

Workforce & Rates Meeting

August 3, 2020

Action items

Action Items/Decisions					
#	Action Item	Assigned To:	Date Assigned:	Date Due:	Status
1	HCA DBHR and Policy staff connect.	Rachel, Suzanne Swadener, Steve Perry	8/3		Done 😊
2	Schedule next Network Adequacy sub-subgroup before next Workforce and Rates meeting	Hugh, HCA staff	8/3		
3	Look at whether legislative requirement for MCOs to identify availability of providers accepting Medicaid clients has expired.	Network adequacy sub-subgroup	8/3		
4	Extend invite to Sarah Walker to join the network adequacy group to discuss potential digital resources to support network adequacy and evidence reviews the EBPI could do.	Hugh	8/3		
5	Establish a sub-subgroup with Mary Stone-Smith, Alicia Ferris, Christy Vaughn, and Laurie to discuss mechanisms for increasing provider rates.	Hugh, HCA staff	8/3		Done 😊
6	For next meeting's agenda: equired ongoing education and training regarding Equity, Diversity and Inclusion (EDI) (Melanie and Danie).	Laurie	8/3		
7	Develop and distribute Workforce recs survey #2	Laurie and HCA staff	83		Done 😊

Notes

Agenda Items	Summary Meeting Notes
WA Council for Behavioral Health member survey	<p>Joan Miller</p> <ul style="list-style-type: none"> The WA Behavioral Health Council is the statewide professional association of licensed community behavioral health agencies with members from all across the state in every county and legislative district. Started surveying members when COVID-19 hit. Handouts (see page x) have data from March and April. Getting ready to send out survey again to capture last quarter data. Providers experienced rapid revenue loss at beginning of pandemic. Telehealth and the behavioral health system have started to stabilize revenue.

- With flexible reimbursement mechanisms at the state and federal level, as well as telehealth services, our clients were able to continue access to some care.
- What we're learning now:
 - Telehealth is not sufficient to serve the complex and vulnerable population served in community behavioral health (people are not picking up their phones anymore).
 - In the beginning, we thought telehealth is going to increase access and remove transportation barriers. 5 months in, we are starting to get concerned with people not engaging; no show rates may start increasing.
 - While there could be savings in the clinical world, most services in community behavioral health do not translate well to telehealth – so much of what our agencies do is in the community.
 - Much of the savings for telehealth are dependent on the payment methodologies and contracts with an MCO; it varies from agency to agency.
 - Feedback that Evidence Based Practices (EBPs) for children and youth do not work well over video and, especially, over phone.
 - A lot of telehealth is not with a video screen, it is telephonic over the phone services.
- Some agencies have begun to resume in person services. Services such as wraparound, tag teams, and outreach have to be done in the community.
- Lack of statewide guidance on when telehealth is appropriate, when we should be doing in-person services, and what the plan is for safety. Some agencies have competent chief medical officers making plans for their agencies; others don't.
- Concerned that next set of data is going to show a decline in utilization and revenue.
- One-time federal relief funds were somewhat helpful in the beginning; relief funds at the federal level were targeted primarily for hospitals, aging and long-term care facilities, and Medicare providers.
- The National Council for Behavioral Health continues to push for \$38.5 billion for Medicaid providers, who even before the pandemic operated on slim margins (80-95% of revenue from Medicaid).
- BHA making tough decisions; with limited staff, determining which needs are critical.
- Staff layoffs and furloughs depicted on the handout have largely been due to operating residential programs at reduced capacity to adhere to social distancing, isolation care if patients or staff test positive, and decreased referral rates.
- We really need a suitable fiscal model that acknowledges BHA as essential health care providers and first responders in our communities.
- Staff morale is low (health and safety concerns, economic worries, stress due to racial injustice, childcare); they are coping while caring for the most vulnerable, difficult to treat members of our communities.
- Concerns around school closures:
 - Potential loss of female workforce because they will need to stay home and care for their children.

- Loss of school based treatment programs in the schools; thousands of children have been disconnected from services; embedding BH services into schools is a core value for many providers.
- Children and youth are one of the populations we are seeing with a decrease in utilization.

Discussion

- School is a protective factor for children and youth. Many referrals come from schools.
- Staff were not expecting to pay for childcare by the time children hit school age.
- WCAAP has been advocating for children to return to school, even in small numbers, because we are gravely concerned about their wellbeing. Talking with the Seattle School Board on outdoor school as safest option.
- Kids' emotional needs are going to be higher. In terms of the MTSS model, saying nobody is at a Tier 1 (general prevention), everybody is at a Tier 2 or Tier 3 which is a higher intensity of need.
- Community behavioral health providers have a lot of knowledge on trauma informed care to provide to teachers; families would welcome help, too (video?) Schools are the first place where we can tap into these problems.
- Is there a potential for OSPI to partner with the Behavioral Health Council?
- Interest in looking at the role of para-professionals doing outreach to address social isolation, do first level assessment, direct people to resources.
- Also, role of peer support counselors in the community. What workforce needs do we have; what are alternatives?
- What structure can we use to fund it?
- Teachers and school counselors are concerned about the emotional and social wellbeing of their kids, and their ability to handle those needs in addition to teaching.
- The public behavioral health system for the most part is Medicaid funded; also kids who are Medicaid eligible may not meet diagnostic criteria and do not want to be formally entered in as an eligible client – which is what is needed for the BHA to receive funding.
- There are restrictions on BHAs regarding prevention work given the low level of referrals and direct interactions people are having with people outside their family.
- Medicaid providers need to be able to bill prior to enrollment, need to be able to connect directly with those family members, especially to provide group therapy and support for families during this time.
- That is where it gets tricky with Medicaid federal funding – The funding requirements are where we struggle in trying to make shifts and reaching out to youth and connecting with youth that are in need of services as behavioral health providers.
- Funds for outreach and engagement were more accessible for us under the BHO system (state non Medicaid dollars); this is impacting our ability to get referrals in the door.
- **These issues also need to be discussed in the school-based subgroup.** We will get better traction if we bring this over to the education community and have conversations where HCA, OSPI and educators are present. If you would like to be a part of that conversation, please contact:
 - Lisa.Callen@leg.wa.gov
 - My-Linh.Thai@leg.wa.gov

	<ul style="list-style-type: none"> ○ cybhwg@hca.wa.gov
<p>Network Adequacy</p>	<p>Lead: Hugh Ewart</p> <ul style="list-style-type: none"> ● An ad hoc sub-subgroup met and will need to meet again as this topic is complex and multi-faceted. It may take some more time to see what a policy change would look like. ● Discussion by HCA about the changes to MCOs’ requirements related to showing child and adolescent behavioral health network adequacy. <ul style="list-style-type: none"> ○ Change the designation of BH provider to become a critical provider type. ○ MCOs will need to show in real time, rather than retrospectively, which BH providers in their network are accepting new patients. ○ Group awaiting input from OIC on details around its process of developing network adequacy requirements for OIC – regulated carriers and how to measure network adequacy <p>Discussion</p> <ul style="list-style-type: none"> ● What would we need to understand those measures? <p>Dr. Bob Hilt (Referral Assist Line)</p> <ul style="list-style-type: none"> ● There are a lot of providers in the community that, if we approach them and make a request, can take a patient or two that fits a particular criteria. ● They do not want to advertise as generically available to new patients as they will get more calls than they can handle. If you are the only person in the county you are going to be flooded with requests. ● There are huge challenges in having a public facing directory, that is updated and expecting the therapist to update whether they’re “available” or “unavailable” when there is so much demand. ● There are also a lot of therapists who would say on a check list, yes I treat children and youth but actually don’t see anybody under the age of 13. ● There are certain categories of patients – such as young children or someone with a developmental disability – that not everyone treats.
<p>Behavioral Health Rate Development Methodology – Stakeholders’ Meeting with HCA and Actuaries</p>	<ul style="list-style-type: none"> ● First meeting was more general, Rates determined retrospectively based on 2018-2019, looking at trends in rates and specifics in how many of the services are Medicaid eligible. ● Talked about rate issues and had a data summary for each combination or regions. Talked about rate cells and data modalities. ● Discussion of what gets taken into consideration (waiver authorities for IMD, new facilities, facility closures, COVID-19, etc.). ● The intent is to improve access to care and improve quality of care. There needs to be more funding, and the MCOs are limited on how much funding can be given to providers. ● Christy Vaughn, HCA - Clarification: What we are doing is setting managed care premium rates, not provider reimbursement rates. The rate development process is dictated by the federal government – Centers for Medicare & Medicaid Services (CMS). <ul style="list-style-type: none"> ○ Need to figure out the appropriate route to solve issues around provider rates through our managed care setting. ○ The rate the MCO’s reimburse providers for is not something that HCA can decide. The managed care rate setting process is not a vehicle to manage provider reimbursement rate

Children and Youth Behavioral Health Work Group – Workforce & Rates

<p>CYBHWG recommendations update</p>	<p>Laurie Lippold & Rachel Burke</p> <ul style="list-style-type: none"> • The subgroup leads are developing a standard template each group will use for recommendations to the larger group, including standard questions such as: <ul style="list-style-type: none"> ○ Does it address racial inequities ○ Would It increase the workforce – is the impact immediate or long term ? ○ What are the pros and cons of the issue?
<p>Workforce Updates</p>	<p>Julia O'Connor, Workforce Board</p> <ul style="list-style-type: none"> • We are hoping to have straw proposals sometime in the next month which we can share with the different subcommittees. Timeline will be adjusted based on furloughs. • Current plan is project team is compiling proposals for stakeholder feedback at the end of August. <p>Sarah Walker, UW Evidence Based Practice Institute (EBPI)</p> <ul style="list-style-type: none"> • 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. <p>Melody McKee, Behavioral Health Institute</p> <ul style="list-style-type: none"> • We just finished our 18th training session. All recordings are on website. <ul style="list-style-type: none"> ○ Getting training series put together for disaster awareness for COD providers. • Hosting virtual conference connected to behavioral health, race, equity and justice on September 21 and 22nd. <p>Philanthropy & universities, focused on:</p> <ul style="list-style-type: none"> • Affordable professional education, conditional grants to students in clinical education programs • Funded sites, for supervised clinical practice • Management of the behavioral health workforce development pipeline • Bachelors level workforce expansion
<p>Review of workforce priorities</p>	<p>Review of priorities for recommendations:</p> <ul style="list-style-type: none"> • Equity, inclusion and diversity (EDI) Keep • Apprenticeships Keep • Integrated behavioral health Move to Rates • Internships for online degree programs Keep <ul style="list-style-type: none"> ○ We are seeing those who did not have an internship are people that have a Master’s degree in ABA – that want to shift to BH. They have a lot of skills we value for children and youth on the spectrum. ○ Previously, they could become an MHP under the supervision of an MHP and could complete their own intake and treatment plans. Things changed with integrated managed care. ○ Currently, even someone with a Master’s degree and 20 years of experience cannot qualify for the MHP Licensure unless they have an internship. • Psychologists’ issues (such as not being able to bill for more than a 2 hr assessment) On hold
<p>Apprenticeships</p>	<p>Laura Hopkins, Executive Director SEIU Healthcare 1199 North West Multi Employer Training and Education Fund “The Healthcare Training Fund”</p>

	<ul style="list-style-type: none"> • We work with the 9 largest healthcare systems in WA State. These systems contribute to a single pot of money for SEIU 1199NW Union staff trainings. • We have been tasked to partner with UW Behavioral Health Institute, to start apprenticeship programs for behavioral health – our intent is to create something that is applicable statewide. • There are multiple path ways in and different wage rates. Can we develop something that is more standardized that employers can be drawn to, develop a clear career ladder? • In that process, we have to identify which occupations are apprenticeable and which ones are not. • A registered apprenticeship is regulated by the state and the federal government. • Labor and Industries (L&I) is the administrator and provides oversight. • 90% is on the job structured training – with specific competencies – there is a process for documenting progress. The other 10% is going to school at night or the weekend is attending a school – they learn the theory behind the job – supplemental education. • The apprenticeship will be paid. There is free education. Apprentices start at a standard rate and the wage rates increase progressively. • The wage rate gets set when you apply to become a registered apprenticeship program. • Support is appreciated for the 2021 session. SEIU 1199 and BHI will also be taking lead. Let’s coordinate efforts. • We want to organize a group people right now who will help us develop those pathways; we hope to get funding from the state to help drive this work. UW will be incorporating this work.If you are interested in joining the apprenticeship planning committee, please email: lhopkins@healthcareerfund.org <p>Discussion</p> <ul style="list-style-type: none"> • We had a meeting with the WA hospital association to discuss this project as well. • We are getting close to a place to start putting the group together and develop competencies for the apprenticeship. • The Council would be happy to think through behavioral health competencies and other aspects of an apprenticeship program.
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Attendees

Endalkachew Abebaw (HCA)
 Kevin Black (Senate Committee Services)
 Rachel Burke (Health Care Authority [HCA])
 Rep. Lisa Callan (Washington State House of Representatives)
 Devon Connor-Green
 Hugh Ewart (Seattle Children’s Hospital)
 Anusha Fernando (Molina Healthcare)
 Alicia Ferris (Community Youth Services)
 Nova Gattman (Washington State Workforce Board)
 Kimberly Harris (HCA)
 Dr. Bob. Hilt (Seattle Children’s Hospital)

Laura Hopkins (SEIU healthcare 1199NW Multi-Employer Training Fund)
 Kristen Houser (Parent advocate)
 Avreayl Jacobson (King County Behavioral Health and Recovery)
 Samir Junejo (Senate Democratic Caucus)
 Maurice Lee (NAVOS)
 Terry Lee (Community Health Plan of Washington)
 Joe LeRoy (Hope Sparks)
 Laurie Lippold (Partners for Our Children)
 Melody McKee (UW)
 Joan Miller (Washington Council for Behavioral Health)

Julia O'Connor (Workforce Training and Education Board)

Steve Perry (HCA-DBHR)

Sarah Rafton (UW)

Sharon Shadwell (DCYF)

Mary Stone-Smith (Catholic Community Services)

Suzanne Swadener (HCA-Policy)

Ashley Taylor (HCA-DBHR)

Christy Vaughn (HCA-Finance)

Keri Waterland (HCA)

Michele Wilsie (HCA-Finance)