Medicare started paying for this on Jan 2, 2017. We hope you join us in supporting the expansion of this important model to Medicaid. Mahalo for the opportunity to testify.

To: Senator Josh Green, Chair, Senator Stanley Chang, Vice Chair, and members of the Senate Committee on Human Services

From: Julienne O. Aulwes, M.D., Chair, Task Force on Improved Access to Psychiatric Care, Hawaii Psychiatric Medical Association

Hearing Date: March 20, 2017
Hearing Time: 2:50pm

Re: HB 1272, HD1

RELATING TO IMPROVING ACCESS TO PSYCHIATRIC CARE FOR MEDICAID PATIENTS

Position: SUPPORT

Dear Chairperson Green, Vice Chairperson Chang, and members of the Senate Committee on Human Services:

Please vote YES on HB 1272, HD1.

Thank you for the opportunity to testify on behalf of the Hawaii Psychiatric Medical Association (HPMA) in Strong Support of this measure, HB1272, which seeks to provide a means by which patients with psychiatric difficulties, particularly in underserved rural areas, will have improved access to psychiatric care.

Such patients can have difficulty gaining access to the expertise of a psychiatrist, especially if they are on Medicare or Med-QUEST. HB1272 seeks to alleviate this access problem by supporting psychiatric consultation to family physicians and their patients with psychiatric difficulties through the Collaborative Care Model: a method of psychiatric care delivery shown to 1) improve access, 2) improve outcomes, 3) improve satisfaction, and 4) reduce costs.

Medicare began covering the Collaborative Care Model with new payment codes on January 2, 2017, but Hawaii Medicaid does not. This is because Hawaii Medicaid will only cover Physician to Patient contact, but Collaborative Care requires psychiatrist to family physician or to behavioral care manager contact. It does not typically involve direct contact between the consulting psychiatrist and the patient.

The purpose of HB1272 is to specify that Hawaii's Medicaid managed care programs, which currently do not cover Collaborative Care, will cover Collaborative Care, specifically, psychiatric services including consultation provided to a coordinated behavioral health care manager and/or a Primary Care Provider through telehealth, in the same way that Medicare began covering these services on January 2, 2017.

Background:

Collaborative Care Model (CoCM)
The Collaborative Care Model is a specific type of integrated care that improves access to evidence-based mental health care for patients in the primary care setting. Over 80 evidence-based studies show that by treating patients with mild to moderate psychiatric conditions right in

their family doctor's office (rather than THE FAMILY DOCTOR SENDING THEM TO A PSYCHIATRIST'S OFFICE SOMEWHERE ELSE), employing a behavioral health care manager there, and contracting with an off-site psychiatric consultant, Collaborative Care results in better medical as well as psychiatric care. It has been shown to achieve the Institute for Healthcare Improvement's Triple Aim: improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations by up to $600-1000/patient/year. Instead of a psychiatrist taking care of only three or four patients in a morning, the Collaborative Care Model allows a psychiatrist to oversee the care of 10-15 patients in the same amount of time. The outcome data is so good that Medicare started paying for Collaborative Care on January 2, 2017. But it is not covered by Medicaid. What we need is for Medicaid to cover the same service that Medicare started paying for, because so many of our neighbor island residents are not on Medicare but rather on Medicaid. That's why we worked with the legislature on HB1272, with companion SB1155 to accomplish this, which should move Hawaii healthcare in the direction of better medical (including psychiatric) care for our entire population at less cost.

The behavioral health care manager is typically a nurse, social worker, licensed counselor, or psychologist, who coordinates the overall effort of the group and ensures effective communication among team members and provides psychotherapy when that is part of the treatment plan. The behavioral health care manager is responsible for coordinating and supporting mental health care within the clinic and for coordinating referrals to clinically indicated services outside the clinic. Primary care practices track and reach out to patients who are not improving and the psychiatric consultant provides caseload-focused consultation, not just ad-hoc advice. They GET FEEDBACK on their patients' behavioral health problems within days versus months. The psychiatric consultant REVIEWS all patients who are not improving and THEN makes treatment recommendations, typically providing consultation on 10-20 patients in a half day as opposed to 3-4 patients in the same amount of time if the psychiatrist were in a co-located or traditional consultation role or even in the same building. As of January 2017, there are reimbursement codes through Medicare that provide compensation for this model of care in Hawaii. But our Medicaid patients here in Hawaii need Collaborative Care too.

Since *Sine Die* of the legislature, the Hawaii Psychiatric Medical Association (HPMA) working with the Hawaii Medical Association (HMA) and the American Psychiatric Association (APA) has:

- created a Task Force on Improved Access to Psychiatric Care with physician representatives on each island of the state to support the development of the collaborative care model in Hawaii including pilot projects
- attended the Hawaii Health Workforce Summit to assess the behavioral health needs of the state and promote the collaborative care model
- provided a free webinar to the public regarding the collaborative care model, 20 participants dialed in
- been working with the Queen's Clinically Integrated Physician Network in launching the collaborative care model in their physician network
- been working with the East Hawaii Independent Physicians Association in planning and implementing the collaborative care model for their member physicians
- met with the Hawaii Primary Care Association in discussion about how to implement the collaborative care model in their Federally Qualified Health Centers
- been working with the Molokai Community Health Center in setting up collaborative care services along with tele-behavioral health services to their child and adolescent population

- reached out to Hana Health Clinic for a psychiatric needs assessment to lay the groundwork for implementing the collaborative care model in that community
- supported the Ka'u Rural Health Community Association in their procurement of a telehealth kiosk which will provide clinical services free of charge to that community and attended their 19th annual rural health conference
- met with Ka'u Rural Health Clinic introducing the collaborative care model
- met with HMSA (Hawaii Medical Service Association) to discuss best practice methods to roll out the collaborative care model including providing behavioral health care managers for their members so collaborative care can be accessible to all, including their HMSA QUEST patients
- trained ten psychiatrists in Hawaii in the collaborative care model who are ready to partner with primary care providers
- reached out to Castle Health Group to provide information on the collaborative care model
- reached out to the Waianae Coast Comprehensive Health Center to provide information on the collaborative care model

HPMA in conjunction with the Hawaii Medical Association (HMA) stand ready to work with **any** lawmaker on helping to deliver quality care to our state's most vulnerable patients. While the solution outlined above is in various stages of implementation across the islands, we caution that there is no solution that will be an instant panacea for the complex issues surrounding the appropriate care and treatment of mental health and substance use disorders. We stand ready to work with interested partners to deliver innovative, evidence-based collaborative care to those who need it most.

Thank you for the opportunity to testify.

Julienne O. Aulwes, M.D.
Chair, Task Force on Improved Access to Psychiatric Care
Hawaii Psychiatric Medical Association

FROM:

Chaewon Im
First year medical student at the John A. Burns School of Medicine

TO:

COMMITEE ON FINANCE
Rep. Sylvia Luke, Chair
Rep. Ty J.K. Cullen, Vice Chair

RE: HB 1272

Position: Support

Thank you for the opportunity to testify in strong support of HB 1272, which seeks to address the psychiatric needs of patients in Hawaii, particularly those in lower socioeconomic or rural areas of the islands.

As both a medical student and an individual who comes from an immigrant family constantly struggling with meeting their healthcare needs (particularly psychiatric) due to finances, it was exciting to hear that Medicare began covering psychiatric services including consultation provided by a behavioral health care manager and/or a Primary Care provider through telehealth at the start of 2017. I am writing this testimony in the hopes that Hawaii's Medicaid managed programs will follow suit and cover these services as well. Many of our neighbor island residents are on Medicaid, including my personal friends and family on the Big Island, and the need for improved access to psychiatric care is great.

The ability for a behavioral health care manager to coordinate care and provide therapy when appropriate right in the primary care physician's office is crucial to improving mental health care for the people of Hawaii. Rather than using a traditional referral model and losing half of these patients who do not follow through (Simon, Ding et al., 2012), utilizing a model of integrated care can significantly improve individual experiences with healthcare, the health of the population of Hawaii, and reduce healthcare costs. Consultations can be provided to 10-20 patients in a half-day instead of 3-4 in the same amount of time if this Collaborative Care model is used. It can also reduce the amount of stigmatization patients feel regarding mental health.

I was able to visit a clinic in Oahu that provides integrated care to all of its patients - Waimanalo Health Clinic (WHC). The Chief Medical Officer of WHC spoke to first year medical students at JABSOM as part of the rural health program, which is an initiative to expose students to rural medicine and spark their interest in providing medical care to underserved areas. She spoke of their attempts to continually find better ways to provide collaborative medical care, of daily morning meetings in which physicians, nurses, nutritionists, behavioral health specialists, social

workers, and more came together to try to address all aspects of the whole human patient they were caring for. It was an extremely inspirational environment, and I realized then the utter importance of all healthcare workers being fully incorporated into a person's medical care. She also explained the patient's perspective, and how many of the patients at WHC do not have adequate health care and are struggling to make ends meet. The option to have their nutritional, psychiatric, medical, and dental needs met in one location and in one appointment has drastically changed these patient's ideas about care and their health outcomes.

Lastly, I would like to reiterate how beneficial HB 1272 would be for one of our State's most vulnerable populations, and thank you for your time.

The opinions listed above do not reflect those of the John A. Burns School of Medicine or the Waimanalo Health Clinic and it's affiliates.

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 20, 2017 9:57 AM
To: HMS Testimony
Cc: eckrothkr@gmail.com
Subject: *Submitted testimony for HB1272 on Mar 20, 2017 14:50PM*

HB1272
Submitted on: 3/20/2017
Testimony for HMS/CPH on Mar 20, 2017 14:50PM in Conference Room 016

Submitted By	Organization	Testifier Position	Present at Hearing
Katherine Eckroth	Individual	Oppose	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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