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

August 27, 2024

Glossary of Terms

BHI: Behavioral Health Integration
CHW: Community Health Worker
DC: 0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood
DCYF: Department of Children Youth and Families
CMS: Centers for Medicare and Medicaid Services
HCA: WA Health Care Authority
IDD: Intellectual and Development Disability
MH: Mental Health
RUBI: Research Units In Behavioral Intervention
UCSF: University of California, San Francisco
WAC: Washington Administrative Code

Meeting Topics

Discussion of proposed BHI recommendations
Learnings from Minnesota's diagnostic assessments, Martha Aby (HCA)
Discussion of preliminary prioritization results & next steps

Discussion Summary

Discussion of proposed BHI recommendations

Recommendation topics and supporting discussion, listed below in the order in which they were discussed. Please see previous meetings' notes for more extensive background details for each issue.

1. Recommendation: Implement a health plan assessment to fund Medicaid mental health counseling "professional fees" at Medicare rates.
    a. This will primarily impact primary care and private practice clinics, but there are some outliers in the community mental health (MH) sector who would be impacted, such as HopeSparks.
    b. The important takeaways from this proposal:
        i. More clinics would bill behavioral health integration (BHI) for kids that do not have it today.
        ii. Clinics that already have BHI would have another financially-viable tool in their toolkit besides collaborative care.

iii. Some private practices would open their panels to Medicaid who are not currently open to Medicaid.

c. There have been questions regarding tensions between the different sectors, and fear that community health could suffer due to this policy, but Q&A clarified the policy will impact ability to deliver care, not necessarily the pay, for behavioral health (BH) professionals in primary care.

d. Discussion of this item including the following:

i. The percentage of this increase that would impact Medicaid and Medicare versus private practice:

1. There was a survey of private practices, and the majority of those who responded who do not accept Medicaid said they would be interested in taking Medicaid patients with a rate increase.
2. The impression is that this wouldn't impact a large number of patients in private practice, but it would make it more viable to serve patients on Medicaid.

2. Recommendation: Allow mental health professionals to provide BH supports to children and teens who may present with symptoms that do not merit a diagnosis.

a. There has been partnership with HCA to move this item forward.

b. This is not a fully-fledged recommendation at this point, but the subgroup wants to progress this issue sooner rather than later.

c. See the notes from "Learnings from Minnesota's diagnostic assessments" below, as well as notes from next meeting's presentation from University of California, San Franciso (UCSF) for more information about how other states are handling this topic.

d. The current recommendation is to develop a recommendation once we learn more about the possibilities for allowing evidence-based early childhood services to be delivered without the need for a diagnosis.

e. Discussion of this item including the following:

i. Looking at the other states' models will be essential to use as a foundation for Washington's model.

ii. It could be beneficial to look into previous programs to provide historical context for delivering this kind of care in Washington.

1. Home Visiting Service Account | Washington State Department of Children, Youth, and Families
2. Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program | MCHB (hrsa.gov)

iii. Clarification regarding where this recommendation fits into the care pipeline in pediatrics.

1. Typically a physician makes a diagnosis, and then collaborates with organizations or agencies to address delays or behaviors.
2. The purpose of this recommendation is to get ahead of diagnoses – by MH professionals providing bridge services in primary care, parent coaching and skills or tools, without requiring a full assessment and diagnosis.

a. This also relates to building and strengthening relationships between providers and families.

iv. Discussion of barriers in the current care model:
    1. To access a MH professional, that MH professional is required to do a full assessment prior to starting any care, even if there is already a diagnosis from the medical doctor (MD).
    2. Community Health Workers (CHWs) can provide the same educational, evidence-based model of care as a licensed clinician, but without the barriers.
        a. Why are there barriers to get to the licensed professional, and how can we break these down?
    3. Why does a MH professional need a full assessment on a child to help families, if the MD already did an assessment and the MH professional can view these records?
        a. In the collaborative care model, the MD, MH professional, CHWs and parents should all be working together.

v. Other models, such as a flexible primary care behavioral health program:
    1. In this environment, warm handoffs are used to bring in a BH consultant into visits with the primary care provider (PCP), child and family.
        a. The BH consultant provides a brief intervention and assessment – looking at the presenting need and barriers, performing a risk assessment, and treatment recommendations in around 30 minutes.
        b. This may still require a diagnosis.
    2. Perhaps it is less important to be attached to the idea that there should not be a diagnosis, and more important to talk about different ways to provide this kind of service.

vi. It is important to normalize diagnoses for parents, and avoid pathologizing.

3. Recommendation: Ensure Pediatric Community Health Workers (CHWs) are a sustained and viable workforce for patients insured on Medicaid through WA State seeking adequate Medicaid rates from CMS.
    a. As the state plan amendment moves forward for CHWs to be a Medicaid benefit, we want to ensure that the rates our state seeks are the highest possible allowable to ensure their salaries are viable in the future.
    b. This is a legacy item and the co-chairs of the work group are meeting to determine the pathway for putting forward and voting on legacy items this year.
        a. Legacy items will likely be viewed as a separate entity from new recommendations, and voted on as a consensus.
4. Recommendation: Research Units In Behavioral Intervention (RUBI) parent training program pilot expansion.
    a. The goal of this recommendation is to elevate care within primary care settings and train frontline providers in the RUBI intervention in how to effectively support autistic and intellectual and development disability (IDD) youth.
        i. There is data to suggest that non-specialists can also be effectively trained in RUBI as well.
    b. This proposal is to run a pilot program where particular sites are targeted to implement RUBI.

   i. There is versatility in the pilot for how this gets implemented, depending on the location and provider options in the clinics.
   ii. It is also important to make sure sites implement the workflows for RUBI to suceed.

Learnings from Minnesota's diagnostic assessments

1. Minnesota's Diagnostic Assessments for Mental Health Services
2. Minnesota has 3 types of diagnostic assessments:
   a. Brief:
      i. Authorizes someone for 10 sessions with a provisional diagnostic.
   b. Standard:
      i. This is considered the "normal rules of the game."
      ii. Allows one to be able to do a year's worth of outpatient psychotherapy or any type of service.
      iii. Each person is eligible for 4 diagnostics per year.
   c. Extended:
      i. Involves at least 3 sessions of gathering data for a complex diagnostic picture.
      ii. Might be for someone who has been given variable diagnoses and their records require more review, or someone who has to go through an interpreter and take more time for the diagnostic process.
      iii. Gets paid at a higher rate.
3. Paperwork requirements in Minnesota are substantially larger than in Washington.
   a. A diagnostic assessment template may be a combination of different insurance providers' requirements, or other funding sources and regulations.
4. Diagnostic assessments are used to submit a claim to Medicaid and determine medical eligibility for a service.
5. Minnesota has been very proactive in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) space.
   a. There is a strong desire to go through the diagnostic process to come up with a clinical formulation to support ongoing care.
   b. There are many other types of funding for that type of work, such as through the Department of Children Youth and Families (DCYF) or grant opportunities.
   c. Because Medicaid is health insurance - you need to follow the rules to have a diagnostic or provisional diagnosis in order to bill Medicaid.
6. Medicaid:
   a. Medicaid is part state funding and part federal funding.
      i. In Washington and Minnesota, it is split about 50/50.
      ii. In other states, there is a higher share of federal versus state funding.
   b. In order to get something as part of the Medicaid benefit set, Washington needs to get it passed by the legislature and then agreed to by Centers for Medicare and Medicaid Services (CMS).
      i. CMS is only willing to pay for certain things.
      ii. There is a negotiated agreement on what gets put in the state plan and what can be part of the Medicaid benefit set in the state.

7. Discussion during the presentation included the following:
    a. The collaborative care model where the assessment starts at the MD:
        i. In Washington, MH providers are being asked to gather information from school and parents, to do an assessment to help determine a diagnosis or other factors; and in order to bill for this, they must have a diagnosis first.
        ii. The BHI subgroup is trying to figure out how to provide services to families prior to diagnosis, and to help prevent a diagnosis, working within the collaborative care model.
            1. The crux of the issue is: are these kinds of services Medicaid billable?
    b. In Washington, people have worked hard to decrease documentation.
        i. This doesn't mean assessment information is being skipped - assessment is critical, but staff can be given guidance on assessment without having to put everything into the chart.
            1. The concern from a compliance perspective, is that there is then no record to be able to bill Medicaid.
            2. Having so much assessment required at the front end impacts the workforce and families, and leads families to go to private practice, where they can get help faster.
                a. Updating the Washington Administrative Codes (WACs) has been helpful, and people don't want to go back to how it was before that process.
        ii. It is unclear if CMS would allow Washington to require less documentation or assessment than the current requirements.

Discussion of preliminary prioritization results & next steps

1. Prioritization survey results:
    a. *Legacy items:*
        i Sustaining and scaling pediatric CHWs (#1)
        ii Ensure social determinants of health assessment and supports (#2)
    b. *New items:*
        i Support for Medicaid: Medicare parity (#3)
        ii Serving children without a diagnosis (#4)
        iii RUBI training (#5)
2. Everyone agrees with moving legacy items forward.
3. Discussion about the three new recommendation items:
    a. RUBI came in last, but is a smaller ask so it might be more feasible than the others.
        i RUBI has been very useful in the clinics where it has already been implemented.
    b. Serving children without a diagnosis:
        i Considerations about changing the title of the "Serving children without a diagnosis" to make it more positive.
        i It is a MH provider's task to gather information and move towards a diagnosis, but to bill currently, the MH provider needs a diagnosis first.
        ii The subgroup will need to figure out the funding structure, because CMS requires a diagnosis, but there is not much Washington state-only funding available at this time.

    1. Looking to the California approach
    2. HCA is interested in helping the subgroup solve this problem.
4. The group will plan to move forward all three new recommendations.
5. The group can continue to seek clarity and refinement until session as long as it does not stray too far from what is voted on by the Work Group.