Workforce and Rates subgroup meeting
July 13, 2020

Agenda Items	Summary Meeting Notes
Rates Network Adequacy	**Lead: Hugh Ewart** **Mandy Weeks-Green (Office of the Insurance Commissioner [OIC])** • The OIC has a series of filings every month where carriers have to review their network adequacy. There are specific requirements related to therapists, psychologists, and child psychologists. • Carriers that do not meet network adequacy standards during their monthly assessment are required to go through a corrective action plan for how they will improve network adequacy. OIC reviews the plans' sufficiency. Carriers that cannot demonstrate network adequacy must provide other means for clients to access services through other network providers. • Rules related to network adequacy and access: WAC 284-170-200 through 284-170-240. • Note: OIC does not regulate Medicaid plans or self-insured plans. • Network adequacy standards require carriers to provide access to identified types of providers in a given time (10-15 days, depending on type of provider) and within a given distance (miles per hour standards). • Individual providers make reports to the carriers, and carriers then compile the data and submit it to the OIC on a monthly basis. • There are massive filings that are actually all mapped, where providers have indicated clinic locations to carriers. • Network adequacy is evaluated on a regional (county) basis. Networks are required by state law to be county-based; provider availability is overlaid on a map to ensure there is adequate access. • OIC has had a two-year federal grant to evaluate behavioral health services provided by state-regulated health insurers. The preliminary report (Dec. 2019) is available here. • Rule-making to implement HB 1099 related to provider requirements to post information related to whether they are open to accepting new patients is underway. **Q&A** • **Question**: How does OIC evaluate whether the network still has capacity? If there are 100 providers in network, but none are accepting patients, how is that tracked? *Answer: They have to track whether providers are open or closed to new clients; not all providers report this information to carriers and not all carriers are sharing that to providers. We do require analysis regarding close and open networks.* **Christy Vaughn (HCA)** • HCA Medicaid managed care contracts include network adequacy standards; network adequacy for Medicaid also refers to the federal rules (CFR) related to those standards. • Those can be found in Section 6 of the integrated managed care contracts online.

Access & integration issues	**Kristin Houser (Parent Advocate)**
	• Access concerns: Are there different ways to organize the workforce, maximize effectiveness and leverage scarce resources using integration models?
	• The WA Leg mandated integration in 2014, and legislation required completion by the end of 2020. Integration has been implemented more widely in adult centers and clinics than it has in the pediatrics realm.
	• Primary care people work in teams and help populations with mild-moderate conditions, not those with more intensive needs.
	• Can collaborative care billing be added to fee-for-service psychotherapy? These services are all included in primary care and should have an embedded pediatric behavioral health professional working with a primary care provider, with backup psychiatric services available. Then you can take advantage of better rates for collaborative care, compensating for things that were not previously compensated for, in addition to the therapy rates we now bill for.
	• Main barriers include: startup costs of initial hiring of behavioral health professionals, registry needed to track patients, IT support.
	• Should we ask representatives of MCO's how to move forward with funding for startup costs?
	
	Sarah Rafton (Washington Chapter of the American Academy of Pediatrics [WCAAP])
	• Startup cost are a barrier to getting this model going. Having a licensed clinical mental health professional in primary is some of the best care we can provide for mild-moderate needs that children may have:
	    o We can overcome significant stigma barriers.
	    o Help transfer the trust that families might have in their family physician.
	    o It's a known place that families are familiar with – it is something they can start right away.
	    o Helping get a kid engaged quickly decreases burden on the system and creates the trajectory for the client (I.e., referring out to specialty care for on-going need).
	    o It also helps improve the primary care provider's skills and ability to manage things independently.
	    o Do not have to wait to be scheduled for an intake.
	
	• Barriers and challenges with startups for clinics that have worked on integration:
	    o You want to understand your workflow in the clinic and systemically screening entire populations, how the team is involved, and how they are going to share care. This requires planning.
	    o There is a ramp-up period; it takes time to get the billing in place and to start to recoup your cost (billing under codes Is a complicated process).
	    o Children do not all fit in the collaborative care model – some need to remain within a fee- for-service model.
	    o It takes time to pull in the revenue to cover the cost of the MH professional.
	    o You need to work through your registries and Electronic Medical Record (EMR) issues, ensuring your EMR is tracking outcomes (more expensive).
	    o The rates for fee for service Medicaid are so low it does not come close to covering costs (they need to at least double). Medicare rates are double what Medicaid rates are for the same service. Some clinics have supplemented losses with Accountable Communities of Health (ACH) payments and philanthropic investments.

	Joe LeRoy (Hope Sparks)
	• We have behavioral health care managed in two pediatric northwest clinics.
	• This is not a co-location model; these are behavioral health care professionals imbedded within the workflow. We spent about a year mapping this work.
	• During COVID-19, we are finding that we are able to enroll many children into collaborative care and get them seen immediately by the care manager. We are immediately mitigating depression, suicide, etc.
	    o We are billing through Puget Northwest; they are billing through EPIC, and we are on their EHR for the collaborative care codes. We are just now modeling out what sustainability looks like. We have signed a 3-year agreement with Puget Northwest and we have signed with AIMS.
	    o We hire, train, and retain the workforce; the revenue sharing is on the backside.
	    o We already had a willing workforce and clinical training program in place to be able to grow and develop that workforce where the primary care providers did not. Our team has a robust plan for training.
	
	Vicki Evans (Molina)
	Addressing questions for MCOs: What support and help do they need in order to help make this happen, are they addressing the startup costs?
	• ACH's received money from the Medicaid transformation funds that came into the state of WA. (This 1115 Medicaid waiver had a primary goal of addressing bi-directional integration.)
	• Each ACH region had the opportunity, with guidance from HCA, to determine how they would respond to doing this work; there are variations across the state on how they decided to advance (contingent on having providers step forward that would be willing to be involved with this work - with the initial steps in terms of how to come together and synchronize that work).
	• Information regarding these projects can be found here under *Initiative 1: Transformation through ACHs*.
	• Part of what we have seen across the state is that much of the work is focused on the adult population and mental health, less on children and youth, and substance use disorder.
	• We are currently meeting with the MCOs, HCA, and Accountable Communities of Health across the state to develop a common tool that will assess integration, some of the MCOs (such as Molina) have had their own self-assessment tool.
	• We are coming together soon to create a process that can help identify progress and opportunities for improvement, as well as what a definition for integration means.
	• Our target is to make sure we have a tool by the end of this year that shows a clear standard for reporting out on integration.

Workforce
Review top 5 primary areas of focus and support items
	Lead: Laurie Lippold
	
	Top 5 priority items
	• Required ongoing education and training regarding equity, diversity, and inclusion
	    o *Decision: Melanie Smith, lead; Danie Eagleton, support.*
	    o Discussion: Last year, a group of social worker did get together to develop a proposal to come and look at a few things related to continuing education requirements for diversity, equity, and inclusion.

	- Flexible funds for community based organizations providing BH services for training and mentoring clinicians. - P5 committee has stepped away from asking about training dollars due to current budget outlooks. *Decision: Remove this from possible consideration.* - Apprenticeships for those interested in working with children and youth - Melody Mckee (Behavioral Health Institute) to circle back with Laurie and Julia O'Connor on conversations/meetings related to apprenticeships. - Apprenticeship programs that we are looking at aren't just going to be for folks that are going to be practitioners but also front line workers. - Effective mechanisms for integrating behavioral health into primary care - Documentation requirements for BH intake. *Decision: Remove from priority list as DOH has efforts underway.* - Decision: Add to priority list: Internships for online graduate degrees - Individuals with on-line graduate degrees who did not have the opportunity to complete an internship within their degree program are finding challenges as they cannot become MHPs and are struggling to get licensed. They are finding they have to go back to school for another master's degree because their original degree did not have an internship. - Since completion of an internship is required, this is a barrier for the behavioral health workforce. - Questions to think about moving forward: How do we do partner with other organizations to provide internships? Is there a way we can help guide those conversations? - Getting the word out regarding internship requirements is a critical first step. - Sharing information about career ladders with institutions, providers, and DOH to map out requirements for internships. *Decision: Melody McKee and Danie Eagleton to take lead.* - Possible additions to priority or support list: - Supporting on-going work around childcare and early learning, especially considering the impacts of COVID-19 on working parents with school age and younger children. Laurie will add to support list - Background checks: Laurie will follow-up with Julia O'Connor (Workforce Training and Education Board) regarding the prioritization of background checks and its impact on the ability to enroll in BH related programs. - Barriers for psychologists regarding accepting Medicaid. Melanie, Hugh, Samantha, and Laurie will meet. **Next steps** - Guidance: It would be helpful if members can look at the chart and draft value statements, pro and con. - Hugh and Laurie will look at the recommendation templates of other subgroups.
Sunrise review issues	**Representative Lauren Davis** There were 3 sunrise reviews (creation of a BA level peer credential, creation of an advanced peer credential, and whether the peer support specialist program should move from HCA to DOH).

	- Right now if someone is going to work as a behavioral health peer they complete a course (40 hours in person or online) and they receive a certificate indicating they have passed. (Note: this is a certificate, not a credential.) - When they go to work at a behavioral health agency, they have to get credentialed as an agency affiliated counselor in order for their services to be Medicaid-billable; there is no off-the-shelf peer credential from which they can choose. - Issues with the fact there is no peer credential: - It is hard to legislate about things such as continued education requirements as they are not identified in statute. - They can only work at behavioral health agencies, which Is limiting. - They cannot bill commercial insurance for peer services because they are not credentialed; they are not included in Title 18 as a credentialed profession. - The original driver for the sunrise review request was the desire for peers to be seen as equals rather than 'less than". - The number one complaint in the peer workforce is the lack of a career ladder. - If peers have their own credential, fees must be collected so it is self-supporting. - Creating a peer credential and an advanced peer enhancement might be the best corrective step moving forward. ***Decision: Support** Rep. Davis' legislation around peer credentials.* - Work is ongoing; Rep. Davis is open to folks being a part of this conversation moving forward. **Discussion on other issue (had come up previously)** - Note; if you're in private practice, you need to be licensed; if your agency is licensed as a community behavioral health agency, your staff do not have to be licensed (agency affiliated). That has worked very well.

Attendees

Endalkachew Abebaw (Health Care Authority [HCA], staff)
Kevin Black (Senate Behavioral Health Subcommittee)
Representative Lisa Callan (5th Legislative District)
Donna Christensen
Devon Connor-Green
Andrea Davis (Coordinated Care)
Representative Lauren Davis (32nd Legislative District)
Danie Eagleton (Seattle Counseling Service)
Jamie Elzea (Washington Association for Infant Mental Health)
Victoria Evans (Molina Healthcare)
Hugh Ewart (Seattle Children's)
Anusha Fernando (Molina Healthcare)
Nova Gattman (Washington State Workforce Board)
Dr. Bob Hilt (Seattle Children's Hospital)
Kristen Houser (Parent)
Candace Hunsucker (Community Health Plan of WA)
Avreayl Jacobson (King County Behavioral Health and Recovery)

Lynette Jordan (Molina Healthcare)
Dr. Terry Lee (UW)
Joe LeRoy (HopeSparks)
Laurie Lippold (Partners for Our Children)
Melody McKee (Behavioral Health Institute)
Joan Miller (Washington Council for Behavioral Health)
Jessica Mikesell (HCA,)
Julia O'Connor (Workforce Training and Education Board)
Steve Perry (HCA)
Sarah Rafton (Washington Chapter of the American Academy of Pediatrics)
Melanie Smith (NAMI)
Mary Stone-Smith (Catholic Community Services)
Ashley Taylor (HCA, staff)
Christy Vaughn (HCA, staff)
Mandy Weeks-Green (Office of the Insurance Commissioner)
Alex Wehinger (Washington State Medical Association)
Kristin Wiggins (Consultant, Perigee Fund)
Michele Wilsie (HCA)

Top Issues Summary – for further prioritization
Updated: 7-18-2020

Issue	Bill/ Budget/ Practice	Does it address racial inequities?	Would it increase the workforce?	Is impact immediate or long-term?	Value statement (pro) and counter statement (con), including potential unintended consequences	Lead	Next Steps
Top issues we should 'lead'							
Required ongoing education and training regarding equity, diversity, and inclusion	Bill Budget? Practice				Value statement: Counter statement:		Melanie and Danie
Apprenticeships for those interested in working with children and youth	Unsure				Value statement: Counter statement:	Melody, Laurie, Julia	Melody will follow up with Laurie and Julia regarding next steps.
Effective mechanisms for integrating behavioral health into primary care	Unsure				Value statement: Counter statement:	Sarah and Kristen	This is more of a rates issue, however, we may also want to take it to the full Workgroup to consider as a whole.
Internships for on-line degree programs					Value statement: Counter statement:	Mary and Danie	
Issues from psychologists					Value statement: Counter statement:	Samantha and Melanie	Samantha, Melanie, Laurie and Hugh will meet to discuss

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Top issues we should support							
Bachelor's level mental health/SUD credentials	Bill				Value statement: Counter statement:		
Supervision requirements	Bill? WAC?				Value statement: Counter statement:		
Incentives for supervising interns and those seeking their license or certification	Budget Bill? Practice?				Value statement: Counter statement:		
Telehealth	?				Value statement: Counter statement:		
Impact of background checks on the ability to enroll in BH related programs, receive a license/certificate, and/or obtain employment in the field	Bill				Value statement: Counter statement:	Julia, Laurie	Laurie will pursue as a possible support or lead items
Peer credential					Value statement: Counter statement:	Rep. Davis	
Impact of child care shortages on BH workforce					Value statement: Counter statement:		

NOTE: Please review the original survey results to ensure that we are not missing a critical item that should be added to our priority or support lists. Additionally, a template document will likely be sent out soon. Issue leads: Please review and begin addressing the questions that will need to be answered!
Thanks to everyone!!