Workforce and Rates subgroup

Wednesday, June 2
10:00 am – Noon

	Action Items				
#	**Action Item**	**Assigned To:**	**Date Assigned:**	**Date Due:**	**Status**
1.	Communicate with Camille Goldy, others, about Healthy Youth Survey data.	Sarah Walker	6/2		
2.	Share BH Council data on open positions.	Joan Miller	6/2		
3.	Consider adding questions differentiating between clinicians serving adults and children, if it doesn't make survey completion more time-consuming or difficult.	BH Council	6/2		
4.	Invite Coordinated Care staff – Marissa, Amy, and Audrey – to next meeting to continue discussion on certification.	Co-chairs and HCA staff	6/2		
5.	Find link on student loan website for clinician needs by region.	Mary Stone-Smith	6/2		
6.	Send info from statewide survey of satisfaction with services.	Sarah Walker	6/2		
7.	Consider meaningful measures of access to services for discussion at next two meetings.	Everyone	6/2		
8.	Focus on strategies to address rates at next meeting.	Hugh Ewart	6/2		
9.	Get CBHAs looking at rate issues to share information at future meeting	Laurie Lippold	6/2		
10.	Arrange presenter on ProviderOne credentialing process for next meeting.	Laurie and Rachel	6/2		
11.	Send issues and questions related to credentialing process to cybhwg@hca.wa.gov.	Everyone	6/2		
12.	Connect with groups, individuals who can provide parent and youth voice.	Everyone, incl. Melanie Smith, Bob Hilt, Mary Stone-Smith	6/2		
13.	Ask professional associations – what are others states' experience? Is there a possibility of a strategy at federal level?	All who are members	6/2		
14.	Develop and send Initial survey to subgroup members – review items from pre-session survey and 2021 session.	Laurie and Rachel	6/2		

15.	Assemble for understanding of current state the various data sources related to access that came up on this call – Council Survey, Healthy youth survey, County risk profile, Mental Health America, state loan repayment website. Also HEDIS measures.	Leads and HCA staff			
16.	Bring to next meeting ideas for how to most accurately to measure access. Ideas should be within specific areas thus far identified: • Workforce (master's level, psychiatrists, psychologists, others?) • Wait times for appropriate services – defined for all appropriate cases including first appointment, follow up appointments, post-discharge from inpatient or other residential settings including ensuring there is a robust medically- informed discharge plan, inpatient setting after presenting in an ED • Distance from home • Others?	Everyone			

#	Agenda Items	Notes

1.	Strategies to address network adequacy/ access	• **Hugh Ewart**
		• To understand network adequacy, can we approach it from a different lens: ***access***.
		• Challenge: Understanding whether existing requirements for Medicaid and private insurers translate into access.
		• Questions:
		    ○ What information and data do you know right now that measures pediatric BH and access?
		    ○ How do we measure access?
		    ○ How do we as a group define access and what would measures for that be?
		    ○ Could legislation call out specific measures that would address access?
		
		• **Discussion**
		• BH Council –30% vacancy rate for all positions; 55% for Masters level. Turnover rates around 30%. No data about wait lists. (Survey conducted 8 months ago.)
		• County risk profiles – RDA. Measures of underlying need – Actual intakes – child and youth – Medicaid.

		• Medicaid rules requireinitial service w/in 10 days; 30 days for services. Harder to get appts on ongoing basis. • Each agency must decide which MCOs to contract with, tell MCOs what their capacity is, then follow measures from those MCOs. • HCA set standards for MCOs – MCOs set them for individual agencies. • Measures focus on WACs, WISe requirements, value-based outcomes (Can you provide an alternative to ED or inpatient?). MCOs talking with us about how we can measure social determinants. Working well for us. Most of those requirements we don't see as passed down to us. • HEDIS measures are the primary way the system measures how it is doing. A lot of the HEDIS measures about process, not quality or outcomes. Don't measures whether outcomes are improving. • Ask consumers: "I was able to get an appt within x days" vs. "I was able to get an appt within x days with a provider who could adequately address my issues" (quality). Access to the right service at the right time in the appropriate setting, not just access. Are you getting the right follow-up care? Is 30 days too long? • Secret shopper system – checking on access…. • Data on population health – Healthy Youth Survey, DOH. • Are there enough prescribers for a meds only approach? (Some youth prefer.) • Agencies giving up on psychiatrists – relying ARNPs and telehealth psychiatrists for prescribing. Also, psychiatrists can name their price; expensive. • Good national looks at child psychiatrists per population. Maps. Do we want to break down by region, type of insurance? • Student loan website has info about where needs are. • Where are we? Where do we want to be? How do we get there? • Cannot do without the involvement of parents, youth, young adults. FYSPRTs, Mary, Melanie, Bob, have contacts. *How to make this representative?*
2.	Strategies to address rates	For discussion at next meeting: What is the relationship between legislated rate increases and how this translates into what providers receive in the end, and organizations' ability to meet needs. Also, at next meeting a group of BHAs will share information about the work they've been doing looking at possible ways to redo the rate setting process.
3.	Certification processes – MCO perspective	**Amy Condon, Audrey Sillman, and Marissa Ingalls, *Coordinated Care*** • In order for someone to become a contracted provider, we require basic info: tax number, copy of license, Medicaid ID, application to be filled out or can pull info from OneHealthPort. • We don't want the process to be burdensome or cumbersome. Would like to do the same way as other carriers. • Turn-around time: 2-3 weeks. • Once approved, you can start billing. • ProviderSource is the credentialing system on OneHealth Port. • A provider has to get a Medicaid ID number through a process through HCA in order to be credentialed by an MCO. **Discussion** • It is unclear why there can't be just one process.

		• Coordinated Care has a credentialling committee that reviews applications, including a review of the person's background checks. • Would be interesting to find if other MCOs had credentialing committees. • Amy: Credentialing – only seen a person's application be rejected because of their history once in the past 2 years. Just because they have a licensing action against them, they can still submit an application. Must be a finding against them. • Good time to examine all gate-keeping functions. • HCA received $100K to look at background checks (see proviso). • Have heard providers must credential twice with the same plan – for Medicaid, and for commercial plan. Molina, Coordinated Care – require just one credential process for all their "books of business". • $599 to get a Medicaid number; rate is set by CMS. *For CBHAs, no fee.* • More discussion re individual practitioners vs CBHAs? • Questions around provider rosters. • BHAs have to fill out a staff roster every month. I t can take up to a week as there are 263 fields that need to be filled out; ProviderOne is an additional process. This needs further clarification at our next meeting. • Way to engage the private practitioners. • We have staff who have left because of all the regulatory requirements and administrative hurdles. • Individuals are required to have a Medicaid ID. • Next time: Should we keep on list?
4.	Review and discuss surge list and subcommittee survey	Laurie and Rachel will develop a survey and send it to subgroup members to get a sense of which, if any, of the items previously discussed should stay on our list for consideration for the 2022 legislative session.
5.	Background checks proviso	We need to track this work, along with the background check work the Workforce Board may be embarking on.
6.	New workforce issues	Please come prepared on June 16 to talk about new workforce issues to consider for 2022. If you cannot attend the June 16 meeting, submit ideas to: cybhwg@hca.wa.gov.
7.	Next meeting	• Continued discussion on access • Info about new group looking at rates • Continued discussion on credentialing process • Review survey results • Add additional items

Attendees

Rachel Burke, *Health Care Authority (HCA)*
Diana Cockrell, *HCA*
Amy Condon, *Coordinated Care*
Brooke Evans, *Washington State Hospital Association*
Hugh Ewart, *Seattle Children's*
Anusha Fernando
Megan Gillis, *Molina Healthcare*
Kimberly Harris, *HCA*
Robert Hilt, *Seattle Children's*
Kristin Houser, *Parent*
Marissa Ingalls, *Coordinated Care*
Avreayl Jacobson, *King County Behavioral Health and Recovery*
Sarah Kwiatkowski, *Premera Blue Cross/Association of Washington Health Plans*
Representative Mari Leavitt, *Washington State House of Representatives*
Laurie Lippold, *Partners for Our Children*
Joan Miller, *Washington Council for Behavioral Health*
Sarah Rafton, *Washington Chapter of the American Academy of Pediatrics*
Audrey Sillman, *Coordinated Care*
Daniel Smith, *Community Health Plan of Washington*
Melanie Smith, *NAMI*
Sarah Stewart, *Washington Mental Health Counselors Association*
Mary Stone-Smith, *Catholic Community Services of Western Washington*
Jim Theofelis, *A Way Home Washington*
Sarah Walker, *UW Evidence Based Practice Institute*
Mandy Weeks-Green, *Office of the Insurance Commissioner*
Larry Wissow, *Seattle Children's*

6-21-2021 Workforce & Rates Chat Log – Edited

Access

- If we asked for any more information updates about wait lists/accessibility from the community mental health agencies, we should be thoughtful that providing that information is not very burdensome, and not creating a new compliance risk for the agency.
- The issue of what measured is coming up for a number of reasons: WISe compliance, value-based, etc. Perhaps this group or a related group should focus on what are the best, small number of measures that are tied to value and access. FYI, there's broad agreement in the field that the HEDIS measures for pediatric mh are not well-performing in the field.
- Yes Mary, those issues, social determinants of health, are key. As often children and youth BH services' 'success' can better be measured by issues like school involvement/engagement, meeting social emotional developmental milestones/skills and utilization.
- Would there be a way to include any of this in the work of the PAL access line? It would seem to be a great resource of people who are seeking care, there's a lot of data about them, and there is contact information. Maybe it's already part of the plan, but one could get back in touch with a sample and look for outcomes. It would not necessarily be a representative sample but could be a start.
- This is a side comment related to the tracking RDA does on child abuse and neglect. Our partners in Child Welfare have been sharing with us a consistent significant decline in reports of possible child abuse and neglect since COVID started and schools closed.
- Here's the contract section and area with HEDIS… Page 166 Section 7.5 https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf …page 503 has some more specifics on HEDIS as well.
- Hi – Sara Stewart here representing the WA Mental Health Counselors Association. We'd love to be a part of this workgroup moving forward. We are striving to come up with a fix to the lack of providers to increase access etc.

- I'm supporting a number of young adults 19-25 who have exited homelessness, some went inpatient, but now are very reliant on getting their meds and in fact prefer to be "meds only" especially after some of the therapist turnover being discussed. Hoping this is considered a service as well given any interruption of meds immediately brings on psychotic sx's which invariably mean a return to homelessness secondary to paranoia etc
- Food for thought about example legislation: SB 5157 passed last session, which requires the development of criminal justice measures that must be included in MCO contracts by October 2022. Maybe something similar could be done for SoDH or children's BH?
- I'll track down the WA sources for this report: https://mhnational.org/sites/default/files/2019-09/2019%20MH%20in%20America%20Final.pdf
- The FYSPRT in KC is definitely more broad. We have a youth and young adult cubco.
- **A**t one point in the past in North Carolina their Medicaid reform for behavioral health did just what you have been taking about – streamlining the enrollment in managed care for any behavioral health provider who was embedded in or collaborating with primary care – and for just a lot of the reasons you are talking about.
- Wanted to circle back on the cost of getting a Medicaid number. It is $599 for 2021. This rate is set by CMS. (applies to individuals only; not agencies)
- Molina: When an individual or agency credentials with us for one line of business, we do not require additional credentialing eitherMore info for those interested about becoming a Medicaid provider: https://www.hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/enroll-billing-provider#do-i-need
- FYI, I just learned that a couple of particular pain points in the state for the referral assistance team in network connection are Snohomish county and Clark County. No agencies are accepting new clients in Clark, and only one agency in Snohomish is accepting any new clients in Snohomish for intake only with no guarantee of receiving care. We know this is because of the workforce hiring challenges….
- It would be really nice if there could be a 'backbone' organization that bills Medicaid and recruits individual clinicians to take clients that are referred to the backbone org, taking burden of regulatory requirements off individual clinicians but expands the workforce.
  > Very interesting idea. It could help engage pvt practice folks if it was a low barrier referral source/funding stream. The one issue is that for many in p/p they value independence very much which is another reason many exit the public agency work. But again an idea that could be explored.
  > Yes, could be a referral source they sign up for, get paid per client/hour for the Medicaid clients. ?? something like that.