Notes

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

September 24, 2024

Glossary of Terms

ABA: Applied Behavior Analysis
ASD: Autism Spectrum Disorder
CHW: Community Health Worker
CMS: Centers for Medicare & Medicaid Services
CPT: Current Procedural Terminology
CYBHWG: Children and Youth Behavioral Health Work Group
DOH: Washington Department of Health
FQHC: Federally Qualified Health Center
HCA: WA Health Care Authority
IDD: Intellectual and Developmental Disabilities
MH: Mental Health
RUBI: Research Units In Behavioral Intervention
NSMH: Non-Specialty Mental Health
SPA: State Plan Amendment
UCSF: University of California, San Francisco
YYACC: Youth and Young Adult Continuum of Care

Meeting Topics

Discussion of the state plan amendment for Community Health Workers (CHWs)
Recap of what's been learned from University of California, San Francisco (UCSF)
Discussion & refinement of 2025 BHI recommendations
Final prioritization survey & discussion

Discussion Summary

Discussion of the state plan amendment for Community Health Workers (CHWs)

1. The draft state plan amendment (SPA) for CHWs to be a Medicaid benefit is available for public comment.
2. If you want to read and comment on the SPA, it needs to be requested:
    a. Email this address HCACHWGrant@hca.wa.gov to request the draft.
    b. Comments are due Sept 30th – if you would like to comment, you should make your request as soon as possible (ASAP).
3. The Health Care Authority (HCA) applies to the Centers for Medicare & Medicaid Services (CMS) to have a new Medicaid benefit (for CHWs in this case).
4. Initial observations on the SPA:

a. The definitions of the services and description of the CHW role in the SPA focus on the following:
    i. Preventing disease and/or progression of disease.
    ii. Promoting treatment goals.
    iii. Ensuring that consideration of psychosocial strength and needs are part of how the CHW supports the family and team.
    iv. Ensuring the CHW helps ensure families preferences are met.
    v. Ensuring that cultural and linguistic needs are met.
    vi. There is a section about care coordination and health system navigation.
    vii. There is a section about facilitating social and emotional support.
    viii. There is a section about health education and advocacy.
b. Concerns arise in the following areas:
    i. The CHWs in this draft proposal would need to be supervised by a licensed practitioner.
        1. Many CHWs are not supervised by a licensed provider.
            a. Interest in asking partners if there is a sense of how many CHWs are being supported by a clinic manager, for example, and not a clinician.
        2. There is the threshold of 2,000 supervised hours under the supervision of a license, which presents some challenges for how clinics are structured.
    ii. The training, supervision and skills described in this document must be met within 18 months of employment.
        1. The training needs to be within the Department of Health (DOH) or another trainer that attests to the competencies described above.
        2. Are the existing learning collaboratives that are underway, or initatives led by Akin, attested to as training to satisfy these requirements?
        3. Challenges with the 18-month requirement
            a. Some folks have been employed now for 18 months already, and by the time this is enacted, they will not have had this sort of information, warning, guidance of what they needed to accomplish.

5. Discussion surrounding this topic included the following:
    a. The length of time required to be supervised before any reimbursement is possible is a concern:
        i. Likelihood of employment without pay is low.
        ii. Need to ensure service is billable for this before all the qualifications are met, to be able to cover salaries.
    b. Requirements for initial training:
        i. DOH has an online training for CHWs, that covers foundational components that you would expect for CHWs.
        ii. Pediatric content will start being available in the Fall.
        iii. There has been some concern about having ample capacity within those trainings.
    c. The desire to have CHWs have regular case-based time with doctors, nurses or mental health (MH) professionals every week.

Recap of what's been learned from University of California, San Francisco (UCSF)

1. California's dyadic benefit:
    a. Licensed MH professionals in California may bill for supportive services to families in the first years of life that will help their social, financial wellbeing, as well as parents, MH and relational health at the dyad.
2. HCA staff looked at the codes that California shared with us and cross walked them with Washington state codes:
    a. Federally qualified health centers (FQHCs) and community MH centers can bill the codes that California is billing at this time.
    b. The gap exists for more traditional medical centers (that are not FQHCs) to be able to do so.
3. There is some concern about licensed MH professionals being the only people who can support social and financial wellbeing and parents' access to MH care in the first years of life, given the paucity of workforce in that space.
4. The LA FQHCs reported that they struggle to find folks to fill these roles who are licensed and would prefer to have non-MH professionals deliver these services.
    a. There are people in the subgroup who share the idea that this need to be licensed MH professional supporting this dyadic.
5. Discussion surrounding this item included the following:
    a. Is there desire to have the legislature ask the HCA to work with this subgroup to develop a dyadic?
        i. This will take conversations with trusted partners.
    b. The definition of "dyadic benefit" – preventative behavioral health supports without the need for diagnosis.
    c. Given the shortage of MH professionals in WA state, and that these benefits are in the preventive space (rather than clinical), the subgroup will need to determine if these professionals need to be licensed MH professionals.
    d. Non-Specialty Mental Health (NSMH) for Outpatient Services Codes
    e. Important update – Current Procedural Terminology (CPT) code 99494 is now a billable service on Medicaid.
        i. CPT code 99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.
        ii. This used to be billable 2 times per month, and is now billable 4 times per month.

Discussion & refinement of 2025 BHI recommendations

1. Legacy item: Sustaining and scaling pediatric CHWs
    a. This recommendation is to ensure rates for CHWs under the Medicaid benefit are viable to employ CHWs at an appropriate wage.
    b. Considering the definition of overarching items that came out of the Children and Youth Behavioral Health Work Group (CYBHWG), the subgroup leads are considering if this item should be overarching.
        i. It has support of the work group, has been a top priority of the work group, has legislative support, and just needs additional funding.
    c. Discussion surrounding this item included the following:

i. This benefit is translated into funding a CHW through a billable code.
    1. CMS published a Medicare rate and new code for CHWs in November.
    2. The bill for patient-facing time needs to be adequate that when you add everything up, it can employ someone.
ii. This will be presented to the co-chairs by support staff as a potential overarching item, but regardless, will be going forward as a legacy item from this subgroup.
iii. There is not a specific number of items that can be overarching

2. New item: Support for Medicaid: Medicare parity
    a. This recommendation seeks a health plan assessment whereby Medicaid managed care plans and commercial plans put up money to demonstrate state investment in Medicaid that then draws down a significant federal match.
        i. This raises professional fees on Medicaid to Medicare rates for MH counseling and PCP services for MH, at about a 30% increase.
    b. Since this has been proposed, subgroup leads have subsequently learned that the pediatric primary care rates that were instituted in 2021, have now dropped about 4%.
        i. This proposal would raise primary care rates back up to Medicare rates.
    c. This would make a difference for MH providers in primary care but would not make a difference for most community MH centers, besides HopeSparks (which is unique).
    d. Subgroup leads don't anticipate that primary care clinics will suddenly be offering higher salaries than they are now, this just allows more primary care clinics to have behavioral health integration.
    e. Discussion surrounding this item included the following:
        ii. This proposal is very broad and happens to make a big difference for MH rates or MH services that a PCP might provide.
            1. It would also impact specialty care, primary care, and MH care.
        iii. This proposal brings in federal funds rather than necessitating significant state funds, in a year when state funds are limited.
            1. State Medicaid managed care plans will put up $18 per member per month (pm/pm) and commercial plans will put up 75 cents pm/pm to demonstrate to the federal government that they are investing in the system.
                a. Medicaid managed care plans get paid back due to the federal match, while commercial plans do not.
        iv. There are clinics providing collaborative care and they are reimbursed higher for collaborative care, so aren't currently providing therapy with these traditional psychotherapy codes.
            1. This proposal would put these codes back as an option for the clinics to use.
3. New item: Serving children prior to a diagnosis
    a. This recommendation is now to direct HCA to work with this subgroup to develop a dyadic benefit.
    b. See above notes from the recap of what's been learned from UCSF.
4. New item: Research Units In Behavioral Intervention (RUBI) training
    a. This recommendation is for $250k to support a pilot for the expansion of RUBI to 10 clinics, to train in RUBI and integrate approach into workflow.
    b. RUBI serves parents and caregivers of children with intellectual and developmental delays.
        i. In WA state we have a shortage of providers across the board that are serving this population.
        ii. RUBI allows for the earliest intervention for these families in the pediatric primary care setting.

iii. This benefit requires a provisional diagnosis, while Applied Behavior Analysis (ABA) requires a Centers of Excellence diagnosis and requires long waitlists.

c. The Youth and Young Adult Continuum of Care (YYACC) subgroup is supportive of this pathway and are putting forward a recommendation around supporting the Autism Spectrum Disorder (ASD)/Intellectual and Developmental Disabilities (IDD) workforce serving children 0-18 years old.
   i. Mary Bridge experiences waitlists for 1 year for children 0-3 years old; and up to 2 years for older children.
   ii. RUBI is a pathway to provide interim skill building to help parents and children before they are able to receive care.
   iii. Hopes to address these gaps in a wraparound with both recommendations if they are prioritized.

d. Discussion surrounding this item included the following:
   i. RUBI is a pretty intensive program for integrated primary care settings; however, this model has been adapted to different settings.
      1. Molina has supported this going into primary care settings for the past 2-3 years.
      2. In the primary care setting, families and care teams learn about all 12 sessions, but the program is implemented with the caregiver or family however they want and need it to be for that specific child.
   ii. Primary care providers are overburdened and adding something more to their plate could be challenging, unless it is adapted in a simple way for them.
      1. RUBI can qualify for continuing education requirements.
   iii. It has been challenging to report data on how RUBI has been working in integrated primary care settings, due to requirements to report an evidence-based practice, whose codes don't align with these clinics.
      1. Molina is working with HCA to make it easier for practices to submit the evidence-based practice codes, which will make it easier to track RUBI in these settings.

5. General discussion about the recommendations included the following:
   a. There is no formal cap on the number of recommendations – each subgroup gets at least one recommendation included in the final slate adopted by the full work group.
   b. The reason we prioritize is to give the work group an idea of what is emerging as top priority for the group.

Final prioritization survey & discussion

1. Prioritization of new items (current ranking):
   a. 1 - Health Plan Assessment (Medicaid: Medicare parity)
   b. 2 - Dyadic benefit (Serving children prior to a diagnosis)
   c. 3 - RUBI expansion
2. Timeline: Final submissions are due by October 1st.
   a. The subgroup leads will update the language for the dyadic benefit recommendation today, then support staff will send out the packet of draft recommendations for voting.