Washington State Health Care Authority

Report to the Legislature

Teaching clinic enhancement rate

Engrossed Substitute Senate Bill 5092; Section 215(74); Chapter 334; Laws of 2021

February 1, 2023

Teaching clinic enhancement rate

Acknowledgements

The Washington State Health Care Authority (HCA) acknowledges the proviso 74 workgroup for their important contributions to this report. Their business acumen, passion for being in service, and willingness to share unfiltered feedback was invaluable to this work and this report.

Washington State Health Care Authority

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Executive summary

Engrossed Substitute Senate Bill 5092 (2021); Section 215(47) appropriated funds for the Washington State Health Care Authority (HCA) to convene a workgroup to develop a recommended teaching clinic enhancement rate for behavioral health agencies training and supervising students and those seeking their certification or license. This work should include developing standards for classifying a behavioral health agency as a teaching clinic, a cost methodology to determine a teaching clinic enhancement rate, and a timeline for implementation. The workgroup must include representatives from:

- The Department of Health
- The office of the Governor
- The Washington Workforce Training and Education Board
- The Washington Council for Behavioral Health
- Licensed and certified behavioral health agencies
- And higher education institutions

To complete this work, HCA convened the workgroup of the representatives required above and executed a contract with Mercer Government Human Services (Mercer) to develop a teaching clinic enhancement rate, identify provider reimbursement strategies, and provide fiscal impact analyses in support of this proviso.

Community behavioral health agencies invest significant time and resources into training, supervising and developing new clinicians only to lose them to higher-paying industry competitors once they complete agency sponsored supervision and become independently licensed. While these investments benefit the broader industry, community behavioral health agencies assume a disproportionate share of the costs, which may not be fully accounted for in the Medicaid rate setting process. This training function is vital for growing the workforce, but may not be sustainable at the current level of Medicaid reimbursement. Providers and their associations represented on the proviso 74 workgroup further believe that a Medicaid rate that more accurately reimburses for the costs of training could help reduce worker turnover and burnout, incentivize hiring, and increase access to services.

The proviso formalized the structures around the teaching clinic model, directs the assessment of costs associated with the model, and directs the development of Medicaid funding strategies to sustain the model.

Note: Mercer's analyses do not reflect an actuarial analysis of an equitable fee reimbursement level. Stakeholders cautioned that Medicaid rates have not kept pace with the cost of inflation and an enhancement rate based on current rates may not achieve the goals of proviso 74. Mercer's analyses and this report also do not address the potential need for non-Medicaid resources to support the cost of the teaching clinic role.

Background

The behavioral health workforce crisis is a complex issue. There is not a single problem facing the industry, nor is there single solution that will fix it. Addressing the challenges will require investments, policy and regulatory changes, and collaboration at all levels. For this reason, the proposed enhancement rate in the Mercer report (Appendix A) will not by itself resolve workforce shortages.

National employment trends are provided in this report to illustrate that workforce shortages are not limited to behavioral health or the broader healthcare industry alone. This information serves as a reminder that although additional funding may help slow worker turnover and incentivize workforce development, additional strategies will be needed to stabalize the workforce. Additional strategies may require statutory and regulatory changes, changes to licensing requirements, diversified funding strategies, including non-Medicaid resources, better alignment across payers, improved workflows and business practices, additional investments in evidence-based practices, alternatives to the traditional education pipeline, more effective DEI recruitment strategies, and retention strategies that focus on worker wellbeing.

Workgroup engagement

Advance coordination

In July of 2021, HCA met with the Washington Council for Behavioral Health and the Workforce Training and Education Coordinating board (WTB) to begin scoping the work for proviso 74 and identifying workgroup representatives. HCA convened the first workgroup meeting in August 2021. Between September and December 2021, HCA and the workgroup drafted teaching clinic and training standards based on the work group's understanding of current clinic practices. To inform these draft standards, HCA developed a provider survey with support from Mercer and feedback from the workgroup. The survey solicited information about the service codes student interns and pre-licensed trainees were billing, cost and revenue differentials for interns and trainees compared to other employees, and supervision and other expenses related to training and supervision.

Teaching clinic vision statement

The workgroup representatives, led by the Washington Council for Behavioral Health, believed it was important to adopt a vision statement to guide the work under this proviso. They agreed on this statement:

> Community behavioral health agencies are recognized as Behavioral Health Teaching Clinics. These teaching clinics are highly desirable settings for students seeking professional education in behavioral health disciplines, for new graduates working toward licensure, and for seasoned professionals providing supervision and support to the next generation of clinicians. Statewide standards ensure excellence in supervision and promotion of best practices in clinical care for people with mental illness and/or addiction disorders. Behavioral health agencies are appropriately compensated for this role, thus contributing to system stability and accessibility.

Provider surveys

HCA developed a provider survey wth support from Mercer and feedback from the workgroup. The purpose of the survey was to obtain current information about the service codes that student interns and pre-licensed trainees are billing, cost differentials for interns and trainees compared to other practitioners, supervision and other expenses, and the impacts on productivity related to a teaching clinic model. After several iterations, HCA distributed the survey to 33 behavioral health agencies and encouraged the two provider associations on the workgroup to distribute it to their members, and encourage their participation. The Seattle Counseling Services also forwarded the survey to the King County provider network to encourage participation. HCA further encouraged association executives and other workgroup members to support their members and colleagues by providing technical assistance or referring them to HCA one-on-one technical assistance meetings.

Completing the survey was a challenge. The provider agencies that participated in the survey receive Medicaid reimbursement through a variety of payment arrangements. Extracting cost and revenue data, by staff type, from these various payment arrangements was complex and required a high degree of technical experties and a significant time commitment. To support providers through this process, HCA hosted three survey walkthrough meetings, four technical assistance meetings, and met with providers one-on-one to support their participation. Seven providers turned in completed surveys. Although the

survey sample was small, the quality of completed surveys provided the information HCA and Mercer needed to develop enhancement rate assumptions.

Note 1: upon their request, Federally Qualified Health Centers were invited to join the workgroup and participate in the surveys. They declined citing, "they work in an integrated model of care, so it would be almost impossible to estimate Cost to agency to deliver service and since most of our patients are coming with PMPM managed care contracts, Revenues Billed for service would not be inclusive of all the revenue associated with their work. Similarly, staff vacancy information would be misleading at an organizational level if the ask is mostly to BH-only agencies."

Note 2: After this report was submitted for HCA approval, one of the surveyed providers informed HCA that the survey data they provided was inaccurate. HCA scheduled a technical assistance session with the provider to update their information. This new information was sent to Mercer to determine if it would change the enhancement rate. Following their review, Mercer concluded that there would be no material change to the conclusions in their report.

Teaching clinic standards

A set of teaching clinic standards were initially developed by the proviso 74 workgroup and then expanded upon based on Mercer's recommendations to align standards with education program characteristics, which include a minimum number of supervision hours; although, Mercer's enhancement rate methodologies include compensation for teaching clinic staff to meet these supervision standards as well as compensation for the time required to interact with the educational facilities.

Upon review of the expanded teaching clinic standards in this report, stakeholders expressed concern that they were over prescriptive, would likely increase the administrative burden on BHAs, and that they do not take into consideration the various characteristics of training program models. For example, small BHAs in rural areas may only have one supervisor to oversee all clinical staff, while other BHAs may have supervisors that only supervise and do not carry a case load. Stakeholders further commented that rigid standards may preclude small BHAs from being able to participate.

Washington Council for Behavioral Health demonstration

In 2021, the Ballmer Group gifted $38 million to various institutions to address the state's behavioral health workforce shortages, including $1.1 million to the Washington Council for Behavioral Health (WCBH) to fund a demonstration project that will recognize, describe and test a formal teaching clinic classification for behavioral health agencies that provide training and supervision for students and post graduates seeking licensure. The project will identify quality standards and financing mechanisms for a rate enhancement, thus supporting essential training and supervision infrastructure at community behavioral health agencies (BHAs), improving the quality of clinical supervision, and sustaining this critical workforce development pipeline. The funds will be used to support subject matter experts in best practices for teaching, training, and supervision, as well as financial consultants experienced in Medicaid financing and alternative payment methodologies.

WCBH launched the demonstration in the fall of 2022 and have identified six behavioral health agencies that are interested in serving as demonstration sites over the next two years. They will provide data and feedback necessary to enhance and build on the foundational work completed by HCA, the Mercer actuaries, and the Proviso 74 workgroup. The project will prepare a final report with recommendations to

share with HCA and the legislature. The Council plans to coordinate this demonstration in ongoing partnership with HCA.

Stakeholder feedback

Stakeholder feedback was encouraged and documented throughout the proviso 74 work. Their knowledge of BHA business operations, workforce challenges, and dedication to quality behavioral health services was invaluable, and their voices are reflected throughout this report, including WCBH feedback on the Mercer report, attached in whole (Exhibit B).

Employment trends

National

Workforce shortages are a national issue affecting American businesses of every size, across every industry, in every state.[1] The Bureau of Labor Statistics (BLS), Job Openings and Labor Turnover Survey (JOLTS), reported that 47.4 million people quit their job in 2021 compared to 42.1 million in 2019. While workers are quitting in record numbers, new hires remain strong and have exceeded quits since November of 2020. For example, the BLS reported that 4.2 million people quit their job in June of 2022 while new hires came in at 6.4 million. Unemployment numbers remain low as well.

According to many economists, people are not quitting the labor force, they are quitting their employer. Although the reasons for leaving vary, there are common themes. These include better wages and benefits, advancement and lateral opportunities, flexibility work arrangements, better work-life balance, remote work options, and a better workplace culture. Given worker attitudes in the current market, traditional recruitment and retention efforts may not be enough to attract or retain workers.

These same trends are apparent in the community behavioral health industry in Washington. According to a 2021 survey by the Washington Council of Behavioral Health, turnover rates for CBHAs range from 28 to 32 percent with an average time to fill master's level positions at five months.[2] Although modest increases in Medicaid rates will help workers and businesses, as mentioned above, it will not be enough by itself to resolve worker shortages. Legislators, funders, payers, and providers will need to work together in ongoing collaboration to address workforce shortages long-term.

Washington behavioral health investments

Over the 2021-2023 biennium the legislature appropriated $131,000,000 in provider relief and increased Medicaid rates by nine percent. These investments were specifically intended to address workforce shortages and the impacts of the COVID-19 public health emergency on Washington's behavioral health industry. Although these investments provided critical resources at a time of significant need, they will not be enough to resolve the high turnover rates common in the community behavioral health workforce.

[1] https://www.uschamber.com/workforce/understanding-americas-labor-shortage
[2] https://www.thewashingtoncouncil.org/wp-content/uploads/2020/05/COVID-impact-survey_wacouncil.pdf

Teaching clinic as a business model component

Historically low Medicaid reimbursement rates have made it difficult for community behavioral health agencies, particularly small agencies and those in frontier and rural communities, to offer competitive compensation packages that attract new talent, retain current talent, or even maintain adequate staffing levels.

> "When clinics have the basic financial resources needed to cover their costs of care, they can provide more treatment to more individuals. Medicaid and Medicare reimbursement rates often require mental health and addiction providers to provide care at a financial loss."[3]

In lieu of attractive compensation packages, these agencies provide training, coaching and mentoring for new and prospective entrants to the workforce who are required to complete a significant number of supervised experience hours – typically between 1,500 and 4,000 hours over the course of multiple years. Some interns are paid a salary for their work, while others are not. Reasons for not paying an intern vary, but may include a cost-cutting strategy to reduce overhead, educational program requirements that prohibit compensation for students, lack of clear guidance that billing Medicaid for services provided by unpaid practitioners is allowable, or the risk of liability for employing unlicensed, low-skilled workers.

Whether or not interns are paid a salary for their service, the training, supervision and mentoring provided by these agencies result in increased business costs. Some of these costs include increased employee-related expenses for training, travel or equipment, and reduced agency productivity.

Student interns and pre-licensed clinicians must complete supervised experience hours to graduate and become a fully licensed clinician. Behavioral health agencies with resources to provide these supervised hours benefit by recruiting entry-level workers at entry-level wages before industry competitors begin recruiting them. As a business model, it's beneficial to the agencies and the workers who both get something they need to reach their goals. Like all business models, there are advantages and disadvantages for both parties.

Advantages and disadvantages of a teaching clinic

Behavioral health agencies that rely on Medicaid reimbursement typically have low profit margins. This is especially true for agencies that do not have diversified revenue streams to support business costs. In industry terms, low profit margins usually result in compensation packages at the lower end of the industry scale. Businesses that offer comparatively low compensation generally look to lower-skilled workers or less experienced workers, because they cannot afford to compete for more experienced workers. Similarly, less experienced workers need additional training and or education to compete for higher wage jobs within an industry. To acquire this training, they typically look for businesses willing to provide this training. Both benefit from the arrangement.

It can take two or three years to develop and train new employees. A business model that relies on entry level workers to meet their workforce needs may experience lower employee productivity, higher

[3] BHECON-Behavioral-Health-Workforce-Fact-Sheet-2018.pdf

administrative costs related to training programs, and higher turnover rates in comparison to industry competitors.

New practitioners generally complete supervised experience hours and become independently licensed clinicians in two to three years. After receiving their license, these new clinicians frequently look for more lucrative opportunities, which not only pay better, but are typically less demanding than community behavioral health settings. When fully trained workers leave for higher paying jobs, agencies lose their multi-year investment in developing these new clinicians.

This business model also benefits industry competitors by feeding them with a steady supply of newly trained and licensed workers. Beneficiaries include large health systems, hospitals, state and county agencies, private practice, national telehealth firms, managed care organizations and institutions of higher education.

While this business model serves as an effective recruitment strategy for community behavioral health agencies and a career ladder for workers, it comes at a cost to the agencies; a cost exacerbated by chronically high turnover, resulting from low wages, demanding work and administratively burdensome documentation and regulatory requirements. Apart from the past two years, Medicaid rates have remained relatively stagnant while the cost of living continued to go up. When the costs of this model exceed a BHA's ability to meet overhead expenses, the ripple effect is tragic and widespread, impacting workers, communities, and vulnerable individuals in need of service. Signs of this became more evident during the PHE with an increase in facility closures, and providers turning down contracts. According to providers, many facility closures were due in part to their inability hire the necessary workforce. In cases where providers turned down contracts, even contracts that they had been operating for years, they cited a lack of workforce or an inability to sufficiently staff the program within the budget proposed in the contract.

In addition to these cost pressures, behavioral health agencies face several pipeline challenges. For example, there are too few students entering the education pipeline to meet the workforce demand and too many workers leaving for more lucrative and less demanding opportunities. In addition, it can take six years to produce a single master's level clinician, and another two or three years for licensure. A six- to 9-year pipeline with high turnover and an insufficient supply is incapable of meeting the workforce needs – current or future.

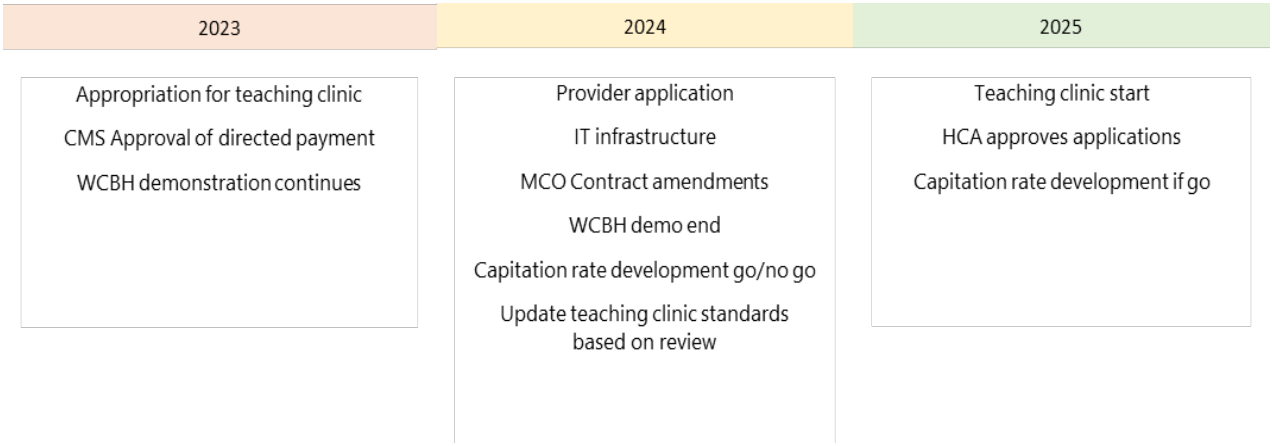
Other factors limiting the pipeline include the high cost of education, low earning potential within the industry, and a lack of alternative training pathways that provide low or no cost access to education and training. An example of an alternative pathway is an apprenticeship program, which allows individuals to earn a living while participating in training. Low and no cost options also reduce inequitable access for communities of color and low-income individuals who may not be able to afford the cost of education and who need to earn an income while participating in a multi-year training program.

Implementation timeline

Timeline background

The timeline for implementation will vary depending on factors such as legislative appropriations, CMS approval of directed payments, IT investments to develop an online application for teaching clinics, and whether this work will require a state plan amendment.

Figure 1: Teaching clinic implementation timeline



Required actions

- Legislative appropriation to fund the enhancement rate
- CMS approval of directed payment
- HCA application for provider registration
    - IT infrastructure
    - Approval process
    - Approval timeline
- Washington Council for Behavioral Health demonstration project
- MCO contract amendments with language for allowable uses of funding
- Capitation rate development

Recommendations

1. **Projected cost of proviso 74 is $39 million to $60 million.**

Over the years, the state has used targeted Medicaid rate increases to support priority services to priority populations. Appropriations for a teaching clinic enhancement rate, targeting BHAs that train a significant number of prospective clinicians, could support the behavioral health workforce by ensuring that the cost of training new clinicians is financially viable, which in turn would support the pipeline into behavioral health careers. Based on Mercer's analysis of current teaching practices, cost incurred and revenues generated, the number of interns and trainees in the pipeline, and the projected number of BHAs likely to qualify as a teaching clinic, Washington would need to appropriate between $39 million and $60 million annually, including federal match. This range may increase or decrease depending on the number of eligible clinics, students and interns. Alternatively, the legislature could decide how much funding to invest in this strategy and scale implementation to fit the appropriation. HCA would need CMS approval for directed payments to implement the teaching clinic enhancement rate.

2. **BHAs that do not compensate interns or trainees are not eligible for enhancement rate.**

Based on the proviso 74 provider survey of costs, revenues and current training practices, and compensation data from the US Bureau of Labor Statistics, Mercer concluded that BHAs that do not compensate their interns/trainees should be able to afford the cost of sponsoring them, without the teaching clinic add-on rate, by billing Medicaid for the services these staff provide. They further concluded that only when BHAs compensate their interns and trainees should the BHA receive the teaching clinic enhancement rate. Based on stakeholder feedback, some BHAs compensate interns/trainees for their service and some do not. While HCA is unable to quantify how many do or do not, BHAs that do not compensate interns/trainees may be missing out on the important benefits of the teaching clinic model, which is the opportunity to hire interns/trainees before their industry competitors do.

> Note: Upon review of this recommendation, stakeholders expressed opposition to the assumption in the actuary's report that billing for Medicaid encounters performed by a student intern adequately addresses the cost incurred by supervising an unpaid intern. Stakeholders strongly recommend that additional consideration is needed to determine if this is accurate.

3. **Amend MCO contract for directed payment to qualifying teaching clinics and require providers to invest the revenue generated in training and supervising interns/trainees, and workforce development infrastructure.**

To ensure appropriations for a teaching clinic add-on payment are used for their intended purpose, HCA should seek CMS approval for directed payments, and amend MCO contracts to include language that requires MCOs to pass the enhancement rate funding through to approved teaching clinics and require providers use funds to support the teaching clinic model and investments in workforce development. Without this language, there is no incentive for providers to use the funding for the intended purpose.

4. **Remove employment requirement in RCW 18.19 and WAC 246-810, and clarify HCA billing guidance for services provided by unpaid student interns and pre-licensed clinicians.**

Based on stakeholder feedback, some BHAs may not be billing Medicaid for services provided by unpaid interns/trainees due to unclear guidance. Mercer concluded in their report that if these BHAs were billing for services provided by unpaid interns/trainees, they should be able to afford the additional costs associated with sponsoring interns/trainees. Complicating this issue are Washington statutes and regulations that provide conflicting guidance regarding whether unpaid intern services may be billed under Medicaid. This issue is noted in the Mercer report below as well as in the 2020 Proviso 57; Strategies for Enhancing the Behavioral Health Workforce Development report[4]. Changes to RCW 18.19 and WAC 246-810 to remove the requirement that Agency Affiliated Counselors must be employed would allow BHAs to bill for services provided by student interns and pre-licensed clinicians regardless of employment status, consistent with the State Plan and SERI guidance. Additionally, HCA should provide clear guidance and technical assistance on allowable billing for services provided by unpaid interns/trainees.

5. **Improve proposed teaching clinic standards using using evidence-based reviews.**

While the teahcing clinic standards in this report reflect minimum standards, more work is needed to develop standards that increase quality of care and best practices in supervision, including developing metrics to measure impact. HCA should use evidence-informed reviews of supervision practices to further inform the standards for a teaching clinic model. This review should include culturally responsive, evidence-informed clinical care as well as practices that address staff wellbeing and lead to better retention. To inform standards, HCA should collaborate with WCBH in the Ballmer Group funded demonstration project to identify best practices in supervision, training programs and care quality. HCA should develop these standards in a way that minimizes the administrative impact to BHAs, including monitoring against the standards.

6. **Reevaluate training program policies that disincentivize hiring.**

Universities, community and technical colleges offering behavioral health education programs should reevaluate policies that disincentivize hiring and paying student interns to better align with industry workforce needs. These disincentives may disproportionetly affect low-income students and students of color by limiting access to education and family-wage careers in the behavioral health field.

7. **Review regulatory, licensing, and supervision requirements to reduce unnecessary administrative burdens.**

As noted in this report, modest rate increases will not resolve the current workforce shortage. The state should consider a variety of additional strategies including but not limited to a review of regulatory, licensing, and supervision requirements, alignment across payer requirements, and other strategies that reduce administrative barriers. In addition to strategies to reduces these these barriers,

[4] https://www.hca.wa.gov/assets/program/strategies-enhancing-bh-workforce-development-20201201.pdf

Washington providers could benefit from resources that address efficient business practices including improved workflows and effective retention strategies.

8. **Develop a framework for reevaluating FTE cost formulas in service contracts.**

Continuing contracts (those contracts issued to the same providers for the same services over multiple years) may be using outdated information to calculate employee related costs. For example, a contract for outreach services executed in 2016 to achieve X performance at X cost may not reflect current employee related expenses. Where they have authority, the DBHR should develop a framework for reevaluating FTE cost formulas in service contracts to ensure formulas reflect reasonable inflationary changes. HCA contract managers should use the framework to reevaluate FTE cost formulas when a contract is extended.

Proviso 74 workgroup recommendations

These recommendations were provided by the proviso 74 workgroup and may not represent the views of HCA.

- While Medicaid is the primary payer for community behavioral health services, there are also programs and populations that are not covered by Medicaid but are equally in need of workforce development supports. A future step would be to assess the true total cost of functioning as a teaching clinic, and then determining which portion can be covered by Medicaid, and what other resources are needed to address the gap. This work can be pursued through the Ballmer Grant Teaching Clinic Demonstration Project, and possibly through future workgroup efforts.
- There is a need to explore scaling of teaching clinic compensation to address clinic size, geographic location, and number of student and new graduates supported. Further consideration of a baseline level of reimbursement to meet basic standards, regardless of volume, would be helpful. This step would ensure inclusion of rural and urban, large and small clinics in supporting workforce development across the state.
- Consider establishing the teaching clinic credential as a form of certification within the DOH behavioral health licensure WACs.
- Designate HCA staff time to collaborate with Ballmer Grant Teaching Clinic Demonstration Project to be supported by proviso funding for 0.5 FTE.
- Secure additional cost data and survey responses before seeking final approval from CMS for the directed payment for an enhancement rate for teaching clinic functions.

Proposed teaching clinic standards and billing guidlines

Teaching clinic standards should accomplish two objectives: first to adequately compensate behavioral health agencies for serving as a training ground for the behavioral health industry in Washington, and second to enhance quality supervision and care standards. HCA, guided by Mercer's analysis, and the workgroup collaborated to develop these minimum standards to achieve these objectives.

Clinic eligibility

A behavioral health teaching clinic will be aligned with the needs and requirements of higher education, comply with scope of practice regulations, and promote evidence-best practices in clinical care. Licensed and certified behavioral health agencies (BHAs) that primarily serve Medicaid eligible individuals with serious mental illness and/or substance use disorders are eligible to become a teaching clinic if they meet the following:

- The behavioral health agency must be licensed and certified to provide behavioral health services under **RCW 71.24.037.**
- The behavioral health agency must be enrolled with HCA or certified by DOH as a teaching clinic.
- The behavioral health agency must primarily serve Medicaid eligible individuals.
- Supervisors in a teaching clinic must meet the criteria for an approved supervisor as defined by Washington State Department of Health.
- Supervisors in a teaching clinic must receive training in evidence-based practices.
- The teaching clinic must provide two and a half hours of supervision time per week for interns.
- The teaching clinic must provide two hours of supervision time per week for trainees.
- Trainees must shadow licensed staff at least 20 hours over the first three months of employment.
- Interns must shadow licensed staff at least 80 hours over the first two months of employment.
- Interns must be under the supervision of a licensed behavioral health agency and an accredited educational institution or program.
    - The behavioral health agency must attest to having an active contract or agreement with an accredited educational institution or program.
- The behavioral health agency must attest to having a formal training and shadowing program in place. The training program must meet regulatory standards and include the following minimum competencies:
    - De-escalation, crisis intervention and safety
    - Conflict resolution
    - Cultural competencies
    - Trauma informed care
    - Confidentiality and mandatory reporting
    - Documentation and compliance
    - Evidence-based clinical practices
- Services provided must be within the scope of an approved training program.
- The behavioral health agency must attest to having an adequate ratio of approved supervisors to interns and trainees.

Billing eligibility

The teaching clinic enhancement rate or add-on payment may be billed for Medicaid services provided to Medicaid eligible individuals by:

- A licensed supervisor or provider in an approved teaching clinic when an intern or trainee is physically present.
- An intern or trainee when a licensed supervisor is physically present.
- An intern or trainee in an approved training program while under the supervision of a licensed supervisor.

Note: the enhancement rate may only be billed when an intern or trainee is paid a salary to provide service.

Appendix A: Mercer Actuarial Report

Mercer

Government Human Services Consulting

Proviso 74 — Teaching Clinic Enhancement Rate Add-on

Washington State Health Care Authority

September 2022

Contents

Section 1
Introduction

The State of Washington (State or Washington) Health Care Authority (HCA) contracted with Mercer Government Human Services Consulting (Mercer) to develop a behavioral health (BH) teaching clinic enhancement rate to respond to Legislative Proviso 74.[1] The Proviso outlined in the report should include three outcomes:

- Develop Teaching Clinic standards
- Determine the costs of providing training and supervision to enhance the rates paid
- Determine an implementation timeline

The enhancement rate is intended to assist behavioral health agencies (BHAs) training and supervising students (interns) and individuals seeking certification or licensure (trainees). Based on discussions with HCA, Mercer focused on the following:

- Assisting HCA with developing questions to collect information from providers to inform the HCA about current provider Teaching Clinic agency practices.
- Reviewing provider submitted information to inform teaching clinic enhancement rate assumptions.
- Identifying provider reimbursement strategies around clinical supervision that incents provider expansion in coordination with HCA workforce development initiatives.
- Developing a reimbursement methodology for a BH Teaching Clinic rate enhancement.

HCA has initiated a stakeholder workgroup that will recommend teaching clinic standards for BHAs and a timeline for implementation. Those elements are outside of the scope of this report.

Terminology

For purposes of this report, "intern" refers to a degree-seeking student and "trainee" refers to a post-graduate individual, including an associate, who is completing supervised work experience while seeking licensure. An associate is a pre-licensure candidate with a graduate degree in a mental health field (RCW 18.225.090) gaining the professional experience necessary to become a licensed independent clinical social worker, licensed advanced social worker, licensed mental health counselor, or licensed marriage and family therapist.

Background

Agencies providing community BH services, which includes both mental health and substance use disorder (SUD) treatment often serve as training grounds for individuals seeking licensure. Licensure requires supervised work experience per State law. BHAs

[1] Engrossed Substitute Senate Bill 5092. 67th Legislature 2021 Regular Session. Available at: 5092-S.PL.pdf (wa.gov)

provide a career pathway for degree-seeking students (interns) and license-seeking professionals (trainees) to gain experience necessary for their educational and career goals. This crucial workforce development setting also allows interns and trainees to explore alternatives to large medical system networks or to re-enter the workforce in community-based settings.

Internships are an increasingly important mechanism for non-profit community-based providers to connect with high quality talent in a competitive labor market. Stakeholders have reported that community BHAs are not fully reimbursed for costs associated with workforce development. However, because the community BHAs are not fully reimbursed for their costs associated with workforce development, they are unable to compensate the new practitioners that they have trained at a competitive market wage. Once interns and trainees complete their required work experience, these professionals often obtain more lucrative positions elsewhere. As a result, community BHAs are unable to retain staff that they have recently trained and may experience turnover rates of roughly 30% in clinical positions that can take three to five months to fill a vacancy.[2]

Some, but not all, interns are compensated for the time they spend gaining work experience required for their degree. Washington statute and regulations offer conflicting guidance regarding whether unpaid intern services may be billed under Medicaid.[3] State statutes create an exception permitting agencies to utilize students and trainees to provide counseling, but regulations require agencies to employ practitioners providing Medicaid reimbursed services. Although HCA has provided policy guidance to managed care organizations (MCOs) via SERI that interns/trainees may bill Medicaid for services regardless of employment status per requirements of the Medicaid State Plan, the lack of clarity in HCA FFS billing policy has contributed to some community-based providers not billing for interns' work and struggling to financially sustain quality workforce training programs.

The lack of clarity has been further exacerbated through contradicting Centers for Medicare & Medicaid Services (CMS) policies that prohibit Medicare billing where the services are provided by practitioners that do not "cost" the agency, but do not explicitly prohibit or permit provision of Medicaid services by unpaid or volunteer staff. Many state Medicaid programs rely on Medicare billing guidance and do not permit entities to bill Medicaid for services provided by unpaid or volunteer staff. If a state Medicaid agency does permit billing for unpaid interns and trainees, Medicaid agencies must ensure that the cost of interns/trainees for Medicare beneficiaries is not shifted to Medicaid because providers often provide services to both Medicare and Medicaid programs.

[2] Washington Council for Behavioral Health. The State of the Community Behavioral Health System COVID Pandemic Impact plus Chronic Underfunding, March 2021. Available at: https://www.thewashingtoncouncil.org/wp-content/uploads/2020/05/COVID-Impact-survey_wacouncil.pdf. Accessed August 25, 2022.

[3] Chapter 18.19 RCW. This statute does not prohibit or restrict the practice of counseling by an employee or trainee of any federal agency, or the practice of counseling by a student of a college or university, if the employee, trainee or student is practicing solely under the supervision of and accountable to the agency, college or university, through which he or she performs such functions as part of his or her position for no additional fee other than ordinary compensation.

Chapter 246-810 WAC. Applicants for agency affiliated counselors must be employed by, or have an offer of employment from an agency or facility that is licensed, operated, certified by Washington, or a federally recognized Indian tribe located within the State or a county. Counselor means an individual, practitioner, therapist or analyst who engages in the practice of counseling to the public for a fee, including for the purposes of this chapter, hypnotherapists.

Proviso 57

In 2020, HCA contracted with Mercer to assist with responding to Proviso 57[4], a related legislative proviso, to outline options for strategies to enhance BH provider reimbursement to promote BH workforce development efforts. Under the earlier effort, HCA directed Mercer to:

- Review historic cost models used to develop BH capitation rates and identify key assumptions related to non-billable clinical supervision activities.
- Identify provider reimbursement strategies around clinical supervision that incents provider expansion.
- Assist HCA to develop questions to collect information from the Managed Care Organizations (MCOs) regarding Behavioral Health Administrative Service Organizations (BH-ASOs) and provider contracting approaches.

As noted in the Proviso 57 legislative report, larger and more sophisticated providers may be able to negotiate more advantageous rates with MCOs that cover workforce development costs, while smaller or less sophisticated providers may not have the negotiating power to contract for robust fees covering all of the providers' costs, including any costs of supervising unlicensed staff, interns, and trainees.[5]

Building on the Proviso 57 work, this report presents a methodology for establishing enhanced reimbursement rates for HCA to recognize and compensate community BHAs that serve as Teaching Clinics to train and supervise interns and trainees while they obtain work experience required to earn educational degrees and to achieve clinical licensure.

[4] Engrossed Substitute Senate Bill 6168 Section 215(57). 66th Legislature 2020 Regular Session. Available at: https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Senate%20Passed%20Legislature/6168-S.PL.pdf?q=20220614133012

[5] Hutchison J. *Medicaid Managed Care Organizations and Providers Caught In Crossfire as States Cut Medicaid Budgets*. October 2010. Available at: https://katten.com/files/20943_Hutchison_AHLA_MedicaidMCOs.pdf. MCOs may contract to pay their network providers for Medicaid covered services based on rates for services provided, using a percentage of billed charges or Medicaid fee tables or as a subcapitated arrangement. The MCO's profit is based on the difference between the aggregate payment received from Medicaid and the total amount paid to providers. The MCO's profit may rely on their ability to negotiate rates with their Medicaid providers, many of whom also participate in the MCO's private-pay programs.

Section 2

Teaching Clinic Enhancement Rate Methodology

In this section, Mercer will:

- Summarize HCA's approach to determining current Teaching Clinic practices
- Outline the considerations for the Teaching Clinic enhancement rate

Approach to Determine Current Teaching Clinic Practices

To inform HCA about current provider Teaching Clinic agency structure in Washington State, HCA developed a survey with support from Mercer. The survey solicited information for state fiscal year 2021 (July 1, 2020 through June 30, 2021) on the following areas:

- The services (Healthcare Common Procedure Coding System [HCPCS]/Current Procedural Terminology [CPT] codes) that interns and trainees are currently billing
- The revenues that interns and trainees currently generate for providers
- Cost differentials for interns and trainees compared to other practitioners billing the same codes
- Supervision and other expenses related to interns and trainees including but not limited to the impact on productivity
- Community BHA expenditures
- Demographics of respondents

In preparation for survey distribution, HCA and Mercer presented the survey to the workgroup on December 2, 2021. In addition to gathering feedback on the survey, HCA asked the workgroup for input on BH providers that primarily serve Medicaid individuals and whose business model include a significant intern/trainee component. Prior to distributing the survey, HCA and Mercer hosted three technical assistance walkthrough meetings to clarify data needed to calculate the add-on payment, provided technical assistance, and responded to stakeholder questions. HCA distributed the survey on January 26, 2022 with instructions to 33 community BHAs. Stakeholders, including two professional associations, were also encouraged to distribute the survey to their members. Providers were allowed three and a half weeks to respond.

HCA held four technical assistance sessions with the community BHAs to offer support along with responding to questions through email. HCA also met with individual BHAs when requested. In total, seven community agencies responded to the survey.

HCA reviewed and compiled the survey responses and requested additional information as necessary with the BHAs. Mercer reviewed the survey responses to inform the enhancement rate assumptions. On April 25, 2022, HCA, with support from Mercer, presented the draft

assumptions under consideration for the enhancement rate to the workgroup. Following the meeting, HCA gathered additional feedback from workgroup participants and responded to outstanding questions.

Enhancement Rate Considerations

Community outpatient services may be covered under subcapitation or other non-traditional payment arrangements; however, these records have not historically included any cost or expenses associated with the service. Historically, Mercer and HCA have developed a 'shadow pricing' approach consistent with a traditional fee schedule development methodology as part of the BH capitation rate development process. The process ensures efficient HCA purchasing of services in a Medicaid managed care environment and may not be applicable for other purposes.

In order to establish the enhancement rate, Mercer relied on the following steps:

- Establishing baseline rates for a professional BH service (i.e., hourly rate for a Licensed Mental Health Practitioner [LMHP]) using a market-based pricing methodology.
- Adjusting rates to reflect the clinical structure for supervision based on current Teaching Clinic practices.
- Establishing rates for trainees and interns using a market-based pricing methodology.
- Calculating the relative differential from the baseline rate to the rate for a professional BH service at a Teaching Clinic, the rate for a trainee, and the rate for an intern.

The general components of the market-based pricing approach are identified below:

- Staffing assumptions and staff wages
- Employee Related Expenses (ERE) — benefits, employer taxes (e.g., Federal Insurance Contributions Act [FICA], unemployment, and workers' compensation)
- Provider overhead expenses
- Productivity assumptions (billable versus non-billable time)

The productivity assumptions reflect a percentage of full-time equivalent staff hours (2,080 hours per year), which translates into direct billable hours. Mercer has historically modeled the productivity of staff separately by service modality to consider the differences in service delivery between office-based services and community-based services as well as the nature of each service as it relates to productive time. For the Teaching Clinic enhancement rate, Mercer considered varying productivity by staff position.

Staffing Assumptions and Staff Wages

Along with consultation with HCA, Mercer identified appropriate staffing levels and positions for consideration. Compensation data was compiled from the US Bureau of Labor Statistics (BLS) data published in March 2022 and trended to a projected time period. The salary data reflects Seattle/Tacoma/Bellevue regional data, which is representative of urban wages. Urban wages were considered to reflect robust funding levels capable of sustaining

additional costs for some non-urban providers who may have lower wage expenses but potentially higher administrative expenses or lower productive hours.

Employee Related Expenses

ERE is assumed to be 25% of wages for full-time workers and 15% for part-time workers, which is in the range of ERE assumptions observed in other states. These expenses include considerations such as health insurance, unemployment taxes, workers' compensation, FICA tax, and contributions for other benefits (e.g., short-term disability, long-term disability, retirement). The amounts included in the fees represent the employer's share of the costs for these items.

Provider Overhead Expenses

Costs associated with general administrative expenses such as program management, equipment and supplies, and other indirect costs necessary for provider operations were also considered. The assumption for administration costs was 15% based on provider responses to the survey.

Productivity Assumptions

Mercer considered adjustments to account for non-billable staff time from two perspectives.

Annual Productivity Offsets

Annual productivity offsets include time for paid time off (i.e., vacation, sick days, and holidays) and training days. For the interns and trainees, additional offsets are included for training days (i.e., more training days than a clinician) and shadowing. These additional offsets for interns are further increased to account for multiple interns over a 260 working day period.

Daily Productivity Rates

Daily productivity rates represent the proportion of billable hours during each workday. It is assumed that a portion of each work day is spent on usual and required non-billable activities such as supervision, travel, and general administrative time. For LMHPs and Clinical Supervisors in a Teaching Clinic, further daily offsets are included to reflect loss in productivity when being shadowed by an intern or trainee.

In general, to account for time spent by staff supervising or being supervised, Mercer has historically considered adjustments for non-billable time spent supervising and being supervised. The following assumptions were used based on provider responses to the survey and discussion with HCA:

- Two and a half hours of supervision time per week for interns.
- Two hours of supervision time per week for trainees.
- One hour of supervision time per week for LMHPs.

The table below illustrates the productivity considerations reflected in the rates and differentials. Productivity rates were further adjusted downwards based on stakeholder input.

Component	Licensed Mental Health Professional/ Mental Health Therapist	Clinical Supervisor	Trainee	Intern
Assumed Working Hours	2,080	2,080	2,080	2,080
Annual Productivity Offsets	31 to 45 days	31 to 45 days	55 to 69 days	82 days
Daily Productivity Rate (Lower Bound)	62.5% to 65.0%	40.0% to 50.0%	60.0%	35.0%
Daily Productivity Rate (Upper Bound)	47.5% to 50.0%	35.0% to 44.0%	45.0%	25.0%
Assumed Billable Hours (Full Time)	820 to 1,120 hours	600 to 860 hours	690 to 920 hours	360 to 500 hours
Productivity as Percent of Working Hours	39% to 54%	29% to 41%	33% to 44%	17% to 24%

Lastly, the enhancement rates also reflect consideration for an absentee factor to recognize the provider must pay their direct care staff for hours on the job when there are missed appointments or the provider is operating under maximum capacity. Mercer assumed a 5% absentee factor.

Enhancement Rate Add-on

The hourly enhancement rate add-on reflects the revenues that the community BHA forgoes because of additional responsibilities as a Teaching Clinic. These activities include:

- Increased time spent by supervisors in supervision of interns and trainees compared to other licensed practitioners.
- Decreased productivity for licensed practitioners who are being shadowed by interns and trainees.
- Lost revenue for training annually provided to all new employees including interns and trainees.

The table below demonstrates these differences as individual components of the enhancement rates on an hourly basis.

Component	Shadowed Clinician at a Teaching Clinic	Trainee	Intern
Estimated cost differential due to wages	N/A	($7.20)	($12.83)
Estimated cost to the Teaching Clinic to provide shadowing experience	$7.10 to $10.25	$3.28 to $3.97	$28.97 to $40.66
Estimated cost to the Teaching Clinic to train interns/trainees	N/A	$12.73 to $15.39	$18.72 to $26.27
Estimated cost to the Teaching Clinic for additional supervision	N/A	$0.99 to $1.19	$4.34 to $6.10

The table below summarizes the range of enhancement rates calculated as the difference of each hourly rate to the baseline LMHP hourly rate:

Position	Consideration included in Enhancement Rate	Enhancement Rate Add-on Range
Shadowed Clinician at a Teaching Clinic	Reduction in productivity due to additional shadowing and additional supervision (Clinical Supervisor).	$7.10–$10.25
Trainee	Differences in productivity compared to a LMHP. Differences in wages compared to a LMHP.	$9.80–$13.35
Intern	Differences in productivity compared to a LMHP. Differences in wages compared to a LMHP.	$39.20–$60.20

Section 3

Provider Reimbursement Strategies and Considerations

In this section, Mercer has identified considerations for HCA to operationalize the Teaching Clinic enhancement add-on. Many considerations outlined below align with the development of the enhancement rate add-on described in this report. Mercer acknowledges this analysis was developed based on information known as of the date of this report. Program guidelines, financing approaches, and other considerations are expected to evolve. HCA may align or choose to establish different standards relative to those described in this report. To the extent additional program information becomes available, the enhancement rate add-on and potential fiscal impact will need to be revised.

Billing Guidance Consistency Needed For Interns

The cost of sponsoring an intern is costly to the clinic and some facilities are only able to afford sponsoring/mentoring interns if they do not pay the interns. Based on the analysis, Mercer observed that Teaching Clinics that did not pay interns, but billed for intern services could financially afford to sponsor/mentor interns. Clinic interns who are not compensated for the time spent gaining work experience required for their degree may need to pursue higher salaries than a non-profit agency can offer after gaining their degree and license.

With the addition of a Teaching Clinic enhancement rate add-on, clinics should be able to afford both the additional costs of sponsoring/mentoring interns and paying those interns. Clarifying the guidance that unpaid intern services may be billed under Medicaid will improve community-based providers' ability to financially sustain quality workforce training programs.

Mercer recommends that HCA clarify when Teaching Clinics may bill for an intern's services. Mercer also recommends that Teaching Clinics should not qualify for the enhancement rate add-on if an intern is not paid a wage but the services provided by the intern are billed to Medicaid. In this case, the clinic should recoup the costs of sponsoring/mentoring an intern through the Medicaid payment. Alternative scenarios are described in the table below.

	Services are *Not* Billed to Medicaid	Services are Billed to Medicaid
Intern is not paid a wage	Recommend that Teaching Clinics receive clear guidance on how to bill for interns services so they may start billing for intern services (see box to the right).	No differential enhancement add-on needed; Clinic recovers the cost of sponsoring/mentoring an intern through billing without paying the intern.
Intern and/or trainee paid a wage	Recommend that Teaching Clinics receive clear guidance on how to bill for interns services so they may start billing for intern services (see box to the right).	Differential enhancement add-on paid to compensate the clinic for the cost of sponsoring/mentoring an intern/trainee and shadowing a clinician.

Educational Program Characteristics Affecting the Enhancement Rate Add-on

Mercer utilized specific characteristics of educational programs that HCA may want to consider as it develops the criteria for Teaching Clinics to be eligible for the Teaching Clinic enhancement rate add-on.

First, as noted above, Mercer utilized the wage costs of the intern to determine the differential enhancement amount. Mercer recommends that HCA establish Teaching Clinic standards such that if the intern is not paid, then the Teaching Clinic should not receive the enhancement rate add-on for the intern position.

Second, the Teaching Clinic should enter into an agreement to provide oversight consistent with the educational facility's requirements for interns. The differential enhancement rate add-on includes compensation for the Teaching Clinic staff to interact with the educational facility. Mercer recommends that HCA establish Teaching Clinic standards such that if the Teaching Clinic does not enter into an agreement with the educational facility's requirements for interns, then the Teaching Clinic should not receive the enhancement rate add-on.

Third, the Teaching Clinic should provide a minimum number of supervisor hours required by HCA. Mercer utilized the following ratios in the differential enhancement rate development:

- Trainees receive at least twice the number of hours of supervision of licensed staff for six months.
- Interns receive at least two and one-half times the number of hours of supervision of licensed staff.

Mercer recommends that HCA set Teaching Clinic standards such that if the Teaching Clinic does not provide the minimum amount of supervision to trainees and interns outlined by HCA, then the Teaching Clinic should not receive the enhancement rate add-on.

Fourth, the Teaching Clinic should provide a minimum number of hours of shadowing required by HCA. Mercer utilized the following requirements for shadowing for the enhancement rate add-on development:

- Trainees shadow licensed staff at least 20 hours over the first three months of employment.
- Interns shadow licensed staff at least 80 hours over the first two months of employment.

Mercer recommends that HCA set Teaching Clinic standards such that if the Teaching Clinic does not provide the minimum amount of shadowing opportunities to trainees and interns outlined by HCA, then the Teaching Clinic should not receive the enhancement rate add-on.

HCA may align or choose to establish varying standards relative to the descriptions above.

Budget Necessary to Implement the Teaching Clinic Differential Enhancement Add-on

The approach described below includes expense illustrations based on publicly available information and Mercer's experience in other state programs; this information is included in order to provide numeric comparisons of various approaches. The analyses illustrated in this report *do not* reflect an actuarial analysis of equitable fee reimbursement levels specific to Washington and Mercer disclaims any use beyond the intended purpose. The proposed approaches below follow federal Medicaid reimbursement principles that Medicaid may only reimburse for the portion of care provided to Medicaid eligibles. Agencies serving a mix of Medicaid and non-Medicaid enrollees will only receive Medicaid reimbursement for the Medicaid portion of their caseload. Services provided to non-Medicaid enrollees may not be funded through the Medicaid rates. The proposed approaches reflect aggregate fiscal estimates without consideration for Federal Medical Assistance Percentages (FMAP).

One approach for HCA to consider would be to increase capitation rates proportionate to the amount of funding that HCA would like to see devoted to additional supervision and training for workforce development when a community BHA has a qualified workforce program for interns and trainees (i.e., the BHA is a Teaching Clinic). Under this approach, Mercer recommends that Washington amend its contractual requirements and receive CMS approval for a directed payment, which would require MCOs to forward the increased funding to community-based providers providing enhanced workforce development oversight satisfying standards put forth by HCA. HCA is in progress of developing Teaching Clinic standards for BHAs in conjunction with stakeholder groups that could support the CMS directed payment preprint.

Under the directed payment approach, HCA would be allowed to establish the parameters for MCOs to pay this additional amount to any Teaching Clinic entity providing supervision for interns and trainees. For example, an MCO could be required to reimburse BHAs billing interns, trainees, or shadowed professionals using a prescribed fee schedule when modifiers are used by the billers. Modifiers would indicate whether an intern (HL modifier), trainee (HO modifier) or shadowed professional is providing the service.

Any HCA directed payment must be approved by CMS in advance and must be tied to delivery and utilization of services to Medicaid beneficiaries covered under the managed care contract. In this case, there is clear CMS guidance on how to apply for and receive approval from CMS on parameters for directed payments to providers of a particular service under the contract including a minimum fee schedule or minimum rate increase. The State's actuary could build an additional amount into the capitation rates and, at the same time, HCA could direct the MCOs to reimburse using a specified rate that would increase unit reimbursement where an intern or trainee was present for that encounter.

No regulatory change would be needed for this approach because the practitioner generates the encounter and receives increased reimbursement for having an intern or trainee present. The increased reimbursement is intended to reimburse for the increased costs to the provider. The intern would not need to have an employment relationship with the entity. This approach would require an update to the State Encounter Reporting Instructions (SERI) for managed care enrollees.

Because SERI does not apply to fee-for-service (FFS), HCA would need to ensure that FFS policy similarly allows interns and trainees to bill under the FFS program. In the FFS provider

billing guides, the Department of Health (DOH) requires providers to have the DOH credential to bill FFS. The DOH credential requires employment, so this credential would need to be updated or clarified. HCA may also need a state plan amendment to provide the enhancement add-on via FFS. *Note: HCA has clarified that American Indian/Alaskan Native providers would follow the HCA provider billing guides (not the SERI) for any core FFS provider agreement with HCA.*

Potential Fiscal Impact

The fiscal impact of workforce development is primarily associated with the lost revenues that the community BHA forgoes because its supervisors spend more time supervising interns and trainees than other employees; its experienced clinicians spend time providing mentoring/shadowing opportunities to the interns and trainees instead of providing other billable services; and its trainers are spending significant time with interns and trainees in formal agency training. There are also additional costs associated with overhead.

In developing the potential fiscal impact, Mercer relied on the survey described in Section 2 and HCA expectations for the Teaching Clinics initiatives. Survey responses related to the number of employees and the proportion of workforce represented by trainees and interns were evaluated to determine the number of individual practitioners. Mercer assumed that the number of shadowed clinicians will not exceed the number of trainees.

Utilizing the educational program characteristics related to shadowing, Mercer determined the estimated hours spent shadowed per clinician. Average number of hours for interns and trainees align with the average assumed billable hours for trainees and interns. HCA provided Mercer with expectations on the number of providers expected to pursue the Teaching Clinic initiative, which informed the range of the number of expected providers.

The total number of hours are calculated as the product of the number of individuals per provider, the estimated hours per individual eligible for the enhancement rate add-on, and the number of expected providers. The enhancement rate add-on for interns accounts for unpaid interns, assumed to be one-quarter of interns at Teaching Clinics statewide.

The aggregate impact of the various ranged assumptions results in a potential impact ranging from $39 million to $60 million.

	Shadowed Clinicians	Trainees	Interns
Number of individuals per provider	45	45	18
Average number of hours estimated per individual per year	52	690 to 920	360 to 500
Number of Providers	70 to 100	70 to 100	70 to 100
Total number of hours	163,800 to 234,000	2,898,000 to 3,105,000	630,000 to 648,000
Enhancement Add-On	$7.10 to $10.25	$9.80 to $13.35	$14.65 to $25.75
Total cost impact	$1.2 million to $2.4 million	$28.4 million to $41.4 million	$9.2 million to $16.7 million

Other considerations

Regardless of the approach selected to operationalize the Teaching Clinic enhancement, providers and MCOs could benefit from additional training regarding the current allowable coding and modifiers under which interns, trainees, and other unlicensed practitioners are permitted to bill under existing HCA policy.

Section 4

Disclosures and Limitations

This report is intended to support HCA efforts to respond to Proviso 74 developed by Washington State Legislature as part of ongoing budget planning. This report is intended to be relied upon solely by HCA and other Washington State agencies and is not intended to be distributed broadly. The illustrations presented in this report are based on publicly available information and Mercer's experience in other state programs; the information in this report is compiled to provide numeric comparisons of various approaches. The analyses illustrated here *do not* reflect an actuarial analysis of equitable fee reimbursement levels specific to Washington and Mercer disclaims any use beyond the intended purpose.

This report relies on data provided by the HCA as part of separate engagements. Mercer acknowledges that the suppliers of data are solely responsible for its validity and completeness. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it.

All estimates are based upon the information and data available as of the date of this report and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely and potentially wide range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. To the extent additional information becomes available that may impact the anticipated structure of the programs, the recommendations and accompanying fiscal analyses may need to be revised accordingly.

The State understands that Mercer is not engaged in the practice of law or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that the State secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work. Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

Appendix A
Current Limitations

Employment Limitations

During the course of the project, HCA staff asked Mercer to focus on community-based providers' workforce development and their ability to receive reimbursement from MCOs to cover the costs of supervision for degree-seeking interns and professionals seeking licensure (trainees).

As noted in the introduction of this report, conflicting statutes and regulations have resulted in a lack of clarity among State staff and providers regarding whether or not providers may bill for intern and trainee services. State statute permits an exception allowing students and trainees to practice counseling, but State regulations limit provider to billing for only employed Agency Affiliated Counselors.[6]

Some provider agencies have received guidance from State licensure agencies, for example, that they may only bill for employed Agency Affiliated Counselors on approved agency affiliated lists. This guidance is correct for FFS delivery systems but there has been different informal guidance for managed care. In FFS, as defined in Washington Administrative Code (WAC) 246-810-016[7], there are a number of agencies, facilities, or counties that can employ Agency Affiliated Counselors including colleges, hospitals, counties, and other health care agencies.

Under those FFS regulations, Agency Affiliated Counselors are required to register with the State consistent with Chapter 18.19 RCW[8] and Chapter 246-810 WAC[9]. Applicants for Agency Affiliated Counselors must be employed by or have an offer of employment from an agency or facility that is licensed, operated, certified by the State, or a federally recognized Indian tribe located within the State or a county. The counselor must have their employer complete and sign the Agency Affiliated Counselor Employment Verification Form[10] provided by the Department of Health. Washington staff utilize form 670-114 to verify that counselors are employed by agencies.

In addition, some agencies have received licensure guidance that they must meet strict guidelines for supervising interns who are not permitted to bill if they do not have an employment arrangement.[11] Licensed BH providers must ensure supervision requirements are met for trainees, interns, volunteers, and students. Requirements include passing a background check; signing a confidentiality statement from the trainee, intern, volunteer, and

[6] Chapter 18.19.040 RCW. This statute does not prohibit or restrict the practice of counseling by an employee or trainee of any federal agency, or the practice of counseling by a student of a college or university, if the employee, trainee, or student is practicing solely under the supervision of and accountable to the agency, college, or university, through which he or she performs such functions as part of his or her position for no additional fee other than ordinary compensation.

[7] Washington State Legislature, WAC 246-810-016. Available at: https://apps.leg.wa.gov/WAC/default.aspx?cite=246-810-016.

[8] Washington State Legislature, Chapter 18.19 RCW. Available at: https://app.leg.wa.gov/rcw/default.aspx?cite=18.19

[9] Washington State Legislature, Chapter 246-810 WAC. Available at: https://app.leg.wa.gov/wac/default.aspx?cite=246-810 and refer to RCW 18.19.040 Exemptions available at: https://app.leg.wa.gov/RCW/default.aspx?cite=18.19.040

[10] Washington State Department of Health, *Agency Affiliated Counselor Registration Application Packet*. Available at: https://www.doh.wa.gov/Portals/1/Documents/Pubs/670110.pdf (Refer to Agency Affiliated Counselor Employment Verification Form)

[11] Washington State Legislature, Chapter 246-810 WAC. Available at: https://apps.leg.wa.gov/wac/default.aspx?cite=246-810

student, as well as the academic supervisor; and being assigned a supervisor approved by the agency administrator or designee. The assigned supervisor must be credentialed by the department for their scope of practice, be responsible for the individuals assigned, and must review all clinical documentation with the individual as part of the supervision process.[12]

HCA might consider clarifying in writing and through statutory and regulatory changes that HCA managed care billing guidance does not require agencies to follow these regulations and would assist the industry in creating sustainable funding sources for workforce development. Ideally, fee-for-service regulations would be modified to allow a BHA to support an intern as Agency Affiliated Counselor Intern without attesting the conventional "employee status". Under this scenario, the provider agency would complete the agency affiliated form and attest that the counselor in training was a student intern and "affiliated" to their agency as such. This may require a change to RCW 18.19.020, which requires a person to be "employed" by an agency in order to be an Agency Affiliated Counselor. This language creates a barrier to registering a student intern as an Agency Affiliated Counselor should an agency wish to do so per HCA's preference of including students under the Uniform Disciplinary Act.

Unlicensed Practitioners May Bill

HCA has issued other guidance permitting trainees, interns, and students to bill Medicaid according to their current credential. HCA already has billing codes and guidance permitting unlicensed, employed practitioners with Bachelor of Arts (BA) and MA education to bill Medicaid if the practitioner is credentialed by the Department of Health. BA and MA practitioners may bill for skill building or psychoeducation. However, through the work completed for Proviso 57, HCA has indicated that interns and trainees may not bill for their future credentials that they have not yet obtained.

[12] *WAC 246-341-0520 Agency requirements for supervision of trainees, interns, volunteers, and students* Statutory Authority: 2018 c 201 and 2018 c 291. WSR 19-09-062, § 246-341-0520, filed April 16, 2019, effective May 17, 2019.

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Appendix B: Washington Council for Behavioral Health feedback to Mercer report

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WASHINGTON COUNCIL
FOR BEHAVIORAL HEALTH

Questions & Comments RE: Mercer Report, Proviso 74, Teaching Clinic Enhancement Rate Add-On
WA Council for Behavioral Health

1. The Council appreciates the foundational work done by Mercer and summarized in the report. However, we would like to underscore the need to more clearly present these results as preliminary. We are concerned with the small sample size that responded to the survey, and whether that sample is truly representative of the broader community behavioral health system statewide.

2. We believe there may be additional substantive costs that were not fully captured by this initial survey. These include:
    a. Team meetings and consultation;
    b. Cost of evidence-based practice training (including trainer and curriculum costs, in addition to lost time/revenue);
    c. Entire cost/student for Medicaid and non-Medicaid services.
        i. We understand that Medicaid can only be billed for Medicaid-eligible encounters; however, other non-Medicaid services and clients are also part of the public behavioral health system and these workforce development costs, and we hope this can be noted in a future step.

3. Salaries constitute the single largest cost for delivering behavioral health services. in our experience, the BLS figures frequently under-represent the local labor market, including the true cost of offering competitive salaries. This is particularly true in the current environment, where we are experiencing extreme shortages of behavioral health professionals and the competition for clinical staff is fierce.

4. *Question:* On the charts included on page 8, what do these costs represent? Differential cost per billable intern/trainee service hour, i.e., the "loss" to the agency?

5. There are several references to clinics that may not pay all student interns for services provided, along with a recommendation from Mercer which states that if interns are not paid, the teaching clinic should not receive the enhancement rate. This assumes that the current reimbursement rate for Medicaid encounters adequately covers the cost of sponsoring an unpaid intern; this rate is not sufficient to recoup the cost of sponsoring. **We strongly believe additional consideration is needed to determine if this assumption is accurate.**
    a. The Council's teaching clinic demonstration project aims to address the concern that current reimbursement rates for Medicaid encounters do not adequately cover the cost of training and supervising interns and will collect data from participating agency sites to inform this evaluation.
    b. Additionally, requiring payment of interns is not a teaching clinic standard established by the workgroup. The workgroup did not engage in sufficient discussion of this complex

topic, which includes requirements imposed by higher education institutions unrelated to internal agency policies, and did not make a value judgement on if requiring payment of interns is a feasible standard. The Mercer recommendation requiring payment of interns is premature.

6. Likewise, the requirement of a minimum number of supervision hours was not adequately discussed by the workgroup, nor does it consider the complexity of varying educational requirements/restrictions and the different supervision requirements related to clinical occupation/credential. We have concerns that enforcement of such a minimum would be inconsistent and challenging to regulate, creating an additional administrative burden for teaching clinics.
    a. We have additional concerns that a universal minimum number of hours could place an unfair burden on smaller and/or rural agencies, who typically employ a smaller number of supervisors.

7. We have concerns with the concept of "shadowing" as presented in the Mercer report, which does not provide an operational definition. Not all agencies structure their internship/training programs to incorporate a specific volume or structure of shadowing; many use different combinations of one-on-one supervision, team consultation, group supervision, etc. and all provide a rich training environment. More analysis is needed to avoid being overly prescriptive in a preliminary report.

8. Finally, on page 12, it is unclear what proportion of the proposed figure ($39M – $60M) is state dollars and/or federal match. Our reading of the report is that the proposed figure *is* inclusive of FMAP but we encourage Mercer to explicitly call out this aspect in order to provide a clearer understanding of what could be the state's fiscal burden.

For more information contact Ann Christian at achristian@thewashingtoncouncil.org