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

TO:
COMMITTEE ON FINANCE
Rep. Sylvia Luke, Chair
Rep. Ty J.K. Cullen, Vice Chair

DATE: Wednesday, March 1, 2017
TIME: 1:00 P.M.
PLACE: Conference Room 308

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.

HB1272

Madam Chair Belatti, Vice Chair Kobayashi, and members of the House Committee on Health

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 referring them out, 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 receive input on their patients' behavioral health problems within days versus months. The psychiatric consultant will review all patients who are not improving and make 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. 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
- 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

As you deliberate upon this bill, please consider amending the bill to improve clarity, specificity, and fidelity to the Collaborative Care Model:

In Section: 1 Line 9, please amend the sentence to read as follows:

The legislature further finds the Centers for Medicare and Medicaid Services recently released a Medicare fee schedule that includes HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCC) G CODES and fee for psychiatric collaborative care management services, which will be used to reimburse primary care physicians for services that psychiatrists provide in the collaborative care model.

In Section: 2(b), please amend the sentence to read as follows:

(b) Required coverage for services under subsection (a) includes psychiatric SERVICES INCLUDING CONSULTATION PROVIDED TO A BEHAVIORAL HEALTH care manager AND/OR A PRIMARY CARE PHYSICIAN (PCP) through telehealth.

Rationale: Without Psychiatric Consultation to a PCP or Behavioral Health Care Manager, the Triple Aim of better outcomes, better satisfaction, and reduced costs will not be met.

In Section 2 please amend by addition of the following definitions:

"Psychiatric Consultation Services" means services provided by a medical physician trained in psychiatry and qualified to prescribe the full range of medications, who advises and makes recommendations for psychiatric and other medical care, including psychiatric and other medical diagnoses, treatment strategies including appropriate therapies, medication management, medical management of complications associated with treatment of psychiatric disorders, and referral for specialty services, that are communicated to the treating physician or other qualified health care professional, typically through the behavioral health care manager.

"Behavioral Health Care Manager" means 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.

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

Dear Finance Vice Chair Ty Cullen,

Please support HB1272 which will be heard in Finance tomorrow at 1:00pm.

Please add the attached slide deck, created by the American Psychiatric Association which explains Collaborative Care, to the testimony already submitted to the House Finance Committee by Dr. Julienne Aulwes of the Hawaii Psychiatric Medical Association.

Collaborative Care can improve access to psychiatric care throughout our state while at the same time save taxpayer money. HB1272 can facilitate this by having Medicaid pay for what Medicare started paying for on January 2, 2017, saving potentially $600-1100 per psychiatric patient per year.

Please vote yes to HB1272 which the evidence shows safely accesses better medical as well as better psychiatric care

Please don't hesitate to contact me if I might be of further assistance to you.

Aloha and Mahalo,

Jeffrey Akaka, MD
Chair, Legislative Committee, Hawaii Psychiatric Medical Association
1-808-341-3472

Julienne Aulwes, MD
Chair, Task Force to Improve Access to Psychiatric Care, Hawaii Psychiatric Medical Association

COORDINATING MENTAL HEALTH CARE WITH PSYCHIATRISTS IN HI

November 1, 2016

OBJECTIVES

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- Primary care practices will learn about the Collaborative Care Model as a solution for increased access, better patient outcomes, and reduced costs.

- Primary care practices will learn about how to get started in Collaborative Care and connected with a trained psychiatric consultant.

TREATMENT FOR MENTAL HEALTH DISORDERS

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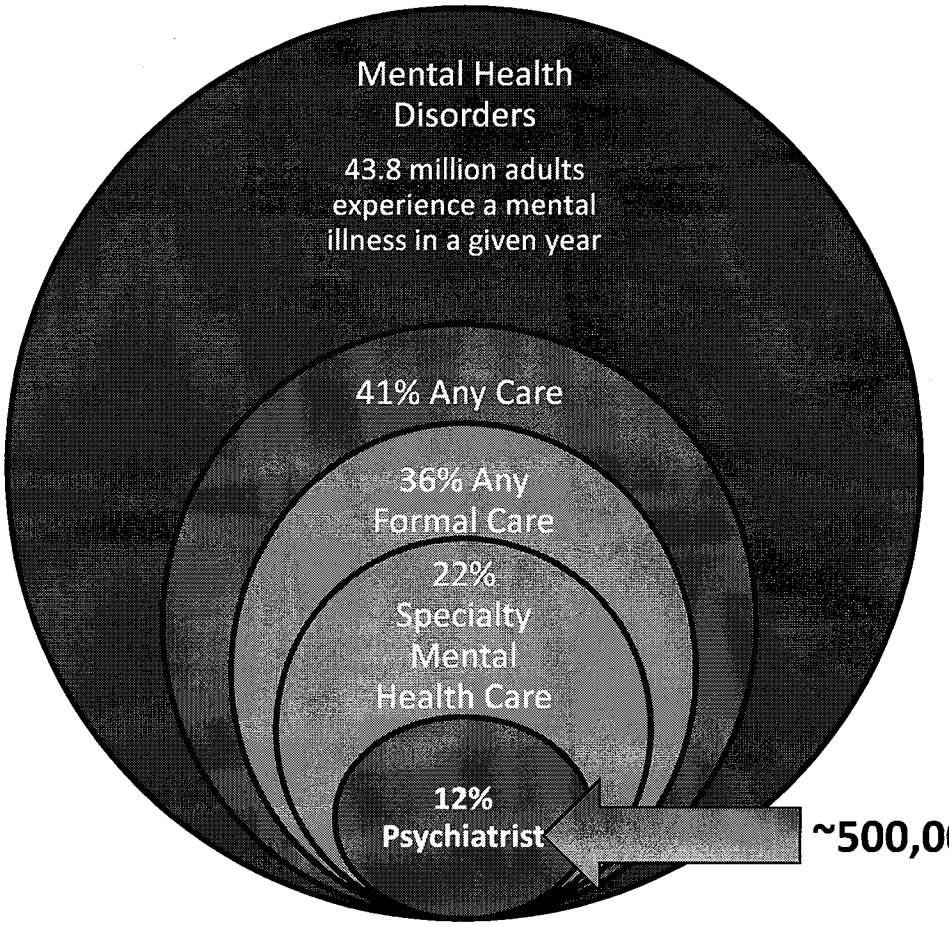

~500,000 see a psychiatrist

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. Arch Gen Psychiatry, 62(6), 629-640.

Any Mental Illness (AMI) Among Adults. (n.d.). Retrieved October 23, 2015, from http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml.

LINKING BEHAVIORAL HEALTH AND HEALTH

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Behavioral Health

Psychiatric disorders cause:

- 25% of all disability worldwide*
- 3x diabetes, 10x heart disease, 40x cancer
- In the US, one suicide every 14 minutes

Health Behaviors

- Unhealthy behaviors are major drivers of health care costs
- Behavior determines ≈ 50 % of all mortality and morbidity
- 40 – 50% struggle with treatment adherence
- Employers struggle with absenteeism and presenteeism

*C. Murray, GBD Study, *Lancet* 2012

BEHAVIORAL HEALTH IS A CHALLENGE FOR PCP PRACTICES

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- Mental illness is commonly treated in primary care: 43–60% of treatment for mental illness occurs in primary care and 17–22% in specialty mental health settings

- More than half of practices (62%) reported using electronic, standardized depression screening and monitoring;

- Among the practices, 54% used evidence-based health behavior protocols for mental health and substance use conditions.

- PCP practices were less likely to have procedures for referrals, communication, and patient scheduling for responding to MH/SU services than for other medical subspecialties
  - (50% compared with 73% for cardiology and 69% for endocrinology).

- Practices reported that **lack of reimbursement, time, separation of MH and health systems and sufficient knowledge** were obstacles to providing care

NCQA, 2014

WHY NOT JUST REFER?
PATIENT FACTORS

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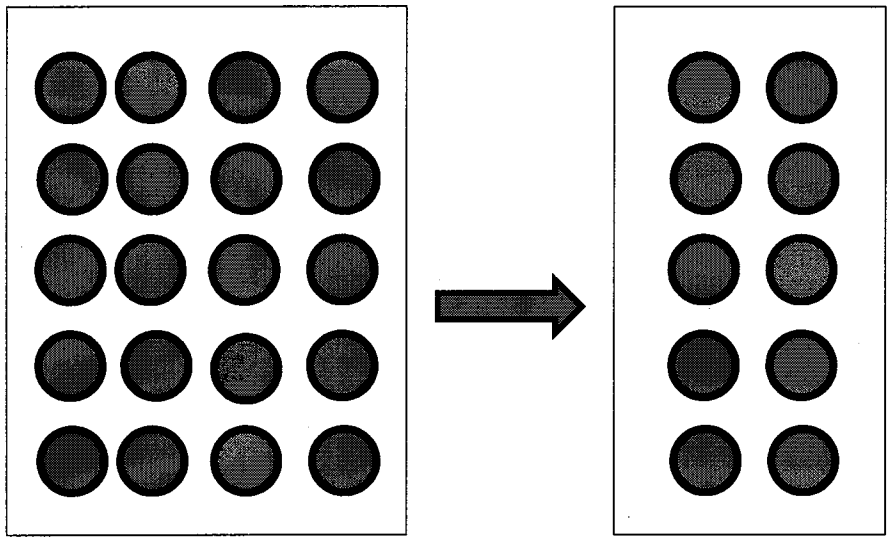
- **Half of those referred do not follow through.**



- **Mean # of visits = 2**

Grembowski, Martin et al., 2002
Simon, Ding et al., 2012

HOW DO WE CLOSE THE GAP?

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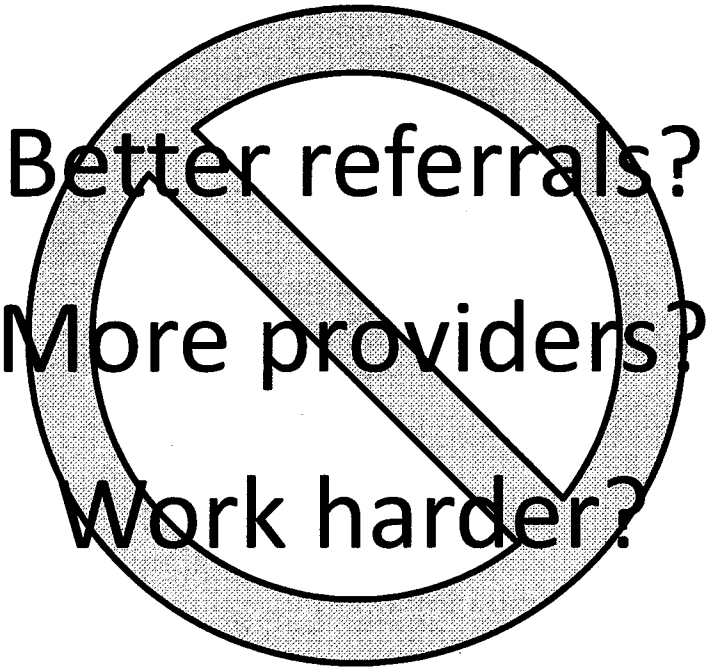

Working smarter = Integrated care

INTEGRATED CARE OFFERS A SOLUTION

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- **Improves access for patients**
  - Nearby primary care clinic
  - More timely appointments
  - Less stigmatizing
  - Lower out-of-pocket costs

- **Increases capacity of mental health providers**
  - Consultation
  - Collaboration
  - Leverages scarce mental health resources

INTEGRATION EFFORTS

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Most models of integrated care are <u>not evidence based</u>

Collaborative Care

- Estimated 5-10% reduction of healthcare expenditures
- Potential annual savings of $26-48 billion
- **More cost-effective**
  - **ROI $6.50: 1**

THE COLLABORATIVE CARE MODEL (CCM)

COLLABORATIVE CARE PRINCIPLES: GOOD FOR ***ANY*** PRACTICE

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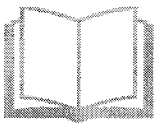
Population-Based Care

Measurement-Based Treatment to Target

Patient-Centered Collaboration



Evidence-Based Care

Accountable Care

Principles: © University of Washington

COLLABORATIVE CARE: THE IMPACT STUDY

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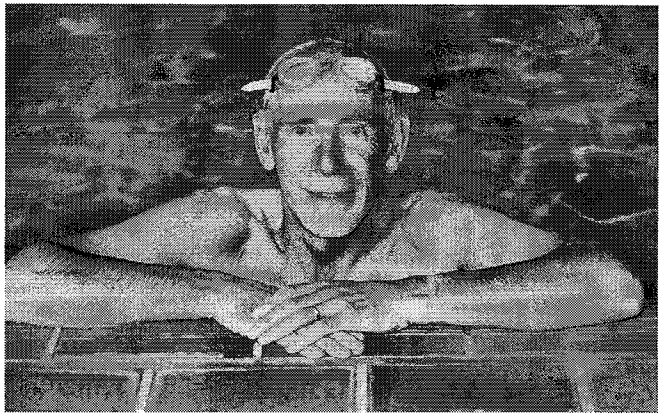
Prepared, Pro-active Practice Team

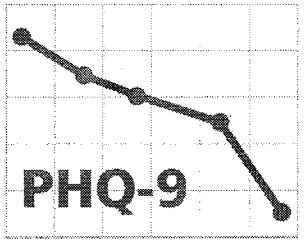
IMPACT

Effective Collaboration

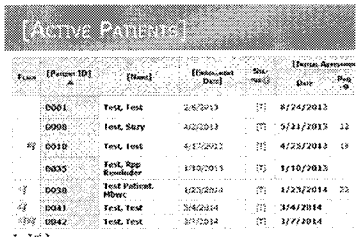


Informed, Active Patient

Practice Support



Outcome Measures



Population Registry

Problem Solving Treatment (PST)
Behavioral Activation (BA)
Motivational Interviewing (MI)
Medications

Treatment Protocols

Psychiatric Consultation

THE COLLABORATIVE CARE MODEL

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Caseload-focused psychiatric consultation supported by a BHP or care manager

Better access	PCPs get input on their patients' behavioral health problems within days/weeks versus months
	Focuses in-person visits on the most challenging patients
Regular Communication	Psychiatrist has regular (weekly) meetings with a BHP/care manager
	Reviews all patients who are not improving and makes treatment recommendations
More patients covered by one psychiatrist	Psychiatrist provides input on 10 – 20 patients in a half day as opposed to 3-4 patients
Shaping over time	Multiple brief consultations
	More opportunity to 'correct the course' if patients are not improving

TRADITIONAL MODEL VS. COLLABORATIVE CARE MODEL

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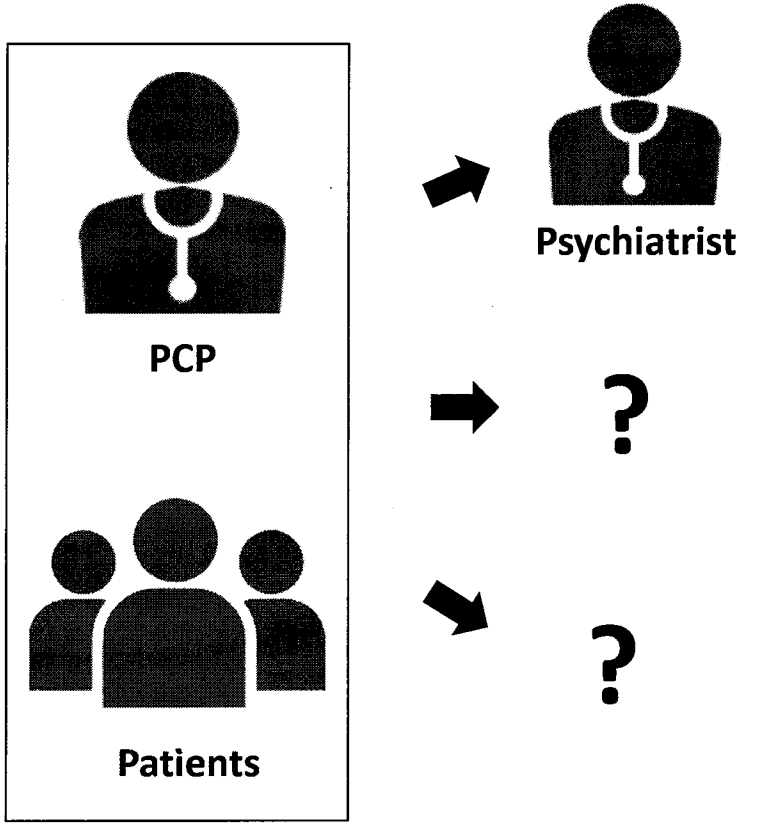
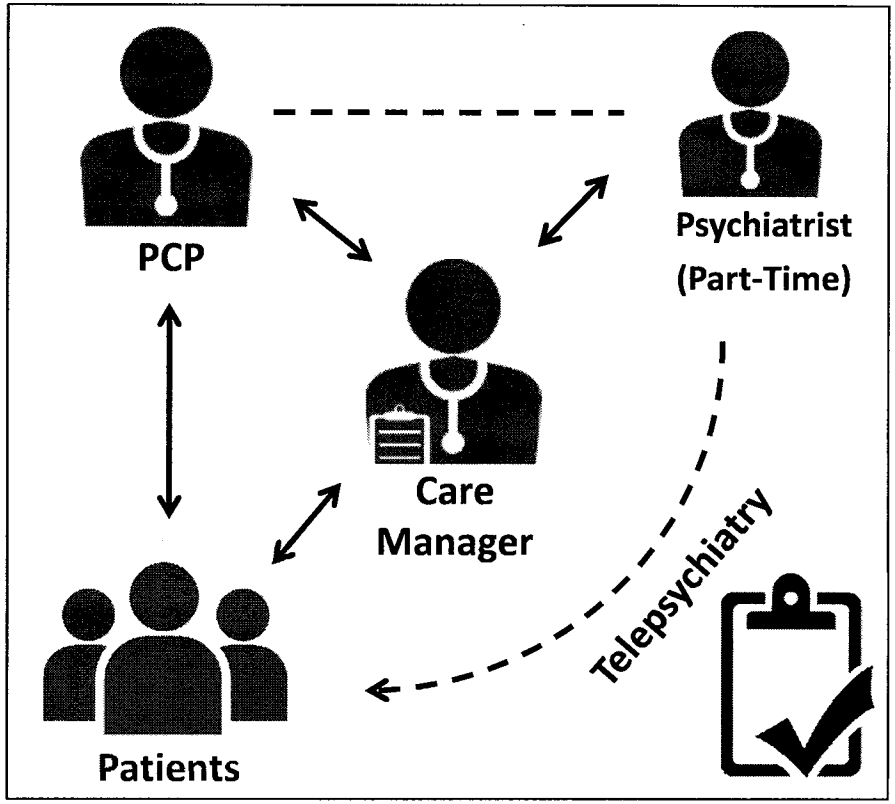
Traditional Model



Collaborative Care Model



PRINCIPLE: **PATIENT-CENTERED COLLABORATION**

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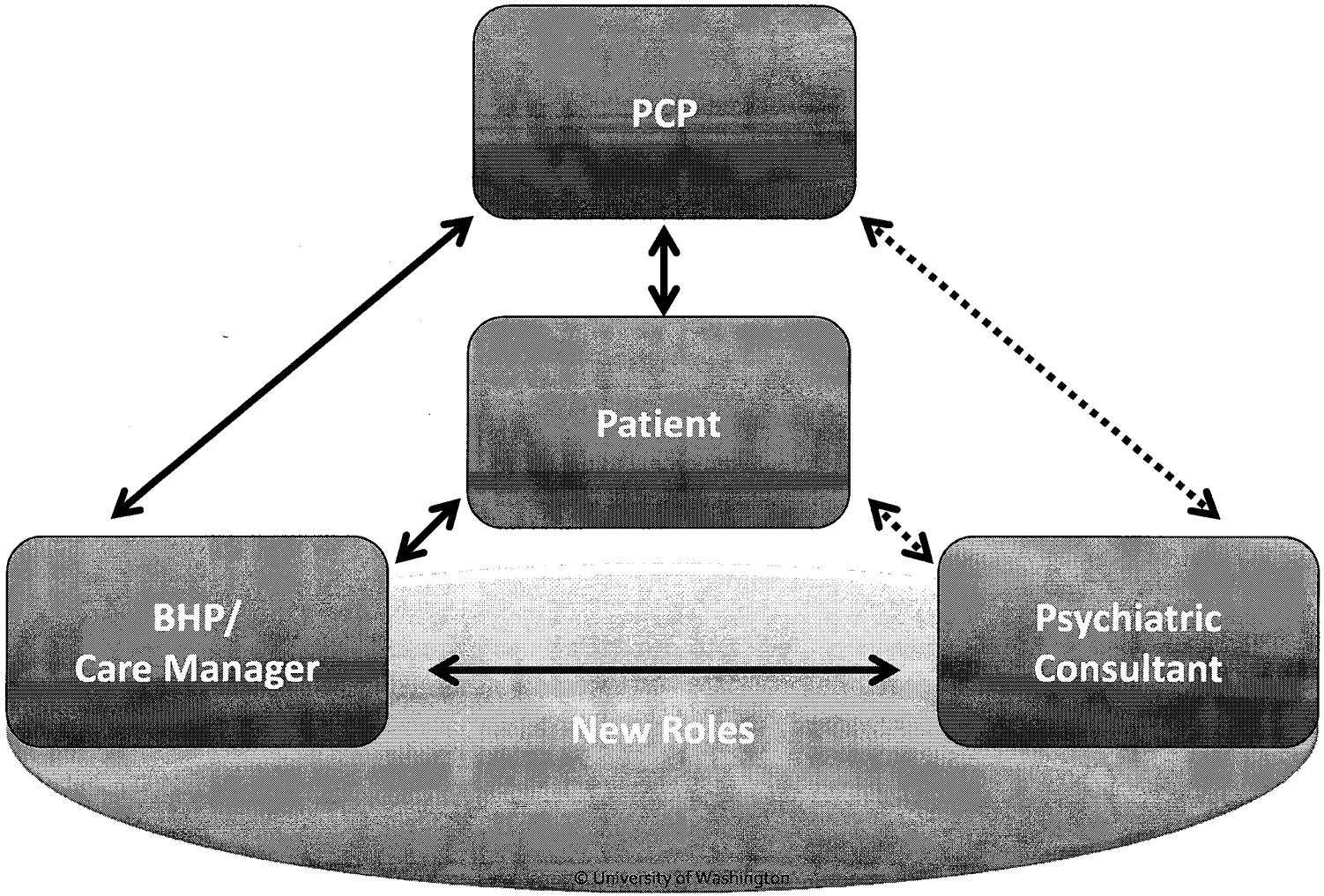

CENTRALIZED CARE MANGER SUPPORTING MULTIPLE SMALL PRACTICES

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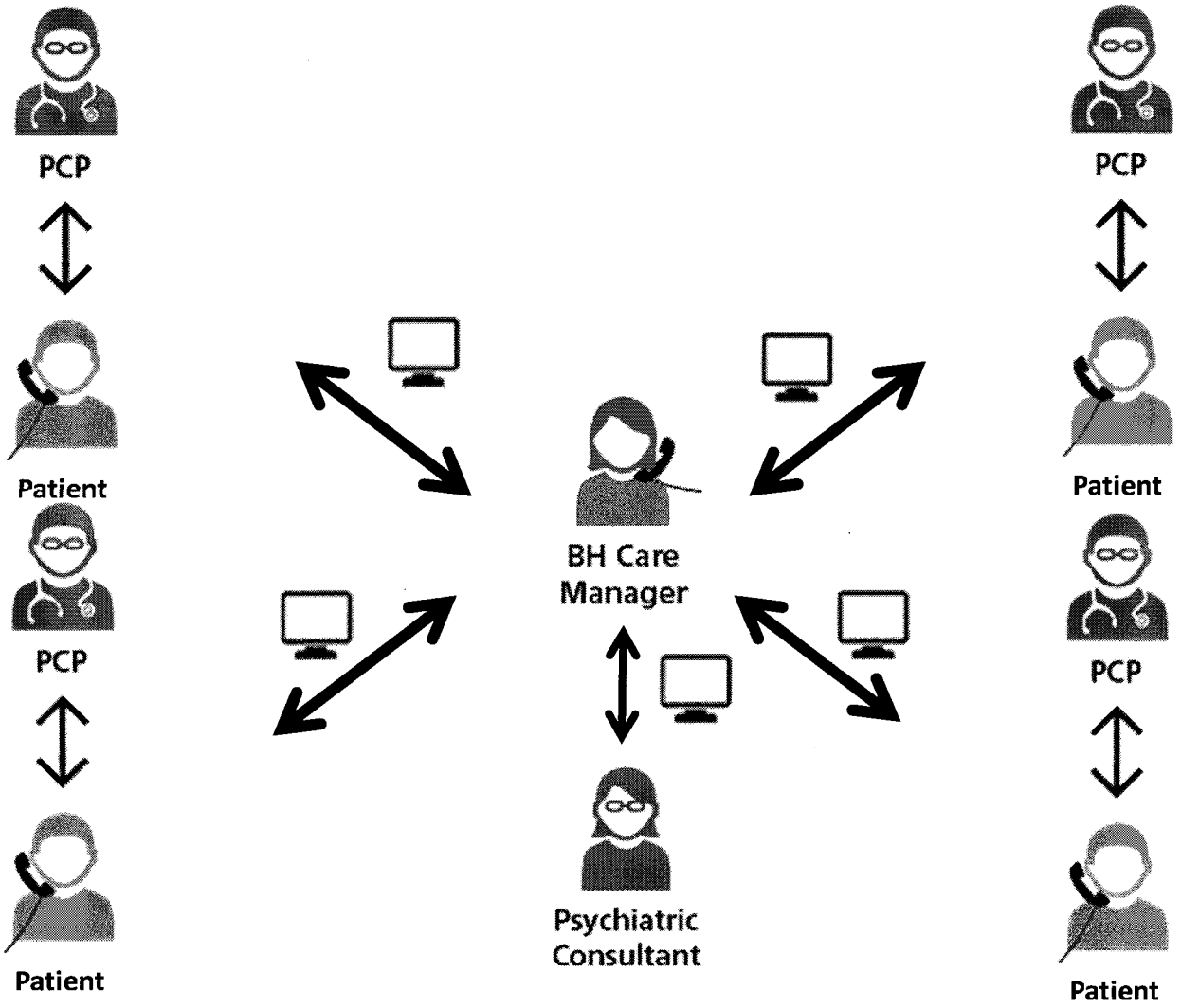
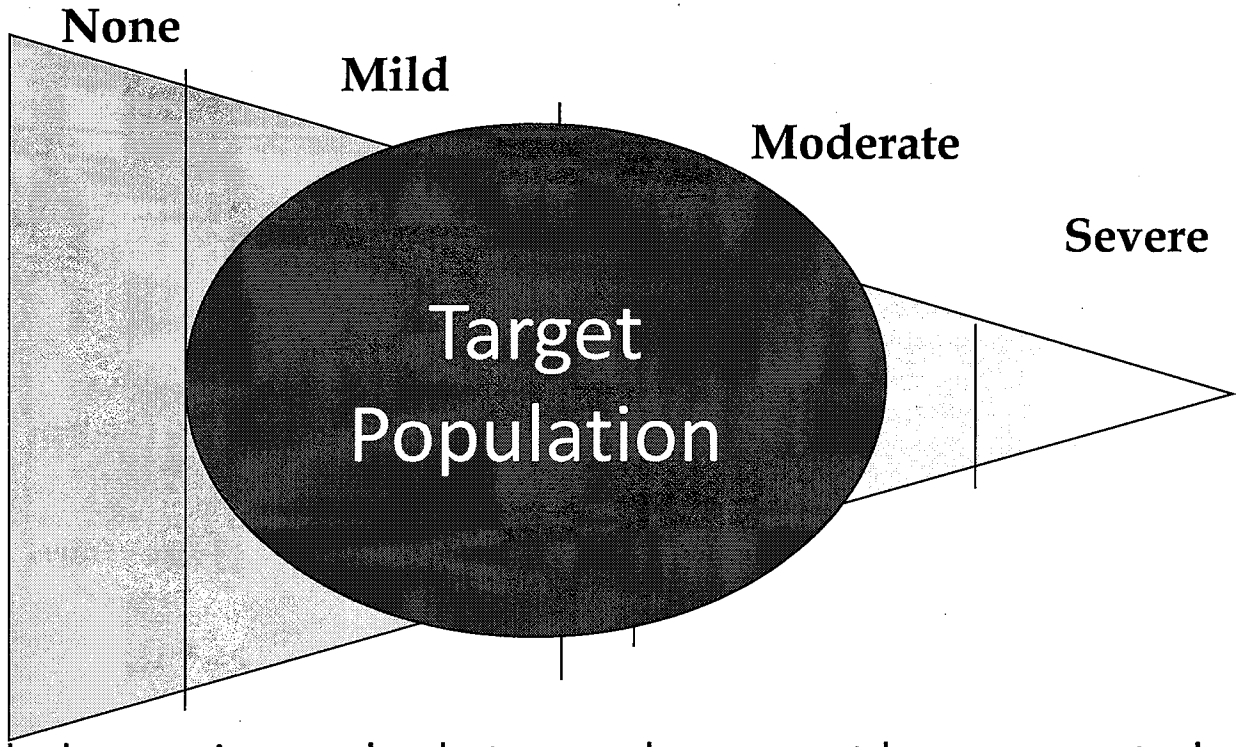


"SWEET" SPOT FOR THE COLLABORATIVE CARE MODEL



- Issues with depression and substance abuse must be pre-empted, rather than treated once advanced.
- Goal is to detect early and apply early interventions to prevent from getting more severe

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POPULATION-BASED CARE

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Caseload Overview

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			⁞ indicates that the most recent contact was over 2 months (60 days) ago				✓ indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ⁞ indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ⁞ Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	⁞ 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	⁞ 12/2/2015	7	29	18	17	-6%	⁞ 12/2/2015	14	10	-29%	⁞ 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

Allows proactive engagement (“no one falls through the cracks”) and treatment adjustment!

EVIDENCE BASE

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- **79 randomized controlled trials**
  - 24,308 enrolled patients
- **Compared to usual care (screening, referral etc.)**
  - ↑ Response and remission rates
  - ↑ Quality of life
  - ↑ Patient satisfaction
  - ↓ Costs over the long run
- **Results are consistent across populations**
  - Stages of life
    - Adolescents → Adults → Older Adults
  - Minorities
  - Diagnoses
    - Depression, Anxiety, SUD
- **Effective integration has the potential to save $26.3-$48.3 billion in overall healthcare spending**
  - Melek, S., D.T. Norris, and J. Paulus, Economic Impact of Integrated Medical-Behavioral Healthcare. Milliman, 2014.

TWICE AS MANY PEOPLE IMPROVE

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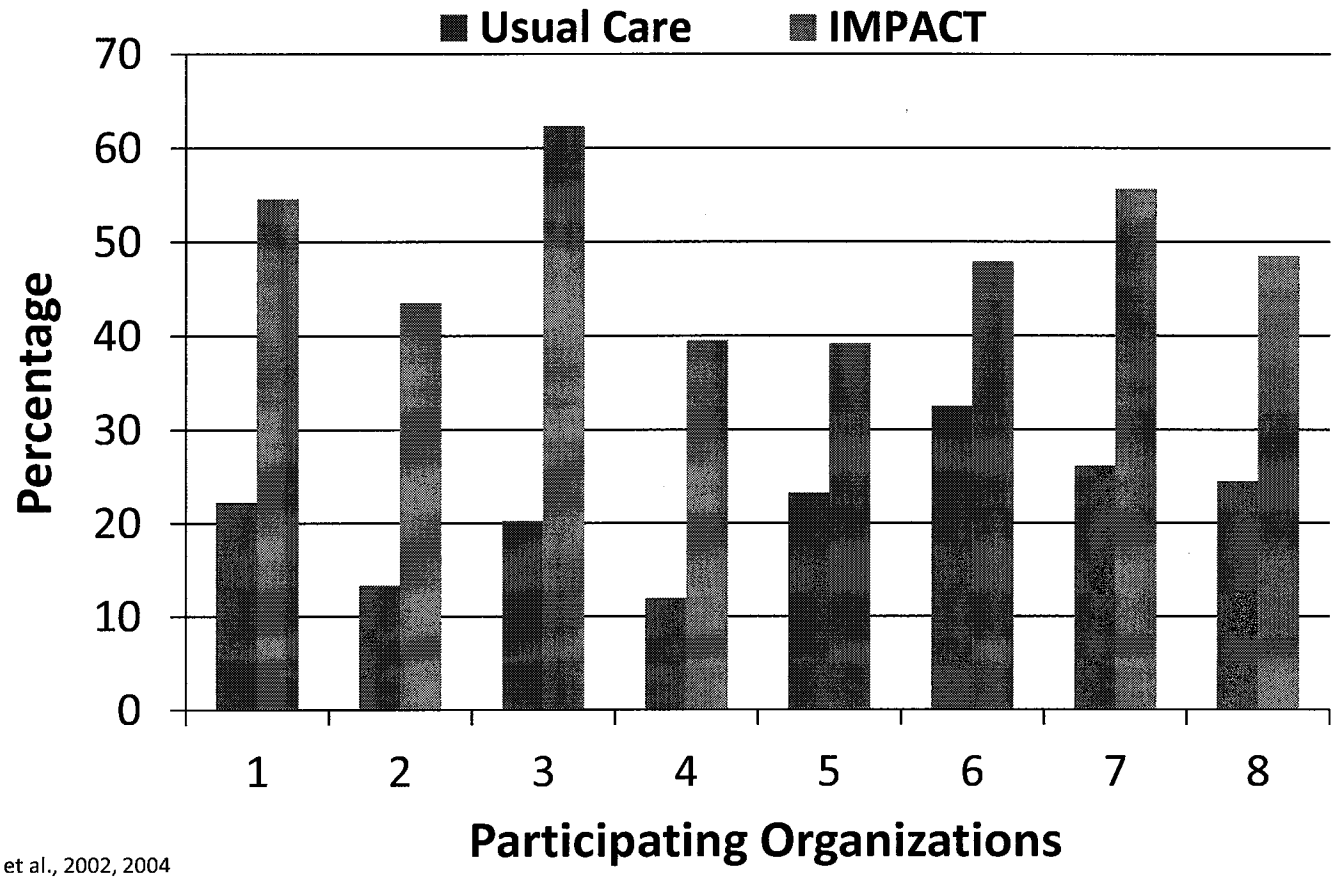
50 % or greater improvement in depression at 12 months



Unützer et al., 2002, 2004

IMPACT

IMPACT: SUMMARY

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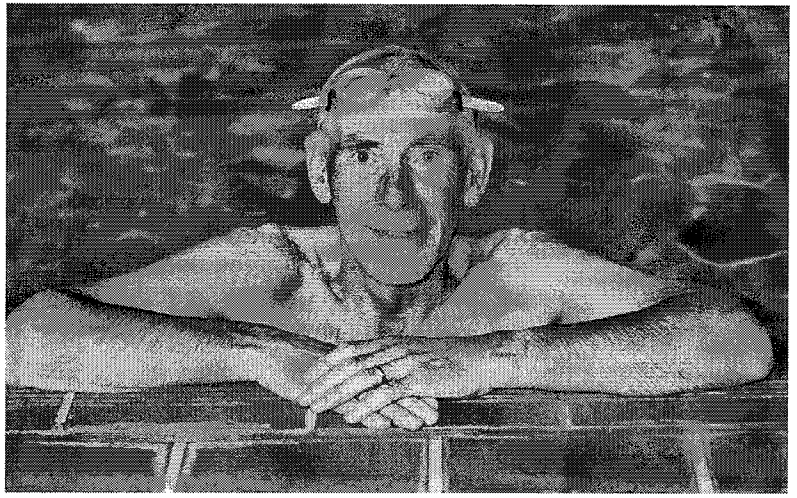
1) **Improved Outcomes**
   - **Less depression**
   - **Less physical pain**
   - **Better functioning**
   - **Higher quality of life**

2) **Greater patient and provider satisfaction**

3) **More cost-effective (ROI $6.50: 1)**



"I got my life back"

THE TRIPLE AIM

IMPACT

TEAMCARE OUTCOMES

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Depression
HbA1c
SBP
LDL

} **All Improved!**

COST SAVINGS: $600 - $1,100 per patient

PCP: "WHY AM I DOING THIS?"

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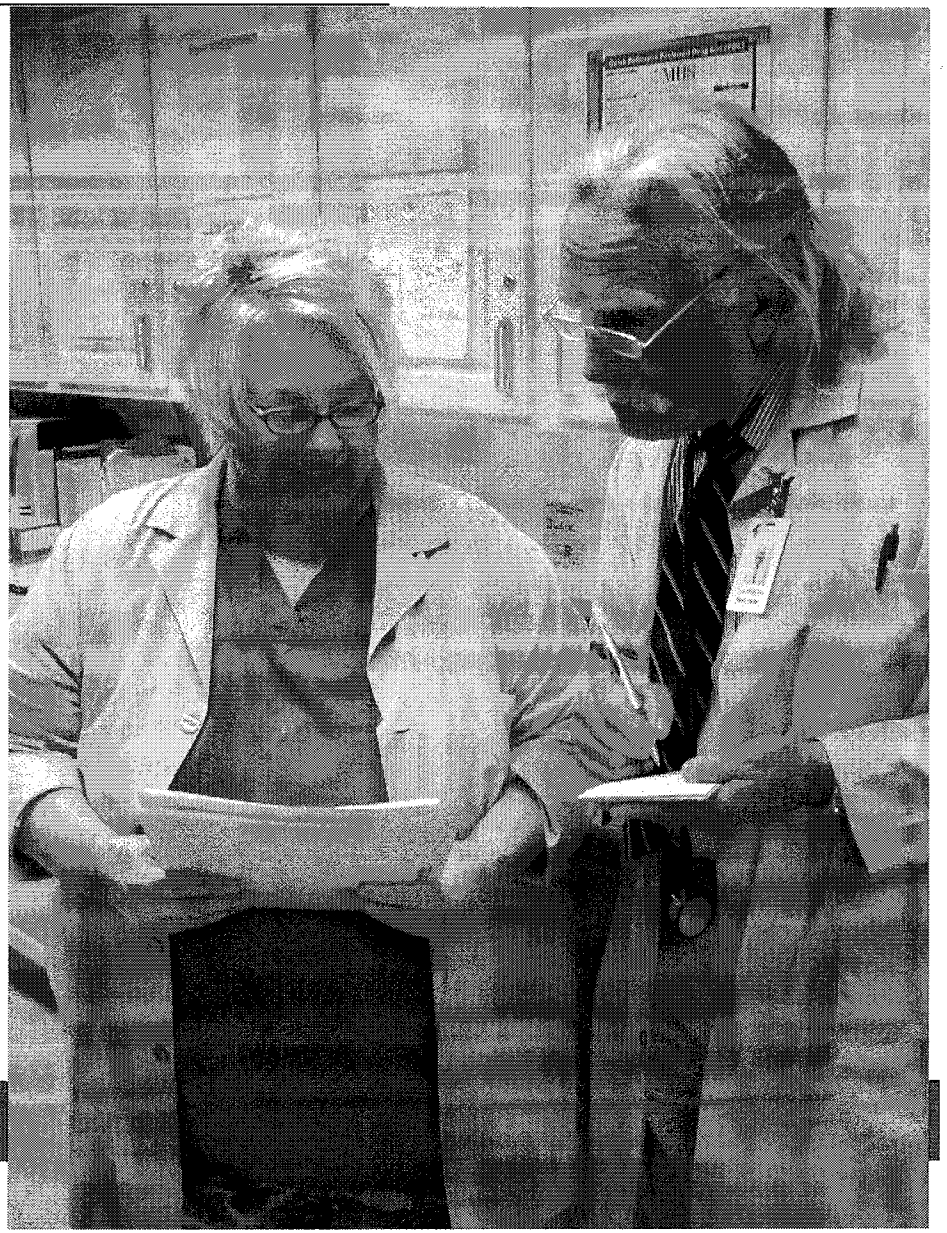
- These patients are already your patients.
- They are not going away.
- We can help with clinic workflow, shorten long appointments, limit struggles over controlled substances, respond to questions... We have your back!
- Can help with chronic disease outcomes, IMPROVE YOUR METRICS!



PAYMENT

COLLABORATIVE CARE IS NOW REIMBURSABLE

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Key Elements of the codes:

1. Active treatment and care management using established protocols for an identified patient population;

2. Use of a **patient tracking tool** to promote regular, proactive **outcome monitoring** and treatment-to-target using validated and quantifiable clinical rating scales; and

3. **Regular (typically weekly) systematic psychiatric caseload reviews and consultation by a psychiatric consultant, working in collaboration with the behavioral health care manager and primary care team**. These primarily focus on patients who are new to the caseload or not showing expected clinical improvement.

CCM CODES

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- **Payment** goes to the **PCP** who bills the service
- Billed on a per patient basis for those that have met the established time thresholds
- The psychiatrist **does not bill** separately.
  - contract with the PCP practice
- The patient must provide **general consent** for the service and they will have a **co-pay**
- Interaction does not have to be face-to-face
- Care manager and psychiatrists can also bill additional codes for therapy etc.

NEW MEDICARE CODES

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**Includes the payment for the time and effort of all three members of the team - the PCP, the BHCM and the consulting psychiatrist*

- G0502: Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manger activities (billable at 36 minutes)

- G0503: Subsequent psychiatric collaborative care management, first 60 minutes in subsequent calendar month of behavioral health care manager activities (billable at 31 minutes)

- G0504: Initial or subsequent psych collaborative care management - each additional 30 min

TRANSFORMING CLINICAL PRACTICE INITIATIVE

TRAINING FOR PRIMARY CARE PHYSICIANS & PSYCHIATRISTS

AMERICAN PSYCHIATRIC ASSOCIATION

In person training

- ✓**PCP**
- ✓**Psychiatrists**
- ✓**Joint PCP and Psychiatrist**

On line training Modules

- ✓**PCP**
- ✓**Psychiatrists**

www.psychiatry.org/SAN

For more information or questions please email:

Lori Klinedinst, APA TCPI Grant Manager, lklinedinst@psych.org
Kristin Kroeger, APA Chief of Policy Programs and Partnerships
kkroeger@psych.org

Hawai‘i Psychological Association

For a Healthy Hawai‘i

P.O. Box 833
Honolulu, HI 96808 www.hawaiipsychology.org Phone: (808) 521-8995

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

Wednesday, March 1, 2017, 1:00 pm, Room 308

The Hawai'i Psychological Association has long recognized the significant barriers to accessing psychiatric services in our state. We appreciate the amendments that have been added to HB1272 HD1 and submit this testimony in support.

HB 1272 HD 1 provides improved definitions that help to clarify key parts of the collaborative care model to include, “behavioral health care manager” and “psychiatric consultation services.”

While this legislation will hopefully help to increase psychiatric consultation services, it should be viewed as one approach and not the only approach given the widespread shortage of psychiatrists both locally and nationally. Having said this, it would be helpful to have a report completed after a specified time period to see the potential impact of this collaborative care model approach.

Additionally, other measures being brought forth in the 2017 legislature focus on a similar intent (HB767/SB384) while recognizing the need to ***increase the workforce*** that can provide access to psychotropic medication rather than spread thin an already limited pool of psychiatrists.

Respectfully submitted,

Julie Takishima Lacasa, Ph.D.
HPA, Chair, Legislative Action Committee

An Independent Licensee of the Blue Cross and Blue Shield Association

March 1, 2017

The Honorable Sylvia Luke, Chair
The Honorable Ty Cullen, Vice Chair
House Committee on Finance

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

Dear Chair Luke, Vice Chair Cullen, 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.

HMSA is committed to seeing telehealth continue to be an integral part of our healthcare system. Beginning in 2009, HMSA's Online Care was the first program in the nation to offer real time web-based telehealth services providing patients with 24/7 access to providers via the personal computer or telephone. Telehealth is a proven, effective and efficient way to facilitate timely access to quality health care, improve health outcomes, reduce the incidence of avoidable urgent and emergent care, and improve access to physician care in high-need and rural or remote communities in our state.

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. 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

From: mailinglist@capitol.hawaii.gov
Sent: Monday, February 27, 2017 7:45 PM
To: FINTestimony
Cc: purebliss4all@icloud.com
Subject: Submitted testimony for HB1272 on Mar 1, 2017 13:00PM

HB1272
Submitted on: 2/27/2017
Testimony for FIN on Mar 1, 2017 13:00PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Matthew Brittain, LCSW	Effective Change, LLC	Support	No

Comments: This bill represents movement forward in recognized clinical standards. Hawaii needs this improvement in mental health delivery due to our remote rural residence locations.

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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February 28, 2017

Rep. Sylvia Luke, Chair
Rep. Ty J.K. Cullen, Vice Chair
House Committee of Finance

Rep. Dee Morikawa, Chair
Rep. Chris Todd, Vice Chair
House Committee on Human Services

Rep. Della Au Belatti, Chair
Rep. Bertrand Kobayashi, Vice Chair
House Committee on Health

Re: HB 1272, HD1 (HSCR585) – Relating to Improving Access to Psychiatric Care for Medicaid Patients

Hearing Date: Wednesday March 1, 2017. 1:00pm

Dear Chair Luke, Chair Morikawa, Chair Belatti, Vice Chair Cullen, Vice Chair Todd, Vice Chair Kobayashi, and Committee Members:

Thank you for the opportunity to testify in **strong support** of HB 1272. The collaborative care initiative is a step closer in helping Mental Health Consumers acquire/retain medication and services that have only been obtainable through face-to-face meetings with health care professionals up until recently. This initiative will allow for continued efforts toward mental health recovery, and allow consumers to be sanguine about taking on meaningful and productive roles in the community in spite of mental health challenges.

This collaborative care initiative aligns with efforts put forth in The President's New Freedom Commission on Mental Health 2003: To achieve the promise of community living for everyone, new service delivery patterns and incentives must ensure that every American has easy and continuous access to the most current treatments and best support services available.

Aloha no,

Ana Kaleopaa, BSW
MSW Candidate
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LATE

March 1, 2017

TO: The Honorable Representative Sylvia Luke, Chair
House Committee on Finance

FROM: Pankaj Bhanot, Director

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

Hearing: March 1, 2017, 1:00 p.m.
Conference Room 308, 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 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.