Workforce/Rates subgroup meeting June 3rd, 2020

Agenda Items	Lead	Summary Meeting Notes
Workforce WCAAP Access Survey	Sarah Rafton	Background: • Conducted in 2019-2020 – pre and post pandemic. • 12 pediatricians' experience, mostly WCAAP board members who are responsible for understanding child health gaps in their community. • King, Snohomish, Skagit, Pierce, Olympia, Tri Cities, Grandview. • Mostly primary care; one urologist, one pediatric specialist. • Responding providers directly learned of the families' access to care by being attentive and following-up with families or having a social worker follow up. Findings: • Children & families on Medicaid experience challenges associated with access to behavioral health services in each region, with an approximate wait time of 2-3 months for care (varies by location). • Staff turnover, interns, and brand-new clinicians often result in families not continuing to engage in care. Families must be persistent and advocate for themselves to get timely services. • The shift to telehealth has helped families who had transportation and financial barriers. • Findings are consistent with an extensive 4-county evaluation in 2017.
Community Referral Assist Service	Dr. Bob Hilt/ Stephanie Tuffay	Learnings about access and network adequacy from referral service requests (based on incoming calls; not a survey: • Access to specialized services (e.g., exposure response therapy, dialectical behavior therapy, selective mutism, eating disorder treatment, autism) is hard to get within all insurance networks in all regions. King County is a little better. • Also difficult to find a primary care physician or nurse practitioner to assist with medication management within some networks (when psychiatrists aren't available). • Difficult to find providers who see younger kids (12 years old or under) • Also difficult to do parent management trainings. • Providers are uncomfortable seeing younger kids over telehealth – which has been a difficult challenge. • In many organizations, therapy needs to be established for 2-3 months before a client can see a psychiatrist; families often disengage. • Families are having to make long commutes to access service. • Hard to filter choices on some insurer websites, esp. infant and early childhood services. • Families have expressed that providers that do not have a private practice are often included on insurers' lists. • Families experiencing the most problems (limited availability of providers, long wait times) have private insurance. • Families with Medicaid MCOs are doing better, though there are geographical differences.

		• For private insurers, the CRA service makes 5-20 phone calls in order to find an available and appropriate provider. Discussion: • Discuss as a small group which insurers are hitting or nearing the mark (from a consumer's perspective) abd what we can learn from them. • What practices are they using? What can a plan do to streamline access? How do plans create actions and principles around access? • How do we measure so we can require it? How do we develop policies to promote best practices? Need to create a level playing field, set and ensure standards for parity. • Not all about insurers and MCOs; there is a fundamental provider shortage in WA – and providers are not required to contrct with a plan. If we don't have sufficient workforce, it doesn't matter how many contracts the MCOs have in place – people won't get timely care. • Question: How do OIC requirements for network adequacy compare with Medicaid standards?
WA Behavioral Health Council	Ann Christian/ Joan Miller	Network adequacy: • Payment rates affect network adequacy. If we are not paid enough to recruit and keep qualified staff, the issues of high turnover, too much care by interns, and not enough specialty care are likely to persist. • Licensed behavioral health agencies are not struggling to participate in managed care networks; challenges stem from terms of contracts, payment models and methods, and payment levels. In this transition period we have moved backwards from progressive payment models (i.e., case rates, tiered case rates, sub-capitation, risk corridors) back to fee for service. • Provider bind: Providers are ready to do more but their payments are lidded by the plans. Providers need to expand capacity to justify a higher rate moving forward but can't do so without funding to pay more staff. Impact of COVID -19: • community behavioral health agencies are struggling for survival – volume of encounters has dropped substantially. • Not all services are individual counseling that can easily be transferred to telehealth; there are also differences in provider readiness/comfortableness with telehealth, as well as situations/populations where telehealth is not appropriate. • Need to protect the existing infrastructure of the community behavioral health system and services/programs that operate as a team based program. • Telehealth may not be an appropriate medium for younger ages (i.e., harder for teens to gain privacy, speaking with children on the phone)
Workforce Board	Julia O'Connor	Background checks: • Looking into the DSHS secretaries' disqualifying list of crimes and negative actions and trying to gain more information on how it compares with and interplays with DOH's licensing review process: Background check doesn't prohibit an applicant from getting a license from DOH but the same applicant cannot be employed at an agency that's credentialed and licensed by DSHS.

		• Gathering more information around Certificate of Restoration Opportunity (CROP). Reciprocity: • Short term emergency rules and WAC changes have been beneficial to reciprocity (i.e., faster application processing). We are looking into potentially making recommendation to extend these short term or emergency changes as a longer term or permanent solution.

Behavioral Health Institute	Melody McKee	BHI's apprenticeship vision:
		• In partnership with the Multi-EmployerTraining Fund.
		• High level plan of action:
		  ○ Secure funding for development and implementation of the system (budget proviso and contract with HCA)
		  ○ Buy-in from key stakeholders
		  ○ Develop occupational pathways and apprenticeship competencies
		  ○ Register apprenticeships through Labor and Industries
		  ○ Program development
		  ○ Community college related supplemental instruction and credit approval
		  ○ Agreements between educational institutions to allow for transfer credits
		  ○ University or community college approval
		  ○ Employer outreach and recruitment
		  ○ Participant outreach and recruitment
		  ○ Implementation
		• The apprenticeships focus is for behavioral health across the spectrum to Increase the competency of front line behavioral health professionals; it does not include specialized training, such as IECMH.

Evidence Based Practice Institute	Sarah Walker	• Continuing conversation with MCOs about potential collaboration around training for child and adolescent behavioral health. • Ideal plan includes collaborating with MCOs to pay for the training with MCO funding $ matched by philanthropy and state dollars. • Focused on training on effective clinical components – modular approaches, clinical competent, flexible, and overall trainings that can be adapted to real world agencies.
UW/Philanthropy	Laurie	• Continuing conversations: What are students getting educated around in both bachelors and master's degrees (i.e., competency based training, supervision, incentivizing interns, and folks working towards license). • Also, conditional grants (as a means of addressing the impact of student debt on workforce retention).
Sunrise Reviews	Sheri	• Evaluate the need for a bachelor level credential that can treat SUD and MH, allows for reimbursement in appropriate settings and can work in conjunction with master's level clinicians. • Assessed the current bachelor level behavioral health credential (limited scope of practice) based on: needs perceived by the industry, availability of voucher programs that can provide such a degree, and what other states are doing. • In a recent survey, 52% of stakeholders stated that such a position is needed or essential as it would help treatment backlogs, and long wait times.

		• 30% responded that it was not needed. Reasons included: BA is not sufficient to diagnose conditions, and experienced clinicians are pulled into supervision instead of direct service. • Alternate strategies: explore existing scope of practice, scholarships, and other approaches to help masters level clinicians. • IUW Bothell is currently working to create a bachelor level credential. • Associate level SUDP credentials are offered at community colleges which can later progress to a bachelor's level program. • Currently, a BA in social work is the most prominent bachelor's level credential for folks in the field. • Conclusion: There may be a need for this type of credential to integrate SUD and mental health training. Additionally, it should be eligible for Medicaid reimbursement as long as it is licensed under Title 18.
Rates Update: HCA rates work	Christy Vaughn	• Mental health IMD waiver has been submitted; CMS process is slowed by COVID-19 impacts. • Working on costs associated with 2E2SSB 5720 (changes to Involuntary Treatment Act), a portion of which would be in rates; as well as an increase in rates associated with ESHB 2642 (removing health coverage barriers to accessing SUD treatment). These are the only items in the supplemental that have a direct impact on HCA's rates. • As requested by the Governor, HCA has compiled a cut list and submitted it to OFM. The final list is determined by OFM and the Legislature. Once reviewed and potentially revised by OFM, these lists are posted on the OFM website. • The process used for identifying areas that may be considered for cuts are optional or new programs, and those that are not required by Medicaid. It is not programs that HCA wants to cut. The list is not prioritized, as decisions are made by OFM and the Legislature. • EHB 2584 requires HCA to assure that appropriate adjustments are made to provider rates when managed care rates are increased, and to implement transparency and accountability mechanisms. This will involve providing additional deliverables out of our rate development process with our actuaries. • Stakeholders meetings will occur in July and October (results). Email cybhwg@hca.wa.gov to receive information.

Attendees

Chewy Abebaw (HCA-DBHR), Lucy Berliner (UW), Kevin Black (Senate BH Subcomittee), Rachel Burke (HCA-DBHR), James Chaney (DOH), Ann Christian (WA Council), Sarah Clifthorne (Senate Democratic Caucus), Diana Cockrell (HCA-DBHR), Rep. Lauren Davis, Jessica Diaz (HCA-Medicaid), Hugh Ewart (Seattle Children's), Anusha Fernando (Molina Healthcare), Alicia Ferris (Community Youth Services), Mollie Forrester (UW-Dept of Psychiatry and Behavioral Sciences), Nova Gattman (Workforce and Training Board), Kimberly Harris (HCA-DBHR), Libby Hein (Molina Healthcare), Dr. Bob Hilt (Seattle Children's), Marissa Ingalls (Coordinated Care), Rep. Mari Leavitt, Laurie Lippold (Partners for Our Children), Melody McKee (UW, Behavioral Health Institute), Joan Miller (WA Council), Julia O'Connor (Workforce and Training Board), Steve Perry (HCA-DBHR), Sarah Rafton (WCAAP), Sharon Shadwell (DCYF), Samantha Slaughter (WA State Psychological Assn), Melanie Smith (NAMI), Mary Stone Smith (Catholic Community Services), Suzanne Swadener (HCA-Policy), Sherry Thomas (DOH), Stephanie Tuffey (Seattle Children's), Amber Ulvenes (Lobbyist, WCAAP), Christy Vaughn (HCA-Financial Services), Sarah Walker (UW), Alex Wheninger (WSMA), Kristin Wiggins (Consultant), Michele Wilsie (HCA-Financial Services).