Notes

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

July 22, 2025

Glossary of Terms

CYBHWG: Children, Youth & Behavioral Health Work Group
CHW: Community Health Worker
HCA: Healthcare Authority
ACH: Accountable Communities of Health
PIN: Principal Illness Navigation
MCO: Managed Care Organization
CMS: Centers for Medicare & Medicaid Services
HCPCS: Healthcare Common Procedure Coding System
CPT: Current Procedural Terminology
WAC: Washington Administrative Code

Meeting Topics

Welcome & Agenda
Information share on Community Health Workers
Q&A Discussion about CHWs
Strategic Inputs Share: Financing and Infrastructure, Embedded Principles
Close & Next Steps

Discussion Summary

Welcome & Agenda

Kristin Houser, BHI Lead, facilitated. The meeting agenda covered community health workers (CHWs), strategic plan inputs, and next steps for the subgroup's work.

Information Share on CHWs

Mary Ann Woodruff and Rachel Lettieri from Pediatrics Northwest shared a presentation on their work with Community Health Workers.

1. Background and Current Status
    a. Washington State implemented a CHW pilot program that ran for 2.5 years, with approximately 50 CHWs funded statewide focusing on school-age mental health and early relational health.
    b. The pilot officially ended on June 30, 2025, transitioning to new Medicaid billing codes that became effective July 1, 2025.
    c. The Washington Chapter of the American Academy of Pediatrics led advocacy efforts beginning in 2019, with strong support from family members on Chapter steering committees.
2. Key Billing Codes Established
    a. Two primary codes were implemented:

   i. Community Behavioral Health Integration Services – authorizes CHW's to provide navigation services to address social determinants of health that impact diagnosis or treatment; it also supports CHW's providing client education and helping with care coordination activities.
   ii. Principal Illness Navigation (PIN) Services - focuses on serious, high-risk conditions and can be delivered by CHWs.
3. Positive Developments
   a. Healthcare Authority (HCA) worked collaboratively with stakeholders to address initial billing restrictions.
   b. Time-based codes allow accumulation across multiple encounters, including direct and indirect services.
   c. Services can include calling community resources, provider consultations, and documentation.
   d. The first visit of the month can be conducted in-person or via telemedicine.
4. Ongoing Challenges
   a. 60-minute minimum billing requirement per calendar month - identified as a significant barrier to successful implementation.
   b. Uncertainty about commercial insurance coverage (approximately half of Pediatrics Northwest's patients have Apple Health, while others have commercial insurance).
   c. Some practices have discontinued their CHW programs due to billing complexities.
   d. Average patient encounters are approximately 22 minutes, making the 60-minute minimum difficult to achieve.
5. Funding Alternatives
   a. Accountable Communities of Health (ACH) provide Medicaid waiver funding for community-based worker hubs.
   b. Pediatrics Northwest secured funding from Elevate Health (Pierce County ACH) for three CHWs over two years.
   c. Enhanced screening payment codes (with 6-fold increase) are available when tied to documented actions, though many practices are unaware of this opportunity.

Q&A Discussion about CHWs

1. Commercial Insurance Coverage Challenges
   a. Key Issue Identified: Community health workers are not recognized as provider types under commercial insurance regulations, unlike their recognition under Medicaid.
   b. Legislative Requirements:
      i. CHWs would need to be established as recognized provider types through Department of Health regulation.
      ii. This would require legislative action similar to the process used for peer support specialists.
      iii. Previous attempts to define CHW scope and certification requirements have faced challenges reaching consensus.
2. Immediate Action Items Discussed
   a. Outreach to Office of the Insurance Commissioner to understand commercial insurer perspectives.
   b. Development of educational materials for hospital systems about enhanced screening payments.

   c. Blueprint development by consultant Liz Arjun to guide implementation strategies.
   d. MCO engagement to educate provider networks about available funding opportunities.
3. Data demonstrates the universal need for CHW services regardless of insurance coverage (See supporting slides).
   a. Pediatrics Northwest's 2.5-year pilot data showed the top barriers addressed by CHWs across all insurance types were:
      i. Social and community support
      ii. Mental health services

Strategic Inputs Share: Financing and Infrastructure, Embedded Principles

Kristin Houser shared the current drafts of BHI Recommendations to the Washington Thriving Strategic Plan.

1. Strategic Imperative 1: Strengthen System Infrastructure
   a. Payment System Recommendations:
      i. Finance sustained team-based care including consultation, care coordination, and navigation services.
      ii. Support startup costs for integrated care implementation, including training, staffing, and workflow changes.
      iii. Endorse value-based care models that provide flexibility for community-specific solutions.
   b. Training and Workforce Development:
      i. Require provider rotations to include primary care clinic experience.
      ii. Fund training for community health workers and peer navigators.
      iii. Establish ongoing regional training programs with continuous quality improvement focus.
      iv. Allow agencies with internal capacity to provide training locally to reduce costs and improve alignment.
2. Strategic Imperative 3: Embedded Principles
   a. Core Recommendations:
      i. Build Integrated Healthcare System - Ensure behavioral health availability through primary care as part of whole-person care, with emphasis on early intervention before problems become full-blown disorders.
   b. Establish Primary Care as Medical Home - Provide ongoing support and stabilization for children cycling through intensive services.
   c. Mandate Community Connections - Create funded, incentivized connections between community behavioral health organizations and primary care.
   d. Equity and Innovation Focus:
      i. Leverage primary care's reach (90%+ of children) to ensure equitable access.
      ii. Utilize trusted community relationships and "third place" positioning.
      iii. Implement compassionate, person-centered care that acknowledges individual journeys.
      iv. Avoid requiring diagnoses before providing support services.

Next Steps & Wrap Up

1. Thank you to everyone who has provided feedback on our inputs for Washington Thriving. If you're interested in assisting with 2026 Legislative Recommendations, please email info@bhcatalyst.org, khouser206@outlook.com, and lawrence.wissow@seattlechildrens.org.
2. The subgroup will next meet on August 5th, from 1-2:30pm. *If you are not already on the BHI mailing list and would like to be added, you can email cybhwg@hca.wa.gov indicating your preference.*

PEDSNW CHW UPDATE

BHIC Meeting
7/22/2025

WA State Journey

CHWs in Pediatric Primary Care

Vital to this story is the central role of parents advocating for meaningful change in primary care, along with determined partnerships and advocacy. A striking example is Dr. Calvin Sia, a pediatrician in Hawaii, who conceptualized the pediatric primary care medical home in the 1960s. This was in direct response to families he cared for with children with developmental concerns. Given the complexities of their children's care, their simple yet profound request was to be seen primarily by a doctor who knew them and their children well. Dr. Sia listened and advocated tirelessly until, in 2007, the AAP, AAFP, ACP, and AOA adopted the Joint Principles of the Patient-Centered Medical Home, setting a standard definition of the medical home.

WCAAP leads the way

The Washington Chapter of the American Academy of Pediatrics leads efforts for Medicaid coverage of Community Health Workers for Relational Health recognizing that supportive, team-based, family-centered care is a way to dismantle systemic barriers and disparities, to build trust, share knowledge of community resources, to address concrete family needs, and to support early relational health, with a goal of flourishing families.

2019

Early Acknowledgements

- Isolation increases risk: lack of social support and community engagement are major risk factors for parental stress and postnatal mortality
- Peer and community supports are helpful, knowledgeable individuals from parents' own communities can better engage parents around reflective strategies and problem-solving
- CHWs for relational health can help improve equity in pediatric health care
- Implementing CHWs in primary care is a workforce solution

2020

WCAAP Learning Collaborative

WCAAP led a Learning Collaborative for instituting Perinatal Mood and Anxiety Disorder Screening at the pediatric medical home in 2 WA counties. Despite being suggested since 2010 by the AAP, few pediatric practices had implemented it. In 2019, the AAP published a Policy Statement, a strong recommendation that PMAD screening be carried out at the 1,2,4,6, and 6-month wellness visits.

2020

First Year Families Steering Committee Created

Comprised of ~30 stakeholders, including two parents. The goals of the FYF Steering Committee:
Uncover culturally competent, community focused care
Screening for social determinants, concrete needs
Developing closed-loop referrals
Assisting practices in acknowledging and addressing systemic racism
2. Explore alternative/expanded staffing models
Incorporation of community health worker/navigator into primary care for prenatal-to-five
The two parents recommended that peer support at the Pediatric Medical Home was vital and necessary

2021

Parent Voice Elevated: Advocacy ensues

Their viewpoints were elevated to advocacy efforts to develop a CHW Pilot program for 50 CHWs in pediatric primary care:

- Momentum built prior to legislative session through many direct WCAAP conversations with legislators.
- The Governor's office is on board with the concept through prior evidence submitted by the Health Care Authority.
- Strong support from Sen. David Frockt, sponsor of SB 5804.
- Sandy Stith, Staff to Senate Ways & Means Committee, and Evan Klein, Staff to Health Care Authority, are both critical to quality outcomes.
- Cooperation and support of the current CHW profession through the Department of Health.

Legislative Priorities were SDOH and Kids' behavioral health

CHWs identified as a priority of the First Year Families & Behavioral Health Integration Subgroup of the Children and Youth Behavioral Health Work Group

2022

50 CHWs Funded

The legislative session funded 50 CHWs for two years starting January 2023 in pediatric primary care

2024

CHW Learning Collaborative

January-December 2023 led by WCAAP, involving many community partners, for training the 50 CHWs and the practices where they would work. Lettieri and Woodruff were part of the faculty for this learning journey.

CHW Billing Codes Established

- A State Plan Amendment was requested by the Washington Health Care Authority for CMS
- SPA approval Fall 2024 from CMS
- WAC created for CHW Medicaid Billing Benefit
- HCA CHW Billing Guide released April 2025
- June 30, 2025: CHW Pilot program ends
- July 1, 2025: Billing Medicaid at primary care by CHWs, four codes

Two unique and dedicated roles for CHWs

- Perinatal to age 5
- School-aged mental health

2023

CHW pilot extended

Legislative session, short session of the biennium, led to an extension of the CHW pilot funding for 6 months, January 1- June 30, 2025

2025

1.) Person-centered planning
2.) Care coordination and health system navigation
3.) Facilitating behavior change
4.) Health education and promotion

Billing Codes

G0019 Community Health Integration Services, SDOH	60 minutes per calendar month	**$47.83**
G0022 add on	Covers an additional 30 minutes per month	**$29.80**
G0023 Principal Illness navigation for high-risk & chronic c	Covers 60 minutes per calendar month	**$47.83**
G0024 add on	Covers an additional 30 minutes per month	**$29.80**
S9446 Health Education & Training	Covers an additional 15 minutes per month	**$5.26**

WAC 182-562-0200 Client eligibility

To receive community health worker (CHW) services, a person must:

(1) Be eligible for one of the Washington apple health programs listed in the table in WAC 182-501-0060, except for the medical care services (MCS) programs; and

(2) Be recommended by a physician or other licensed practitioner of the healing arts, as specified in 42 C.F.R. 440.130, following an initiating visit with one of the following criteria:

(a) An unmet health-related social need (HRSN) that limits the ability to engage in health care services;

(b) A positive adverse childhood experiences (ACEs) screening;

(c) One serious, high-risk condition that places the client at risk of any of the following:

(i) Hospitalization;

(ii) Institutionalization/out-of-home placement;

(iii) Acute exacerbation or decompensation; or

(iv) Functional health decline or death;

(d) Two or more missed medical appointments within the previous six months;

(e) The client, client's spouse, or client's family member expressed a need for support in health system navigation or resource coordination services;

(f) A need for recommended preventive services; or

(g) A condition that requires monitoring or revision of a disease-specific care plan and may require frequent adjustment of the medication or treatment regimen or substantial assistance from a caregiver.

Community Health Integration V.
Principal Illness Navigation Services

Community Health Integration Services (CHI)

Address social determinants of health needs that significantly limit the ability to diagnose or treat problems. This includes:

- Housing
- Transportation
- Food insecurities
- Utility difficulties

Principle Illness Navigation Services (PIN)

Services focused on a serious, high-risk illness by certified or trained auxiliary personnel. Examples of a serious, high-risk condition, illness, or disease include:

- Cancer
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Dementia
- HIV/AIDS
- Severe mental illness
- Substance use disorder

Updates to billing guide

1st visit of the month can be conducted either in-person or via telemedicine, depending on the needs and preferences of the patient

What is billable?

G0019
G0022
G0023
G0024

Can include both direct services to the patient and services performed on the patient’s behalf, such as care planning, documentation, coordination, and communication with providers, or community resources; these are all considered part of the reimbursable service time, even if the patient is not physically present.

Time-Based Codes

Time can be accumulated across multiple encounters, including direct and indirect activities. The services do not need to occur in a single visit.

When submitting claims, the date of service should reflect the first day services were delivered, and the total time must be reported on a single claim line.

CURRENT CONCERNS

-COMMERCIAL INSURANCE

-MINIMUM 60 MINUTES PER CALENDAR MONTH

Identifier			Eligibility Criteria						Contact Details									
MRN	Name	DOB	HRSN?	Positive ACEs?	High-Risk Condition?	2 or more missed appts in 6 months	Expressed a need?	Patient consent?	Session #	Actual Contact Date	Contact Type	Place of Service	# Billable Minutes	Care Manager Notes	Next Follow-up date	Date of next PCP Appointment	Misc. (PCP, Dx, Minutes)
12345	Mickey Mouse	1/1/2020	☑	☐	☐	☐	☑	☑	1	3/28/2025	Direct	In-person c	45			6/1/2025	Woodruff - F43.25
									2	4/3/2025	Indirect	phone	27	CHW spoke with community resource on patient's behalf			

Other funding opportunities?

SCREENING-->

- U1 + U2
- SDOH

ACH

Thank You