Workforce & Rates Meeting June 22, 2020

Agenda Items	Summary Meeting Notes

Rates
Network Adequacy
	Lead: Hugh
	
	• Here are current best practices by commercial health carriers that seem to most efficiently and effectively facilitate connection of families to care and services:
	  ○ Broad networks for medical & behavioral healthcare – tend to be quicker at connecting families with behavioral health services.
	  ○ Case management staff that work directly with the mental health referral assistance staff increase speed in which families connect with services.
	  ○ Lower deductibles and co-pays.
	  ○ Lower out-of-network rates.
	  ○ Variation in terms of services that require a process by which the family and parties involved get authorization; some carriers have an efficient and immediate authorization process.
	
	Discussion
	• How we define network adequacy - HCA developing some models for defining network adequacy – this might be a good group to share them with.
	• Lack of specialists – only one private psychologist for all 5 MCOs.
	• Barriers for specialists/clinicians to serve Medicaid clients:
	  ○ Must complete 2 applications, one with ProviderOne and one with MCO.
	  ○ ProviderOne application is difficult to fill out.
	  ▪ Questions raised: Could HCA and DOH be instructed to collaborate to enter all licensed professionals into the system? Could HCA use the OneHealthPort application, which providers have to do for most health insurance network applications? Developing an interface between OneHealthPort and ProviderOne could reduce a lot of barriers.
	  ○ Low reimbursement rates – and differences in what MCOs/BHOs pay, even though the Legislature sets rates.

Value Based Payment (VBP)	**Sarah Rafton, Washington Chapter of the American Academy of Pediatrics (WCAAP)**
	• In recent years, an HCA-convened work group that developed an "ideal" VBP model for pediatric primary care delivered by pediatricians, family physicians, and nurse practitioners.
	• This is a primary care model with behavioral health imbedded.
	• A pilot of the model has been delayed by the pandemic.
	• Ways in which we recommend payment occur:
	  ○ Prospective payments (per member per month) for common primary care services under Bright Future standard of care – vaccines and screenings (vision, hearing, development, autism, etc.), many of which are behavioral focused.
	  ○ Tier-ing the amount of that payment to recognize the level of behavioral health integration a clinic has (i.e., do they have someone on their team that can provide psychotherapy or prescribe medications?). When services are available, those codes are included within the prospective payment structure.

	○ Fund per member per month care coordination, no matter what the level of behavioral health integration is within the team, to ensure children and adolescents can access specialized care based on their needs. ○ Additional quality incentive payments based on performance measures, such as immunization rates and well child appointments. (Performance measures could be enhanced to include more developmental and behavioral measures.) • The work group acknowledged providers' differing levels of behavioral health integration. • The group did not tackle bi-directional integration; the primary target was primary care. **MaryAnne Lindeblad, Medicaid Director, Health Care Authority** • HCA has a contractual requirement with our managed care plans; by the end of 2021, 90% of the payments that go out through MCOs must be VBP. Plans receive incentives for quality measures and move toward VBP. • We are working with a cross section of providers, for both Medicaid and commercial insurance, including pediatricians. • Focus has been on care coordination within primary care, including behavioral health services offered by primary care. • Have not worked as much with BH providers, though COVID has provided more opportunities to do so. • On-going work with plans to develop and create more opportunity for behavioral health providers to have a VBP mechanism. These mechanisms can be more predictable (capitation, bundled payments), particularly for larger providers. **Discussion** • The turn-around time may not be adequate, given the scarcity of models and data. • Ideas: ○ Develop a recommendation for HCA about how to facilitate discussions with BH providers – perhaps a sub-subgroup with more providers involved. ○ Gather (National Council of Behavioral Health Resources) or create some sample models that could be discussed.
Workforce Workforce Updates	**Lead: Laurie Lippold** **Julia O'Connor, Workforce Board** • We are hoping to have straw proposals sometime in the next month – we can share with the different subcommittees. Timeline will be adjusted based on furloughs **Sarah Walker, UW Evidence Based Practice Institute (written report)** • Recently conducted a statewide training on delivering evidence informed clinical care over telehealth and have upcoming webinar regarding evidence based practices and evidence informed practice with cultural humility.

SUD/MH Certification Update	**Alicia Ferris, Community Youth Services**
	• The legislation, as passed, concerning dual credentials for masters level counselors licensed through DOH to get add-on certification for substance use was well-intentioned, but has met a number of barriers to implementation.
	• Problems include:
	  ○ Limitations around supervision and training individuals.
	  ○ Individuals must be trained by someone with full SUD credential, not a masters level counselor with an add-on SUD credential.
	  ○ Language around education reads that DOH needs to approve the specific curriculum; other education is not considered meaningful and additional steps are required.

Review/Feedback of Survey Results	**Laurie Lippold & Rachel Burke** • Survey was sent to everyone on the Workforce and Rates subgroup mailing list (90+ people); we received only 14 responses. • *See attached summary for results.* **Discussion** • Create a value statement that supports the area of priority, along with a counter statement that allows us to get a clear picture of the systemic barriers that are present (i.e., what is the primary challenge behind this objective) . • Pay close attention to regulatory requirements; be mindful of unintended consequences associated with regulatory requirements and complexity. • Approach our objectives with the end goal in sight; ensure we are engaging providers for input. • Identify long vs. short term impact and how we can move forward with incremental steps. • Considering our budget outlook, how can we prioritize our recommendations that do not require asking the Legislature for money? Additionally, how can we as providers better streamline our work, especially around statutory changes, and areas that can be changed by HCA? • Our ultimate goal is to improve, increase, and expand the workforce and we need to figure out what the best mechanisms are for tackling that challenge, keeping in mind that we are as concerned about expansion as we are about competency. • On-going conversations about standards for competency (i.e., internship requirements for masters level graduates) • On-going conversations and legislation around inpatient providers being able to meet the needs of youth who go into beds for behavioral health. Challenges in finding beds: – inpatient providers can refuse any referral – some providers will say a patient's condition is too acute, others will say it is not acute enough. Issues around providers being unprepared to handle patients for behavioral reasons.
Diversity, Equity and Inclusion	• How to increase diversity on this subgroup and more generally in the work group and the field?

Attendees

Endalkachew Abebaw (HCA)
Lucy Berliner (Evidence Based Practice Institute)
Kevin Black (Senate BH Health Subcommittee)
Rachel Burke (HCA)
Rep. Lisa Callan (WA State House of Representatives)
Diana Cockrell (HCA)
Devon Connor-Green (WCAAP)
Jessica Diaz (HCA)
Jamie Elzea (WA-AIMH)
Victoria Evans (Molina Healthcare)
Hugh Ewart (Seattle Children's)
Alicia Ferris (Community Youth Services)
Kimberly Harris (HCA)
Dr. Bob Hilt (Seattle Children's)
Kristen Houser (Parent)
Candace Hunsucker (Community Health Plan of WA)
Marissa Ingalls (Coordinated Care)
Avreayl Jacobson (King County BH and Recovery)
Joe LeRoy (HopeSparks)
MaryAnne Lindeblad (HCA)
Laurie Lippold (Partners for Our Children)
Joan Miller (Washington Council for Behavioral Health)
Julia O'Connor (Workforce Training and Ed Board)
Steve Perry (HCA)
Sarah Rafton (WCAAP)
Samantha Slaughter (WA State Psychological Assoc.)
Sharon Shadwell (DCYF)
Melanie Smith (NAMI)
Mary Stone-Smith (Catholic Community Services)
Suzanne Swadener (HCA)
Ashley Taylor (HCA)
Amber Ulvenes (WCAAP)
Christy Vaughn (HCA)
Alex Wehinger (WA State Medical Association)
Kristin Wiggins (Perigee Fund)
Michele Wilsie (HCA)