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WASHINGTON COUNCIL
FOR BEHAVIORAL HEALTH

November 26, 2024

Sydney Rogalla
Office of the Insurance Commissioner
PO Box 40260
Olympia, WA 98504-0260

Re: WSR 24-211-152 – Network access standards and contracting for behavioral health providers.

Dear Ms. Rogalla:

I write today on behalf of the Washington Council for Behavioral Health regarding OIC's proposed rules for network adequacy standards and commercial plans contracting with behavioral health providers. The Council is the professional association of licensed community behavioral health agencies (BHAs), representing 40 agencies across the state. Our members provide a full range of community mental health services, evaluation and treatment, residential and supportive housing, and substance use disorder services for both adults and children. Of particular note, these agencies also provide many of the current crisis response services across the state, including 24/7 crisis call lines, mobile crisis outreach, ITA evaluations by designated crisis responders, and crisis triage and stabilization.

Our comments will focus on WAC 284-170-205, the new section related to behavioral health emergency services provider contracting. Overall, the Council and our member agencies are very supportive of this proposed rule. As we know, behavioral health crises can happen to anyone, regardless of insurance status. However, there are many barriers in place making it extremely difficult for behavioral health crisis providers, which primarily serve Medicaid enrollees, to bill commercial insurance plans when their members experience a behavioral health crisis. We appreciate the effort on the part of OIC to remove some of those barriers with this rulemaking. In particular, we strongly support the following three policies:

- Medicaid behavioral health providers already experience more significant administrative burdens than other provider types. The current landscape requires a provider to negotiate, establish, and maintain dozens of contracts if they want to bill commercial plans, which for many agencies is simply too heavy of a lift. Requiring commercial plans to first try to contract with the regional BHASO to alleviate this burden on providers would be a significant step to expanding the number of crisis providers that would be able to accept commercial insurance.
- Requiring commercial plans to accept and reimburse billing codes from the Service Encounter Reporting Instructions (SERI) will make a huge difference in ensuring commercial plan enrollees receive comprehensive behavioral health treatment during a crisis. Our members have cited many times that one of the biggest barriers to billing commercial plans is their inability to recognize the SERI codes.
- This rulemaking would also eliminate another significant billing barrier for providers by requiring commercial plans to accept the agency license as the sufficient credential rather than requiring each individual provider who bills to be independently licensed. Commercial payors are often not set up to accept claims from non-licensed individual providers, which is a huge barrier for community behavioral health because we rely heavily on new clinicians who have an

associate's license or an agency affiliated credential but still need supervision hours to receive their independent license. In addition, clinicians who provide crisis services at a BHA are providing team-based care and are covered under the BHA's liability insurance, so an independent license doesn't offer as much value as it does for a clinician hanging their own shingle. Many BHAs have seasoned clinicians with ten or fifteen years' experience who can't bill commercial insurance because they don't have an independent license. This rule would allow us to better utilize the workforce we have in community behavioral health in way that could be more payor agnostic.

One concern we do have is related to implementation. How will the BHASO know which commercial payor the client is enrolled in? People in crisis often are not in a position to accurately report their insurance, so crisis providers usually do not know insurance status at the time they're transmitting the service to the BHASO. We have to do research post-contact to determine insurance coverage. Any reporting timelines in the BHASO/commercial plan should take this delay into account.

Finally, Washington State is on its way to implement a new Medicaid model, Certified Community Behavioral Health Clinics (CCBHCs), statewide by FY2027. One of the requirements of this model is that the CCBHC must provide services to any individual who walks in the door, regardless of insurance coverage. We would welcome the opportunity to explore how we can remove some of these same barriers for outpatient behavioral health services, which would allow CCBHCs and behavioral health agencies to more easily bill their commercial clients' insurance plans.

Thank you very much for the opportunity to provide written comment on these proposed rules. Please let us know if you have any questions.

Sincerely,

Joan Miller, JD
Chief Executive Officer
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