Children's Mental Health Work Group

2016 Final Report Recommendations and Outcomes

On November 1, 2016, the Children's Mental Health Work Group approved 13 recommendations for the 2019 legislative session. At the conclusion of the 2017, 2018 and 2019 sessions, various bills containing Work Group recommendations were enacted, including:

- 2017: E2SHB 1713 (Chapter 202, Laws of 2017) and E2SHB 1819 (Chapter 207, Laws of 2017).
- 2018: E2SHB 2779 (Chapter 175, Laws of 2018) and SSB 6452 (Chapter 288, Laws of 2018).
- 2019: 2SSB 5903 (Chapter 360, Laws of 2019) and 2SHB 1216 (Chapter 333, Laws of 2019).

I. PRIORITIZED RECOMMENDATIONS

2016 Prioritized Recommendations (in order of priority)	2017 Legislation	2018 Legislation	2019 Legislation
Relating to Medicaid Rates. 1. The Legislature should provide funding to increase Medicaid Rates to achieve equity with Medicare rates, in order to increase the number of providers who will serve children and families on Medicaid. After the rate increases have been implemented for two years, the Legislature should require an outcome-based study on providers, analyzing the impact on the workforce and the number of providers who serve children and families on Medicaid.			• Bi-directional behavioral health rates increased for health and behavior codes and psychotherapy codes identified through the stakeholder workgroup process required under Chapter 226, Laws of 2017 (SSB 5779). • *Also of note: Increases in behavioral rehabilitation services (BRS) rates as mandated in ESHB 1109.*
Relating to Screening and Assessment 2. The legislature should require the Health Care Authority (HCA) and the Division of Behavioral Health and Recovery (DBHR) to assemble a work group or work groups to: • Identify a standardized list of culturally and developmentally appropriate screening tools for children aged 0-20, for use by all primary care practitioners whether covered by Medicaid or commercial insurance; • Identify standardized mental health assessment, outcome, and diagnostic tools that are culturally and developmentally appropriate for children aged 0-5 that support access to Behavioral Health Organization (BHO) services, and clearly delineate what substantive	E2SHB 1713: Provider reimbursement required for depression screens for: - youth 12 - 18 (annual) - mothers of infants birth - 6 months *Effective January 2018.*		**2SSB 5903**-Children's mental health: DCYF must contract with an organization to provide coaching services to early achievers program participants to hire one qualified mental health consultant for each of the six department-designated regions. The consultants must support early achievers program coaches and child care providers by providing resources, information, and guidance regarding challenging behavior and

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mental health challenges look like in young children. Identify billing options and propose coverage for a new or redefined code with an adequate reimbursement rate for the following services performed during an Early and Periodic Screening Diagnostic, and Treatment (EPSDT) visit, or other primary care office visit for a child: - Maternal depression screening to be provided when children are aged 0-5; and - Behavioral health screening, including depression screening, for children aged 0-20.			expulsions and may travel to assist providers in serving families and children with severe behavioral needs. In coordination with the contractor, DCYF must report on the services provided and the outcomes of the consultant activities by 6/30/2021. *Development of an infant/early childhood mental health consultation model was in SHB 1876 (not passed; companion bill to 5903).*
Relating to Children's Mental Health Workforce Supports and Incentives 3. The Legislature should provide a tuition loan repayment program targeted for child psychiatrists, therapists, and clinicians working for BHO- or MCO-funded agencies that serve a high percentage of children, youth, and families on Medicaid. The tuition loan repayment program should be directed at professionals in the above fields who make a commitment to work for 5 years in the public sector setting, working more than 20 hours per week on average. Loan repayment amounts should be commensurate with the average training costs for the respected specialties.	E2SHB 1713: One 24 mo. child psychiatry residency at WSU.	E2SHB 2779: One 24 mo. child psychiatry residency at UW. *Effective July 1, 2020.*	**2SSB 5903**-Children's mental health: • # of residencies increased to 2 at WSU and 2 at UW. • M increased from 12 to 18 months. **2SHB 1668**-Washington health corps: • Establishes the Washington health corps, a behavioral health loan repayment and conditional scholarship program for credentialed health professionals serving in underserved behavioral health areas. (Not child and youth specific.)
Relating to Mental Health Service Delivery and Care Coordination 4. The Legislature should: • Fund a FTE mental health lead at each of the nine Educational Services Districts (ESDs) and a coordinator in the Office of Superintendent of Public Instruction (OSPI). The mental health leads	E2SHB 1713: OSPI to pilot mental health and substance use leads at 2 ESDs. *Report due: 12/1/2019* *(Original bill included a Lighthouse ESD*		*Bill passed but not funded, so not implemented:* **2SHB 1216**-School safety & well-being: • Each regional school safety center must provide behavioral health

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will help coordinate Medicaid billing, mental health services, and other system level supports; • Create 2-3 regional pilot projects to fund a provision of mental health services in school districts struggling to address mental and behavioral health needs in K-12; and • Fund one "lighthouse" ESD with experience in providing mental health services to serve in an advisory role for the other districts. The "lighthouse" ESD will have experience with providing mental health services and billing through Medicaid.	*and MH leads in all ESDs.)*		coordination to the school districts in its regionto include, at minimum: ○ Support for school district development and implementation of plans for recognition, screening, and response to students' emotional or behavioral distress as required by RCW 28A.320.127 ○ Suicide prevention training for school counselors, psychologists and social workers ○ Facilitating partnerships and coordination with behavioral health services and supports to increase student and family access ○ Identifying, sharing and integrating behavioral and physical health care service delivery systems ○ Providing Medicaid billing related training, TA, and coordination between school districts ○ Guidance in implementing best practices in response to, and to recover from, the suicide or attempted suicide of a student
5. The Legislature should require the HCA to incorporate care coordination into larger primary care provider practices. The care coordination model must: • Use a psychiatric registered nurse or master's level health clinician with specified knowledge and training in mental health care, including but not limited to mental health screening, motivational interviewing, and suicide prevention. • Provide advocacy and engagement services which foster warm hand-offs to mental health professionals, tracks compliance with recommendations and referrals, facilitates communication between health care providers, and provides education to children and families.	E2SHB 1713: HCA must oversee care coordination; BHOS and MCOs must maintain adequate capacity, follow up to ensure appointments secured, report back to primary care on treatment, provide information on behavioral health resource line, maintain accurate list of providers including current availability.	SSB 6452: Requires HCA to enforce contract requirements to ensure care coordination and address network adequacy concerns.	

II. Supported Recommendations

2016 Supported Recommendations (organized by topic, not in order of priority)	2017 Legislation	2018 Legislation	2019 Legislation
Relating to Network Adequacy. A. In addition to network adequacy reporting requirement established is E2SHB 2439 (2016) and other federal requirements, state agencies should ensure network adequacy and promote continuity of care in multiple settings for both commercial and Medicaid coverages by: i. Performing quarterly evaluations of network adequacy; ii. Encouraging MCOs to contract with private behavioral health providers who are part of the BHO; iii. Increasing primary care provider and care coordinator awareness of the Partnership Access Line (PAL) consultative services; and iv. Facilitating or requiring provision of telephonic or telemedicine consultations with psychiatric care. B. The HCA should establish performance measures for MCOs relating to the delivery of: i. Developmental screenings; ii. Behavioral health screenings for children aged 5-12 iii. Adolescent depression screenings; and iv. Maternal depression screenings	E2SHB 1713: HCA must report annually on # of provider's available, % accepting new patients, and languages spoken. BHOs and MCOs must provide information to providers and plan members about the 24/7 behavioral health resource line. Reimbursement required for providers delivering services via telemedicine.	E2SHB 2779: HCA must report annually on network adequacy related to eating disorder treatment. SSB 6452: HCA and OIC must develop an alternative funding model for PAL and PAL for Moms and Kids and report to CMHWG and Legislature by 12/1/18. Makes PAL permanent (removes pilot designation). Implements a 2 year PAL for Moms and Kids pilot (beginning January 1, 2019). Requires HCA to enforce contract requirements to ensure care coordination and address network adequacy concerns.	**ESHB 1099**-Health carrier network adequacy (not children and youth specific): • OIC to amend rules on electronic provider directories to require carriers to include a notation when any BH provider is closed to new patients. • Beginning 1/1/2020, carriers shall prominently post the following information so it's easy to find and understand: ○ Whether the carrier classifies MH and SUD treatment as primary or specialty care and the # of business days within which an enrollee must have accesses to covered BH services under network standards for primary or specialty care; ○ Actions enrollees may take if they are unable to access covered BH services, including info on finding available providers and filing a complaint with the OIC; ○ Instances where OIC has taken disciplinary action against the carrier for failing to comply with network access standard for covered BH treatment services;

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			○ A link to the commissioner's report on # of consumer complaints per carrier regarding lack of access to BH treatment services; ○ Resources for persons experiencing a mental health crisis.
Relating to Screening and Assessment. C. The Legislature should: i. Require the HCA and DBHR to provide outreach and education to primary care practitioners and mental health providers regarding: a. Expectations of services to be performed during an EPSDT exam; b. Maternal depression or other contributing mental health conditions that directly impact the child in the child's treatment plan; and c. Billing requirements for mental health screening and referrals to mental health services, including new billing and coverage options developed pursuant to recommendation #2 from the prioritized list. ii. Identify a full complement of medically necessary behavioral health services to be covered by all commercial carriers. D. The Legislature should enlist local health districts and other appropriate venues and providers to provide behavioral health screening to all children aged 0-20.		SSB 6452: Same-day consultation and support to health care providers in assessment/treatment of maternal depression. E2SHB2779: Advisory committee to review PIT process, including the definition of "medical necessity" for emergency mental health services.	
Relating to Paperwork Reduction. E. In accordance with the federal Paperwork Reduction Act of 1995, state agencies should reduce the amount of paperwork required by clinicians providing mental health services to children on Medicaid by replacing current rules with regulations that focus on the use of best practices of age-appropriate, strength-based psychosocial assessments, including	E2SHB 1819: DSHS must streamline documentation requirements, provide a single set of regulations by 4/1/18, and simplify/align audit practices.		**E2SSB 5432**-Behavioral health integration: Neither HCA nor the department may provide initial documentation requirements for patients receiving care in a behavioral health agency which are substantially more

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current needs and relevant history in areas such as behavioral/emotional, mental health safety/risk, and functional impairment. State agencies should eliminate duplicate documentation requirements in state rules for provider agencies, except when this documentation is required for medical necessity or meeting access-to-care standards. *F.* State agencies should review the E3SHB 1713 Sec. 533(4) report and the Workforce Training and Education Coordinating Board 2017 report regarding paperwork reduction, and suspend the development of any new rule changes related to behavioral health until rule integration is finished in 2017			administratively burdensome to complete than initial documentation requirements in primary care settings, unless such documentation is required by federal law or to receive federal funds. (Not children and youth specific.)
Relating to Medicaid Rates G. State agencies should remove limitations on treatment options focused on treating the family dyad or a particular familial relationship. H. The Legislature should provide increased funding for specialized children's mental health services and training including, but not limited to: i. Infant mental health services and training {IMH-ER, Level 3}; ii. Early interventions for treating psychosis; iii. Wraparound with Intensive Services (WISe); iv. Treatment for eating disorders; and v. Interventions and services that are culturally and linguistically appropriate.		E2SHB 2779: Adds "family support" as an allowable component of BHO outpatient services programs. Requires the HCA to report annually on mental health and medical services for eating disorder treatment in children and youth. Requires DCYF and HCA to develop a strategy to leverage Medicaid funding for home visiting.	**2SSB 5903**-Children's mental health: HCA shall collaborate with UW and a professional association of licensed behavioral health agencies to develop a statewide plan to implement evidence-based coordinated specialty care (CSC) programs that provide early identification and intervention for psychosis in licensed and certified community behavioral health agencies.
Relating to Children's Mental Health Work Force and Incentives. I. The Legislature should incentivize clinical supervision of therapists working in MCO or BHO agencies through individual agency contracts, by restricting counselor-to-supervisor ratios in contracts with MCOs and BHOs, and/or by capping the caseload size for supervisors to be consistent with recommendations from evidence-based and research-based practices.		E2SHB 2779: Requires BHOs to allow reimbursement for time spent supervising providers working towards credentials.	
Relating to Recruiting and Maintaining a Diverse Workforce J. The Legislature should increase options for payments and increase the variety of professionals who can help provide mental health interventions, such as parent-family partners and peer support in communities and non-traditional locations, including settings such as primary care, education,		E2SHB 2779: Allows BHOs to reimburse providers for partial hospitalization or intensive outpatient treatment.	

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child welfare, and juvenile justice, in order to increase the diversity of the settings in which mental health services can be provided. K. The Legislature should require the Washington State Institute for Public Policy, or a similar organization, to conduct a study in collaboration with interested stakeholders and communities to evaluate the children's mental health system and available workforce. At a minimum the study should evaluate: i. The number of mental health providers serving children, including children birth to age 5 and those on Medicaid; ii. The demographics of providers and their clients including, but not limited to, race and ethnicity, languages services are provided in, ages of children served, the use of screening tools and assessments that are culturally and linguistically appropriate, and the level of cultural competency training received by providers; iii. The availability of culturally and linguistically diverse services and providers. The study should also review the public mental health services available to children and the corresponding child outcomes in order to determine where racial and ethnic disparities exist and the severity of those disparities. Racial and ethnic disparities should be monitored on an ongoing basis.			
Relating to Child Care Services. L. State agencies should provide at least 12 months of stable child care through the Working Connections Child Care (WCCC) program for children involved in the child welfare system or who are homeless, regardless of the employment status of their parents or guardians. M. The Legislature should require the Department of Early Learning (DEL) to reinstate and expand mental health consultation and coaching for child care providers who care for children with behavioral health needs. N. The DEL Early Achievers program should provide funding to assist participating child care providers in meeting the necessary training and	SHB 1624 (2017): Extends WCCC availability to families who have received child welfare, child protective, or family assessment response (FAR) services in past six months. E2SHB 1713: DEL must establish a child care consultation program for providers.		**2SSB 5903**-Children's mental health: DCYF must contract with an organization to provide coaching services to early achievers program participants to hire one qualified mental health consultant for each of the six department-designated

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supervision requirements for an Infant Mental Health Endorsement (IMH-E®) at the infant family associate or specialist levels to serve children birth to age three. *Relating to Mental Health Training and Education.* O. The Legislature should fund development of expanded behavioral health training and coaching opportunities for early learning through K-12 providers, educators, administrators, and parents, which are culturally competent and utilize multiple approaches including employment of paraprofessionals and peers. P. The Legislature, state agencies, and school districts should implement developmentally and culturally appropriate K-12 Social Emotional Learning (SEL) standards and competencies to complement existing early learning SEL standards, using the proposed SEL framework outlines in the October 1, 2016, Legislative report, "Addressing Social Emotional Learning in Washington's K-12 Public Schools."		E2SHB 2779: Requires ESDs piloting a lead staff person for behavioral health to deliver a mental health literacy curriculum to students in one high school in each pilot site. Curriculum should be designed to improve mental health literacy for students and support teachers.	regions. The consultants must support early achievers program coaches and child care providers by providing resources, information, and guidance regarding challenging behavior and expulsions and may travel to assist providers in serving families and children with severe behavioral needs. In coordination with the contractor, DCYF must report on the services provided and the outcomes of the consultant activities by 6/30/2021.