Notes

Children and Youth Behavioral Health Work Group – Behavioral Health Integration (BHI) Subgroup

May 6, 2025

Glossary of Terms

B&O: Business and Occupation
CHW: Community Health Worker
EPSDT: Early and Periodic Screening, Diagnostic, and Treatment
HCA: Health Care Authority
MCO: Managed Care Organization
PAL: Partnership Access Line

Meeting Topics

2025 Session Reflections: BHI and related priorities
Presentation/Discussion of principles related to pediatric integration for input to the Strategic Plan
Next Steps & Wrap Up

Discussion Summary

2025 Session Reflections: BHI and related priorities

Amber Ulvenes gave an update on the 2025 session, including the following:

a. The final budget included $6 billion in cuts and about $9 billion in new revenue.
b. New revenue includes gross receipts taxes on healthcare providers via a Business and Occupation (B&O) tax.
c. Funding (about $2.5 million per year for the biennium in general fund state and $10 million federal) was secured for pediatric community health workers (CHWs) to pay for the codes that have been established for this position.
d. There will be a 1% across-the-board cut for Managed Care Organizations (MCOs), for both medical and behavioral health care. This may possibly affect providers as well.
e. The enhanced Medicaid rates – which bring Medicaid rates for the most common pediatric primary codes nearly to or at parity with Medicare rates and include a 15% increase for pediatric specialty care and hospital care – were preserved in the final budget.
f. The legislature's planned cuts to postpartum coverage from 12 to 6 months did not pass, so the entitlement remains at 12 months.
g. The value-based payment proviso went through with only minor edits, obligating the Health Care Authority (HCA) to engage with organizations to develop a primary care value-based proposal program.

2. Discussion surrounding the legislative updates included the following:
    a. The Governor has not yet signed the budget as of 05/23/25:

i. He is not expected to make substantial changes that would require calling the legislature back into special session.
ii. The Governor has the ability to veto any particular appropriations item.
iii. The Partnership Access Line (PAL) and Washington's Mental Health Referral Service for Children and Teens are receiving less funding than needed from HCA and are in the process of determining staff cuts. They will keep BHI Subgroup informed of their status and capacity in the coming 1-2 months.
    1. The subgroup needs to continue to raise up centralized resources that contribute to behavioral health integration, such as the PAL.

Presentation/Discussion of principles related to pediatric integration for input to the Strategic Plan

1. Subgroup leads reviewed the proposed principles related to pediatric integration for inclusion in the Strategic Plan (see slides for more detailed information about each principle and its essential components).
2. Discussion surrounding each principle included the following:
    a. Principle 1: The essential role of primary care in the child/youth/family behavioral health system
        i. The subgroup needs to develop a succinct way to describe families with kids who have combinations of developmental, emotional, behavioral and social challenges, and that are often multi-generational – these are the target folks for early prevention.
        ii. Developmental delays should be called out specifically.
        iii. There is a misconception that behavioral health in primary care is for "little problems," but in reality, it involves complex issues and prevention services during the development of significant mental health challenges.
        iv. It is worth defining the stepped care model at the beginning of the principle, and relatedly, the second section/paragraph could be clarified and condensed to help audiences understand the components in primary care that make up step care.
        v. A parent perspective that highlights the importance of having a pediatrician who works with children who have intellectual disabilities and mental health needs, who seeks out partnerships and collaboration in behavioral health to better understand a child's condition; and affirms how this helps decrease stigma and isolation.
        vi. As providers continue to practice their roles in collaborative care, they are getting better at understanding the needs of different kids and the variability of the roles they play in the system on a case-by-case basis.
        vii. It may be worth noting the role of connecting care to school in Principle 1, as the importance of input from teachers, principals, counselors and other school-based professionals is imperative.
    b. Principle 2: What primary care can do for children/youth and families
        i. The second section/paragraph should call out explicitly that treatment should be for (at least certain) developmental challenges directly in primary care.
        ii. Many children are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – whose anticipatory guidance helps to prepare families and

caregivers on what to expect and be prepared to address in each developmental stage.

1. What does this guidance look like from a primary care provider, across different diagnoses (e.g., how to determine and/or address hearing difficulties in children with Down Syndrome)?
2. The principal statement should include language to specify typically developing children and those with developmental challenges.

iii. A proposed rewording of section/paragraph two, to address the above: *Primary care practices need to create a foundation of well-being by delivering diagnostic, preventive and indicated treatments that are person-centered, culturally appropriate and that meet a child or youth's emerging physical, behavioral and developmental stage. Treatments should be trauma-assumed and evidence-based or informed to the greatest extent possible.*

c. Principle 3: Support for practice transformation
   i. Subgroup members agree that this principal statement highlights the main points but could be "word smithed."
   ii. A parent perspective that a portal for mental health care for providers, evaluations, medications, clinical and summary notes, diagnostic tests, etc. would be immensely helpful for parents and providers to keep track of history.

Next Steps & Wrap Up

1. Next BHI Meeting: June 3, 2025, at 1pm.
2. Subgroup members should continue to provide feedback on the case statement – which provides supportive information for each input to the Strategic Plan.
   a. The main inputs the subgroup should provide for Washington Thriving are the following:
      i. A cohesive narrative description of integrative care.
      ii. What it will take to actualize the subgroup's highest priority components.
      iii. What pathways can be established to make these components part of an inherent and sustainable mental health care system, that is able to transcend fluctuating budgets and decisions each session.
3. Next meeting is a good opportunity to home in on some of these specifics via small group discussion about top priorities and issue areas that BHI can build upon from existing work.
4. At the second meeting in June, Washington Thriving (Prenatal through Age 25 Behavioral Health Strategic Plan initiative) will be presenting the emerging integration-related content and ensure it reflects the subgroup's understanding.