Behavioral Health Integration subgroup

Tuesday, September 14
10:00 am – Noon

Agenda Items	Notes
Update: HCA data findings – Behavioral health services	**Teresa Claycamp & Grant Stromsdorfer,** Health Care Authority (HCA) *See page x for slides.* • Originally shared data for primary care; now including what we can get around data for BH agencies. 2019 data. • Primary Care (PC) – Must be licensed w/ DOH (Masters level) – does not include BA or Associates level clinicians. • Behavioral health (B)H data set – Per member per month (PMPM) managed care. • Data is for mental health services only in primary care, (primary care practices (PCPs) Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs). • Provider types (slide 15) – the other category includes peers, associates, etc. • Medication management in BHAs – resource issue - some practices do not have ARNPs with med management privileges. BHAs are challenged with getting these resources – expensive. • Bifurcated system – primary care and BHAs bill through different systems. *Question: is this bifurcated system serving us? Pros and cons to moving toward a single system.* **Discussion/Q&A:** • Potential for duplication if seen in PC and BHAs, or multiple PCs? Unduplicated clients. An individual can be served on both sides. • Psychotherapy treatment in PC: Is that a PCP's visit for ADHD, or is that a visit with a therapist? Why is more in PC for psychotherapy than med management. *See slide 23. Our BHC is doing the psychotherapy. I'm not billing for psychotherapy, just the ADD code.* • Sometimes we have BHAs providing therapy in the PCPs but would still be billed to the BHA even though it is in the PCP setting. • Since BHAs are serving in PCP settings, we don't get a count of how much of that is happening. • HopeSparks is unique because it is a BHA under the PCP frame. • It was nice to see that about 75% of the kids in both settings got 3 visits. • Get rid of FFS for BH in PC; provide a bundled payment. Good point. Part of the challenge – what drives the actuarily sound rate is the utilization (# of encounters). If utilization is driving, how to move to this system without having Medicaid rates take a nosedive. • Many get meds from PCP and therapy from BHA. Service volume figures – occasional med management appts, mostly treatment. **Action items** ➢ Teresa – Look into Alice Lind's data – more info?

Small groups finalize draft recommendations	Priority 1: Reimbursement for non-licensed staff like Community Health Workers Payment for non-licensed staff to support care **Ask:** Fund per member per month for children insured on Apple Health adequate for clinics to provide these critical support services. **Discussion / Q&A** • These are transformative services that are provided by a team of providers, normalized, keep kids in system, don't use up BH resources. • Startup costs is a good number and have done a good job to all out specifics of what a BH/PC should do. • At the point to determine needs, blueprint with $$ amount attached is a good place to start. • Parallel group called Primary Care – had discussion what would be the eligibility of a clinic to get the funding needed? • 1 yr. transformation period, hopefully start July 1 with funding in place. • Hope that what we come up with will be adopted by multiple insurance payers/carriers. • Can convert to PMPM that private carrier and Medicare can use. • Looking for all primary care needs and more funding for services. • If we got funding, would it still be possible for HCA to use admin authority to set meaningful criteria? *Eligibility for funding would be targeted at those clinics deemed by HCA to have a viable plan for implementation of integrated care.* • Services and billing must be different. • Would the funding come through ACH to be deferred/allocated where it is needed? *Makes sense and may be a cleaner path to go through HCA. MCO's have more experience with funding.* • American rescue plan funds – BH challenges have increased due to Covid – noted that recovery/relief act funding is available and may be applicable to this effort. • IBH system in recommendations, group 1 & 3; we come up with PMPM for universal screening, BH, ACES, etc.…. • PMPM for care coordination. Ask for funding HCA to MCO's for service translated into PMPM. • Value based contract that can start 7/1 which would be a value service. Can be applied to a rural practitioner that is seeing multiple kids, which would give them a start. • PMPM for screening and care coordination is needed now. • Discussed a model for long term sustainability through value based bundled payment. This could include, for example, per member/ per month rates for activities such as screening and adding to patient registry. • Need more system wide analysis to determine the gaps/needs.
	Startup funding for first year **Ask:** Provide $3 million to fund eligible clinics to put integrated care programs in place and for training and technical assistance provided by programs which have established pediatric BHI in primary care to advise on start-up activities. Based on experience of several existing programs,

	$200,000 in start-up funds is needed for a clinic to establish an integrated behavioral health program, including necessary training.
	
	• Provide start-up funds to clinics which demonstrate objective and specific readiness to build collaborative care behavioral health integration programs in primary care.
	• Eligibility for funding would be targeted at those clinics deemed by HCA to have a viable plan for implementation of integrated care, that includes, but would not be limited to, the following:
	  o A primary care champion or proponent of the program
	  o Support for implementation at the highest level of clinic leadership
	  o A behavioral health professional located at the clinic
	  o Check with P5RH, Perigee re ABC program – double-check if funding is included
	  o An arrangement for psychiatric consultation and supervision
	  o A registry tracking the symptoms of patients
	  o A team approach to care
	  o Universal screening for behavioral health issues and social determinants of health
	  o Provision of care coordination, including coordination with schools, ED's, hospitals, and other points of care
	  o Family and child engagement
	  o The ability to bill under the collaborative care codes (this is not to preclude billing under other codes in addition, such as those for psychotherapy)
	  o Ensuring "closed-loop" referrals and engagement in specialty behavioral health care when indicated
	Start-up costs covered would include:
	• Training, including in such operational elements of integration as developing workflows to ensure that team-based care is provided, and in evidence-based practices, including brief interventions for children with mild to moderate behavioral health challenges
	• Development of reliable and systematic workflows, including a multi-disciplinary team approach to screening parents post-natal and children and teens ages 11 and older as indicated by Bright Futures standard of care
	• Commitment to monitor screening rates and modify workflows as needed to ensure universal screening
	• On-boarding of behavioral health professional, with salary support while developing a caseload
	• On-boarding of psychiatric support person (M.D. or ARNP), including initial salary support
	• Clinical oversight
	• Development of partnerships with community mental health centers for referral of patients with higher level needs
	• IT infrastructure, including necessary EHR adjustments and creation of a registry
	• Space needs for additional staff
	<u>Recommendation re BHI Training Centers</u>
	The subgroup recognizes that there are organizations with significant expertise based on experience in setting up BHI programs tailored to the unique needs of pediatric populations, that are evidence-based and effective. We believe that there will be

	significant benefits, including cost-savings, from supporting centralized training and technical assistance to clinics in implementing pediatric-specific BHI programs.
	Funding for primary prevention services what are currently non-billable clinical services that are unique to children and families **Ask:** Establish payment methodology and funding to reimburse primary prevention services which do not necessitate a behavioral health diagnosis, but to prevent future diagnosis. **Discussion** • Universal screening for SDOH, ACEs, etc. – cover the cost of care; currently $1 PMPM for all screenings. $2 for universal screening; covered but reimbursement doesn't cover the cost of care. Also, perinatal screen follow-up that doesn't meet the cut line. • Children diagnosed with developmental delays – RUBI program – parent training in developmental measures. (Can only be paid for with a diagnosis.) https://www.rubinetwork.org/about-us • VBP for PC by 2023 – scaffolding for PMPM for screening (how to define services covered by PMPM?) • How much is Legislature's role in defining VBP and how much autonomy does HCA have in defining it? • Navigation services, CHW services – pilot to determine costs. • A lot of these other programs are funded by the state in other places such as ECEAP. • Look for LGBTQ+ programs – not diagnosable condition but high risk. • Use WSIPP EBP list: Updated Inventory of Evidence-Based, Research-Based, and Promising Practices: For Prevention and Intervention Services for Children and Juveniles in the Child Welfare, Juvenile Justice, and Mental Health Systems. **Priorities** • Use data to look at regions to see what is happening what areas doing well vs. areas that are not doing well • Look at bundle payments to make sure services provided are reflective for services rendered **Action items** • AAC – ask – Sarah – prevention services, follow up with Sheryl Morelli • CMS – prevention services
Report Outs	**Group 1** • Identified things that aren't – missed this… • Make sure list isn't redundant; go through things that aren't redundant • What does care coordination look like from an MCO perspective? • Utilization rates of care coordinators reported by MCOs? • MCO's have their own care coordinators and programs; how do we collaborate, use the expertise to inform of system needs. • Look at value-based payment and care coordination and how to incorporate into BP model. • Some of our questions may turn into action items.

<table>
<tr>
<td></td>
<td>

- Teresa: CMS - Medical services are rooted in medical necessity. If it doesn't fit in medical necessity, is there a way to bill for it?

Group 2

- Document captures essential elements.
- Sound out legislators – how should these funds be disbursed – ACHs, MCOs, HCA to providers – or should be silent on this? (Talk about on Friday)
- Can COVID relief funds be used to move these forwards? (American Rescue Plan)
- VBP discussions not at the detailed level.
- If we don't participate, it will be an adult system.
- Example – improving Medicaid rates and improving outcomes – not lowering rates – WISe.

Group 3

- Look at programs and resources to utilize best practice examples.
- Make sure we are connecting/collaborating services between PC & BH; no wrong door.
- Program to teach parents skills/tools to utilize and be more informed
- Screens/developmental screen are underfunded

Action items:

- Sarah: Follow up with Charissa Fotinos and Judy Zerzan re providing services that are not medical necessity.
- Kristin and Sarah: HCA transformation in primary care group, headed by Judy Zerzan – need to coordinate with that group.

</td>
</tr>
<tr>
<td>Group discussion</td>
<td>

Kristin Houser & Sarah Rafton

Discussion

- Are we going to prioritize?
- W&R adopting some of our recs.
- Proposal: roll item 3 into 1.
- Proposal: Startup costs as priority.
- Complexities re care coordination – not sure we have the right people at the table.
- Startup funds are where practices are really having trouble now.
- Non-licensed professional – workforce issues.

</td>
</tr>
</table>

Next meeting: Oct. 5, 2021

Attendees

Rachel Burke, Health Care Authority (HCA)
Dr. Phyllis Cavens, Child & Adolescent Clinic
Teresa Claycamp, HCA
Dr. Thatcher Felt, Yakima Valley Farmworkers Clinic
Libby Hein, Molina Healthcare
Dr. Robert Hilt, Seattle Children's
Kristin Houser, Parent
Whitney Howard, Molina Healthcare
Avin Lao, UW Kent-Des Moines Clinic
Edna Maddalenam, Washington Chapter of the American Academy of Pediatrics (WCAAP)
Mike McIntosh, CCSSW
Dr. Sheryl Morelli, Seattle Children's
Liz Perez, Community Health Plan of Washington
Deborah Pineda, Child & Adolescent Clinic
Wendy Pringle, HopeSparks
Sarah Rafton, WCAAP
Shannon Re, Kitsap Children's Clinic
Caitlin Safford, Amerigroup
Tatiana Sarkhosh, WCAAP
Grant Stromsdorfer, HCA
Amber Ulvenes, WCAAP
Cynthia Wiek, HCA