# Children and Youth Behavioral Health Work Group – Behavioral Health Integration (BHI) Subgroup

*August 13, 2024*

## Glossary of Terms

ACA: Affordable Care Act
AIMS: Advancing Integrated Mental Health Solutions
ARNP: Advanced Registered Nurse Practitioner
BH: Behavioral Health
BHA: Behavioral Health Agencies
CCBHC: Certified Community Behavioral Health Centers
CHW: Community Health Worker
CMS: Centers for Medicare and Medicaid Services
CoCM: Collaborative Care Model
CPT: Current Procedural Terminology
DOH: Department of Health
FQHC: Federally Qualified Health Center
HCA: Health Care Authority
MCO: Managed Care Organization
MH: Mental Health
RCW: Revised Code of Washington
RUBI: Research Units In Behavioral Intervention
WSMA: Washington State Medical Association
UW: University of Washington

## Meeting Topics

Presentation: WSMA State Plan Assessment proposal, Alex Wehinger (WSMA)
Presentation: Medicaid:Medicare parity, Heather White, MPH student
Discussion of BHI priorities to-date and initial prioritization

## Discussion Summary

### WSMA State Plan Assessment Proposal

1. The presentation on the 2025 WSMA Medicaid campaign included the following (refer to slides for more details):
    a. Background information on patient access, proposed rates increases, discussion of workforce, and historical rates flucuations. This included:
        i. The need to increase rates to boost patient access and account for the increase in Medicaid enrollment.

ii. The impact a rates increase would have on the health care workforce to cover the costs of providing care and increase independent practice viability.
iii. A historical overview of rates over time, including the Affordable Care Act (ACA) primary care Medicaid increase through 2015, followed by Washington state legislature's 2021 and 2023 investments for specific service categories.

b. WSMA's ask to increase Medicaid rates up to the Medicare floor, including:
   i. Across the board increases, for both primary care and speciality services.
   ii. An inflation adjustment.
   iii. An annual cost of $400-500 million.
   iv. The legislative response – to bring a dedicated revenue source to achieve the proposed increases.

c. WSMA's Medicaid Access Program, including:
   i. Rate increases funded via "covered lives assessment," which is a safety net assessment that leverages funding from the federal government to support investments in the state's Medicaid program.
   ii. The proposal applies to insurance carriers based on their enrollment, and applies to managed care organizations (MCOs) and state-regulated commercial health plans, but not self-insured plans.
   iii. The differential rate, based on federal requirements that the plan apply to Medicaid and commercial insurance:
      1. $18 per member/per month (pm/pm) for Medicaid MCOs.
      2. 50 cents pm/pm for commerical insurance carriers.

d. Frequently Asked Questions (FAQs):
   i. Other states with similar policies to those outlined in WSMA's proposal: Illinois, California, and New York.
   ii. The experience in 2024:
      1. There has been a lot of support from the hospital community, patient groups and healthcare providers, but pushback from the commercial insurance side and questions from state agencies.
      2. WSMA has spent their interim learning more about their proposal and working with agencies to incorporate feedback – the bones of the proposal from 2024 to 2025 will be very similar.

2. Discussion following the presentation included the following topics:
   a. The proposal applies to Medicaid rates for professional services – Medicaid codes commonly billed by physicians, physician assistants and Advanced Registered Nurse Practitioners (ARNPs).
      i. This applies to services provided by mental health (MH) professionals, including 30 and 60 minute psychotherapy sessions, counseling, and family therapy.
   b. This proposal would impact private practice MH providers, and MH providers within primary care who bill for MH counseling.
   c. The proposal does not apply to certified community behavioral health centers (CCBHCs) or Federally Qualified Health Centers (FQHCs) unless those centers bill for psychotherapy independently.

## Medicaid: Medicare Parity

1. The presentation on assessing the impact of raising Medicaid rates for youth mental health access included the following (refer to slides for more details):
    a. A project overview – the purpose being to understand if an increase in Medicaid rates for MH counseling to parity with Medicare would impact access to MH care for youth, and how it could impact clinics.
    b. A summary of Heather's 9 stakeholder interviews, whose concerns included the following:
        i. Inaccessibility of MH services for youth.
        ii. Increased demand for MH providers.
        iii. Overwhelmed healthcare workers.
        iv. Previously unsuccessful rate increases.
        v. High provider turnover.
        vi. The importance of training.
        vii. Burdensome paperwork.
        viii. Medicaid isn't attractive to some providers and practices when patients are able to pay more out of pocket.
    c. Description of a brief SurveyMonkey survey that was distributed to all stakeholders and hundreds of people working in primary care, mental health agencies and private practice mental health., and a summary of results, including the following:
        i. For those in primary care and community health centers:
            1. 93% of these respondents provided MH services to children and youth insured on Medicaid.
            2. 91% of those accepting Medicaid said a 30% rate increase would allow them to serve more children and youth.
            3. 95% of those polled said a rate increase would help address unmet MH needs in their community.
        ii. For those in private practice and the "other" MH provider population:
            1. Only 59% of respondents accept patients on Medicaid.
            2. Of those who don't take Medicaid, 69% reported that a 30% rate increase would allow them to start serving children and youth on Medicaid.
    d. Examples of responses to the open-ended questions in the survey, which revealed some of the following:
        i. Some providers don't take Medicaid due to low reimbursement rates in Washington.
        ii. Paperwork for government funded insurance is too extensive.
        iii. A 30% rate increase would allow practices to continue providing services for those in need, and would allow more recruitment and retention of providers, as well as larger populations of patients to be served.
    e. Conclusions and Steps forward, which include the overarching takeaway that Medicaid: Medicare parity would improve access to MH care for children and youth.
        i. Additionally, it is crucial that the Health Care Authority (HCA) ensures all qualifying providers and clinics receive any proposed rate increase.

ii. Legislation to streamline paperwork and reduce administrative burdens would be helpful, as well as looking at other opportunities to examine school-based MH services and providing incentives for those who accept Medicaid.

2. Discussion following the presentation included the following topics:
    a. Integration of behavioral health into primary care – everyone interviewed was interested in integration, if they weren't already part of it.
    b. Partnering with schools and thinking about how to incent payment to drive integration of care between the schools, Behavioral Health Agencies (BHAs) and primary care.
    c. The Current Procedural Terminology (CPT) codes that would be impacted by the WSMA rate increase proposal.
    d. The funding of the rate increase – there will be some upfront costs associated with getting the program running, but over time it won't require a state contribution due to the health plans' contribution and the federal government match.
    e. Concerns about workforce shifts due to incentivization of codes in one area versus another (such as private practice versus community or primary care).

## Discussion of BHI priorities to-date and initial prioritization

1. A main issue this subgroup is discussing is providing support when a child is exhibiting behavioral health (BH) symptoms and needs support but does not have a diagnosis.
    a. There are capacity challenges for PCPs to provide extended visits or extra support.
    b. There are new extended codes to allow for more payment for more time, but these are prohibitive because you must reach 60 minutes to bill these codes.
    c. Another gap is how providers can navigate the initial steps of connecting with a family to provide care.
        i. Providers can feel like their hands are tied in making sure diagnostic and assessments components are done, when instead they could engage a family and utilize community health workers (CHWs) to provide a decent treatment package without the need for long psychosocial assessments first.
        ii. There is a lack of understanding in pediatrics for what is required to bill the collaborative care code.
            1. The billing that was set up for HCA is based on what the Advancing Integrated Mental Health Solutions (AIMS) Center said were required elements of the collaborative care model (CoCM), based on their research.
                a. AIMS Center said their work does not include strong evidence for those under the age of 13 – it is an adult model that has shown evidence for adolescents.
                b. There needs to be more conversation surrounding what is needed to support children and youth under age 13 – whether it is using these AIMS treatment codes and models or evaluating the service gap for people who don't yet require MH treatment.

        c. The CoCM was designed to be used after a diagnosis was already made, not as a prevention-oriented model.
    2. The rules are a negotiated agreement between HCA and Centers for Medicare and Medicaid Services (CMS), and any changes in rules have to be put forth in administrative code and renegotiated with CMS.
        a. There are numerous institutions and agencies who oversee the requirements and codes, depending on the provider institution – from CMS to the state Revised Code of Washington (RCW), to Department of Health (DOH), and the CPT codes, as well as professional standards for clinicians surrounding assessment and diagnosis.
    3. How can we look at the different types of models and rewrite the process so that it is more effective for pediatric patients?
        a. A model from Minnesota that could be helpful in this discussion.
- d. What are potential fixes for providing coaching and support without assessment?
    i. Anything that can be done upstream saves money – providing care before the needs and costs get higher and more complex.
- e. Viable recommendations need to be proposed by August 28th, but the particular ask can be refined until the first week of October.
    i. The goal: Identify ways for MH providers to serve children as early as possible with evidence informed interventions prior to necessitating a diagnosis.
    ii. If there are potential proposed solutions (even without a defined ask), such as provider trainings or billing codes, this could be put in as a recommendation that can be refined.
        1. Perhaps the group can put forward the broad concept and then ask for funding for HCA or a contracted entity to work on this?

2. Potential recommendations from BHI Subgroup:
    a. Continue and sustain pediatric CHWs.
    b. Medicaid: Medicare parity for MH professional fees.
    c. Ability to serve / support the youngest children who have behavioral needs with MH professionals in primary care without diagnosis (if diagnosis is not yet needed/merited).
    d. Research Units In Behavioral Intervention (RUBI) ask, which involves:
        i. Payment to help and assist training for all primary care behavioral health providers in primary care clinics in Washington state.
3. A survey will be sent out to ask about prioritization from the group.

## Look Ahead: 24/25 Schedule

Next Meeting: August 27, 10AM-11AM

# Assessing the Impact of Raising Medicaid Rates for Youth Mental Health Access

# The Challenge & Project Overview

Understand if an increase in Medicaid rates for mental heath counseling to parity with Medicare, would impact access to mental health care for youth, and how it could impact clinics.

- Determine the rate difference between Medicaid and Medicare
- Talk with stakeholders to gather insight on barriers and potential impact
- Assesses potential impact via survey

# Stakeholder Concerns

**9 Interviews Conducted with:**

-Primary Care Providers
-Child Advocates
-Mental Health Agencies
-Mental Health Counselors
-Psychiatrists

- Inaccessibility: mental health care services for youth are hard to access
- Demand: increased need for mental health professionals
- Overwhelmed: healthcare providers feel powerless
- Previously unsuccessful: prior rate increases have not been passed down or benefitted providers
- Turnover: high degree of provider loss
- Training: importance of long-term hiring and teaching
- Paperwork: burdensome for coverage initiation
- Medicaid isn't attractive when people are able to pay more out of pocket

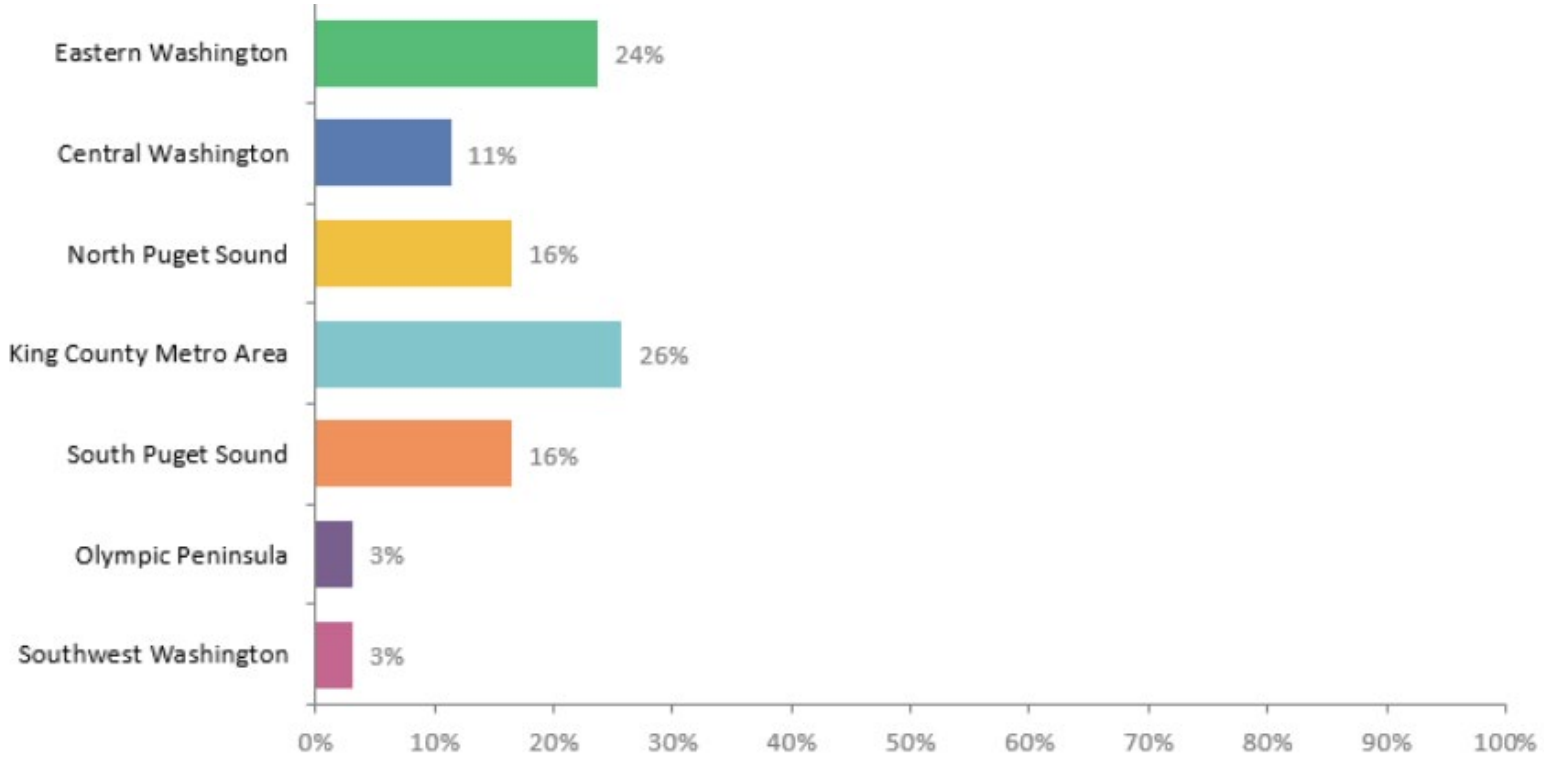
# Survey Structure

- Brief Survey Monkey assessment including 15 questions and 3 open-ended requests
- Distributed to hundreds of people over 4 weeks
  - Primary care
  - Mental health agencies
  - Private practice mental health
- 123 people in total responded
- Responses representative of Washington state

# Washington State Representation

Locations of survey respondents within Washington State

n=97



# Survey Architecture

Primary Care

Community-Based Behavioral Health Centers

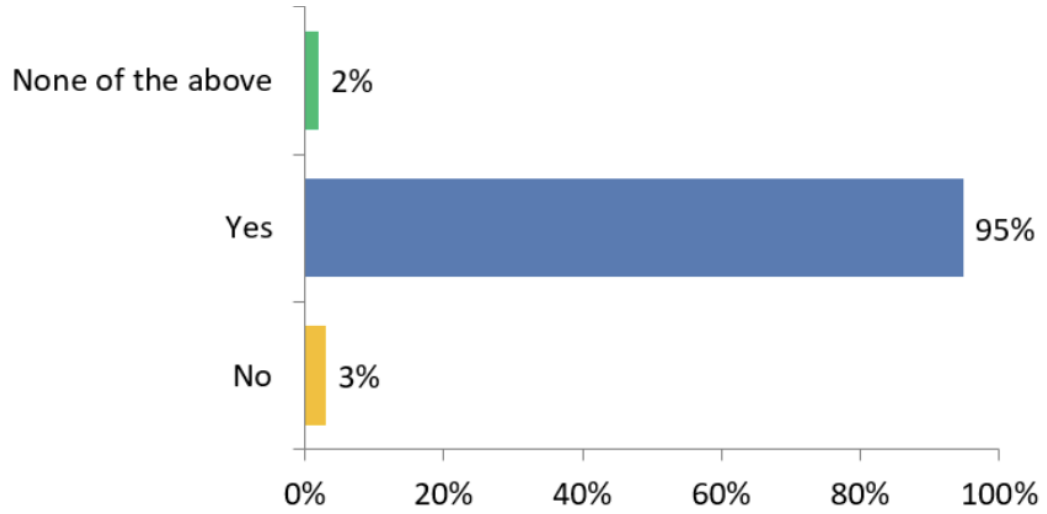
Private practice mental health professionals

Mental health “other”

# Primary Care & Community Health Agencies

- 74% of respondents
- 93% provided mental health services to children & youth insured on Medicaid
- Nearly half of clinics reported 51% or more of their patients insured on Medicaid
- 91% of those accepting Medicaid would serve more youth with a 30% rate increase
- 95% believed a rate increase would address unmet community needs
- 85% would expand services or hire additional staff with a rate increase
- 87% said an increase would impact the clinic's financial stability either 'very or somewhat significantly'

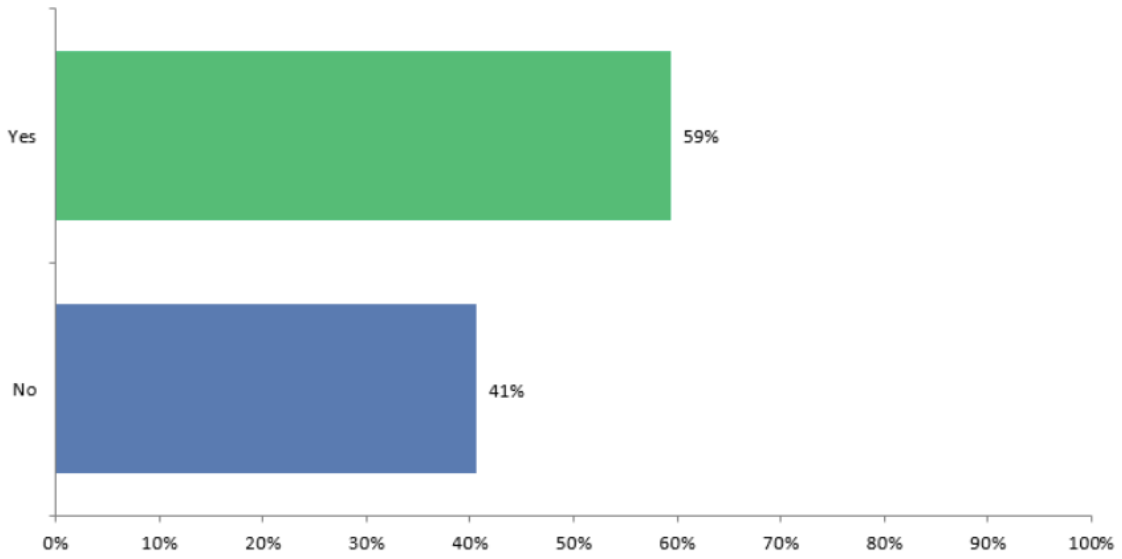
Would a rate increase help address unmet mental health needs in your community?
n=97



# Private Practice Providers & Mental Health "Other"

- 26% of survey respondents
- **Only 59% accept patients on Medicaid**
  (compared to 91% in primary care/BH Center)
  - 28% serve 20% or less on Medicaid
  - 39% serve 21-50% on Medicaid
  - 33% serve over 50% on Medicaid
- Of those that don't take Medicaid, 69% reported that a 30% increase would allow them to start servicing children and youth on Medicaid

Do you currently accept patients on Medicaid?
n=32



# Comments from Private Practice Providers & Mental Health "other"

If you don't take Medicaid what is the reason?

- "We accept Oregon Medicaid, but not Washington Medicaid due to the extremely low reimbursement rates"
- "The paperwork for government funded insurance is extensive and takes away from my cognitive and emotional availability for attending to clients."

What would allow you to start serving children & youth insured on Medicaid?

- "Simple credentialing and billing process"
- "Better rates and easier process "
- "Increased pay and easier documentation standards with fewer audits that eat at profits"

# Comments from all groups

**Would a 30% Medicaid rate increase have other impacts on your practice?**

## *Recruit*

- "I would strongly consider taking on another fulltime provider - doubling my patient care capacity."
- "It would allow more accessibility to a highly skilled therapist. "
- "It would enable hiring of a second therapist and enable dedicated support staff for scheduling , follow up and transition to community therapy"

## *Retain*

- "We would be able to recruit, train and retain quality therapist."
- "Since we have lower reimbursement and a high number Medicaid, we have less finances to keep competitive and offer prospective provider applicants"
- "Retention of seasoned counselors and therapists"

## *Serve*

- "We would be better able to serve the mental health needs of our community and hire more providers which are desperately needed in our community."
- "Yes, we could actually see more people. As it is, we fit in a few here and there, but I lose money on all of them
- "Allow me to see more Medicaid patients"

"We are struggling financially, and we plan to decrease the number of Medicaid Medicare clients as we are having challenges staying in business. If an increase would come, we would be able to continue to provide services for the ones in need"

# Conclusion & Steps Forward

- Medicaid: Medicare parity would improve access
- The Health Care Authority must ensure all qualifying providers and clinics receive any proposed rate increase
- Legislation to streamline paperwork and reduce administrative burdens
- Other opportunities:
  - Examining school-based mental health services
  - Incentives for those taking Medicaid

# Thank you

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