# NASW Maine Key Points, Rationale and Stories to Amended LD 1196: An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health

1) **Sec. A-1. 24-A MRSA §6903, 13.** Behavioral health care reporting. Beginning January 15, 2023 and annually thereafter, the [Maine Quality) Forum shall submit to the Department of Health and Human Services and the joint standing committee of the Legislature having jurisdiction over health coverage and health insurance matters a [annual] report on behavioral health care spending using claims data from the Maine Health Data Organization and information on the methods used to reimburse behavioral health care…for behavioral health care spending based on claims data reported to the Maine Health Data Organization and information on methods of reimbursement reported by insurers.

**Why?** Under current law, the Maine Quality Forum has been required to submit a similar annual report on primary care spending since 2020.

Unlike medical care services, Maine has no understanding of what portion of insurance dollars are going to behavioral health care and where behavioral health service dollars are going.

Not having this data limits evidenced based visioning, planning and policy making for behavioral health services.

**Story:** Policy could be overly influenced and driven by the loudest or the best funded voices, who have the time and resources to show up.

2) **Sec. B-2. 24-A MRSA §4303, sub-§2, paragraph A** is amended to include**: 2. Credentialing**. A carrier may not use a credentialing process for a provider of behavioral health care services, or a provider that integrates primary care services with behavioral health care services, that is more restrictive than the credentialing process used for any other provider.

**Why?** Patient access to care is limited by administrative burdens which increase costs for provider organizations. Instead of hiring clinicians, they have to hire more billing/coding specialists.

High need for outpatient behavioral health care, where Mainers are not getting their behavioral health needs met. Behavioral health agencies report a wait list of 2300 (Maine Health Summit, November 2021). Health Affiliates Maine reports a wait list of 3000 (Kate Marble, testimony to HCIF Committee on LD 1920, January 27, 2022).

Carving out behavioral health from health credentialing and billing structurally separates the body from the mind. Separating the body from the mind leads to disease, dysfunction, and death. (dramatic, but true)

**Story:** Agencies that provide both behavioral health and medical services need two lines of specialists talking to departments in each insurance carrier about credentialing.

"I spend Fridays not seeing patients, in order to take care of paperwork required by insurers."

"The never-ending expectations around re-credentialing are extremely time consuming. Each insurance company has its own products, programs, lingo, and electronic platform, requiring a learning curve for each. In addition, these electronic platforms often malfunction or are being rebuilt or serviced, which translates into a huge waste of time for providers."

3) **Part B, Sec. B-3. 24-A MRSA §4303, sub-§2-B** is enacted to read: **2-B. Prohibition on carve-out for payment for behavioral health care**. A carrier may not use a process for submitting a claim for payment for a provider of behavioral health care services, or a provider that integrates primary care services with behavioral health care services, that is more restrictive than the process used for any other provider.

**Why?** Agencies that provide both behavioral health and medical services need two lines of specialists talking to departments in each insurance carrier about billing and reimbursement. More money going to administration, means less money for more clinicians.

**Story:** "I am considering moving to private pay due to insurer reimbursement issues." [further reducing Behavioral Health access for Mainers who can't pay cash.]

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| "I have decreased my caseload and stopped taking referrals in the hopes of getting a part-time job to compensate for the loss in income stemming from insurance non-payments since July 2021." |
| 4) **Sec. C-1. 22 MRSA §3187-A 2. Licensing of primary care provider**. ***Add the verbiage outlined in blue italics.*** The department may not require under the MaineCare program that a provider that integrates primary care services with behavioral health care services to obtain a separate license or authorization as a provider of behavioral health care services as a condition of *(equivalent)* reimbursement under the MaineCare program. ***Reimbursement rates can be no lower than the current behavioral health organizational reimbursement rates*** (MaineCare Manual Chapter 3). |
| **Why?** A medical care agency without a behavioral health agency license is penalized by receiving lower reimbursement rates. Having a behavioral health agency license adds additional paperwork (KEPRO), fees, monitoring, and pre-authorizations.<br>Behavioral health billing is more restrictive than medical billing, with rules, codes and reimbursement rates varying, depending on agency license, provider license, service provided and billing code (see Behavioral Health Billing Grid)<br>Most people's first point of contact re: behavioral health issues is with their primary care provider. Persons with untreated behavioral health conditions have high rates of chronic medical disease, difficulties with adherence to treatment, poor lifestyle habits, quality of life and shorter life-spans.<br>Agencies that provide both behavioral health and medical services need two lines of specialists talking to two different departments in each insurance carrier about billing and reimbursement.<br><br>**Story: F**or Maine primary care-based integrated behavioral health services to be financially viable, community behavioral health agencies place their providers into primary care offices, with supervision and billing coming from the behavioral health agency. This structural barrier:<br>a) prevents sharing of information and collaborative care between providers (due to HIPAA),<br>b) hampers relationship development between the on-site behavioral health and medical providers, and<br>c) continues the separation of the "mind" (behavioral health) from the body (medical health). |
| 5) Require DHHS to complete its review of the reimbursement rates under MaineCare for behavioral health services no later than December 31, 2022. |
| **Why?** The 2020 MaineCare Rate Evaluation Study was comprehensive for medical services, even the medication management behavioral health services, but NOT comprehensive for behavioral health services. This has led to lack of comparative data to other states on many behavioral health services in the community.<br>From an informal survey from NASW Maine, Maine reimbursement rates for outpatient behavioral health counseling are 1/3 to over ½ less than reimbursement rates in MA, VT and NH.<br><br>**Story:** Low reimbursement rates are the single most contributor to Maine's workforce shortage. 40% of social work graduates in Maine leave the state after graduation (USM, 2021). |