Children and Youth Behavioral Health Work Group – Prenatal through Five Relational Health (P5RH) Subgroup

September 25, 2024

Glossary of Terms

CMS: Centers for Medicare & Medicaid Services
CPS: Child Protective Services
DCYF: Department of Children, Youth, and Families
ECEAP: Early Childhood Education and Assistance Program
ESIT: Early Support or Infants and Toddlers
FMAP: Federal Medical Assistance Percentage
HCA: Health Care Authority
IECMH: Infant and Early Childhood Mental Health
IECMH-C: Infant and Early Childhood Mental Health Consultation
NICU: Neonative Intensive Care Unit
MHAYC: Mental Health Assessment For Young Children
MHC: Mental Health Counselor
MSS: Maternity Support Services
UW: University of Washington
WISe: Wraparound with Intensive Services

Meeting Topics

Legacy Recommendations Presentations and Prioritization
New IRecommendations Presentations and Prioritization
Group Discussion of Prioritization Results & Consensus for Advancement

Discussion Summary

Legacy Recommendations Presentations and Prioritization

1. Legacy recommendations of the P5RH subgroup are those which
    a. Have been generated by the subgroup and had success in the legislature in previous years
    b. Are categorized as such to inform the legislature that these items are really effective, there is high demand, this subgroup recognizes their value, and this is a continued opportunity to invest more effort and capital to sustain the ongoing work.
2. **Investment in Infant and Early Childhood Mental Health Consultation (IECMH-C)**
    a. There was increased investment in the Holding Hope program last year and they are in the process of hiring new consultants across the state.
    b. When the program is fully staffed with a team of 25 people, they will be able to serve around 4% of the 6,000 licensed providers across the state at any given point in time, given caseloads.

        i. The goal is to get to serving 10% of providers at any given point in time.
    c. Holding Hope is dedicated to supporting mental health consultants (MHCs) in child care settings; since a lot of childcare settings are blended funding with Early Childhood Education and Assistance Program (ECEAP) and Head Start across the state, Holding Hope is getting multiple requests from ECEAP providers who have had difficulty locating MHCs to provide the services for them, resulting in consultants serving blended roles for childcare and ECEAP sites.
        i. An area of growth for Holding Hope is to have a coordinated and consistent approach for mental health consultation.
    d. The program has an increasing capactiy to serve Spanish speaking providers, with a diverse team to deliver culturally-sensitive services.
    e. Discussion surrounding this item included the following:
        i. ECEAP and Head Start have their own funding for MHCs; however, often there aren't any MHCs to hire.
            1. It is extremely common for both ECEAP and Head Start providers to contract with local mental and behavioral health agencies to provide those services.
            2. There is also a referral process for kids and/or families who require more care to reach out to local providers for help.
            3. In Eastern Washington, ECEAP contracts with the consultants who work for community minded enterprises, and they have blended ECEAP and holding hope caseloads and funding.

3. **Early ECEAP Slots**
    a. The state has different kinds of zero to three programs – Early ECEAP is a center-based program that combines the mental and behavioral health pieces and the two-generation approach with early learning.
    b. We are waiting to hear from the Department of Children, Youth, and Families (DCYF) regarding their potential expansion of Early ECEAP, which may be another avenue to serve these families.
    c. This program is primarily focused on families in childcare desserts and connected with Child Protective Services (CPS) or experiencing homelessness.
        i. There are a lot of programs colocated with the Therapeutic Child Care Exclipse or situated within transitional housing.
    d. The ask is for 200 additional slots.
        i. If the state grant for 75 slots goes through from the Federal government, that would allow the ask to be reduce to 125 slots, which is much cheaper.

4. **Complex Needs Funds**
    a. This was put in place for ECEAP a few years ago due to needs in classroom to hire an extra person, get equipment for special needs, to hire someone to do training for developmental disabilities, depending on the needs of the program.
        i. This subgroup took on adding complex needs funds to child care.
    b. The ask is to maintain the same level of funding from the last biennium.
        i. The ask was adjusted to cover only the amount not included in maintenance - $5.5 million.

5. **Legacy priority order vote:**
    a. Increasing IECMH is clearly the #1 priority.
    b. Complex needs funds appears to be #2.
    c. Early ECEAP slots appears to be #3.

New Item Issue Leads Presentations and Prioritization

Recommendations 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. **Family therapy reimbursement rate**
    a. There are two significant areas for reimbursement disparities being addressed in recommendations this year:
        i. The disparity between reimbursement rates by funding stream and provider type.
            1. The Behavioral Health Integration (BHI) subgroup is elevating a recommendation that involves a 30% increase for providers reimbursed out of a lower rate funding stream, to bring their rates closer to the Medicare rates.
                - This is complementary to the P5 recommendation.
        ii. This recommendation addresses the disparity between family psychotherapy rates and individual psychotherapy rates.
            1. Health Care Authority (HCA) submitted a decision package (DP) related to the family psychotherapy rates for children birth through five this year.
                - This DP was catalyzed by the findings from the statewide tour published last year.
                - This current subgroup recommendation comes from that decision package.
    b. This recommendation includes two parts to address the two separate funding streams:
        i. The first is for a 25% increase in family psychotherapy rates for folks who are funded out of that community behavioral health funding stream.
        ii. The second is for a 65% increase in family psychotherapy rates for basically all the other infant, early childhood mental health treatment providers who are funded from that second stream.
    c. As we think about potential unintended consequences of this recommendation for providers and families, the subgroup must consider what happens when the child reaches six years old and continues to need services, and all of a sudden, the providers are faced with a huge drop in reimbursement rates.
2. **Sustainable funding to enhance behavioral health capacity among home visiting providers**
    a. The recommendation is for $500k ($250k/year) to allocate sustainable funding to enhance behavioral health capacity among home visiting providers to support the whole family unit following an infant's Neonative Intensive Care Unit (NICU) stay and or a diagnosis of developmental delays.
    b. The main issue is that there is a lack of sustainable funding for trainings around supporting caregiver emotional wellbeing:

i. This leads to missed opportunities for whole family support and improved infant outcomes.
ii. There is inequitable and inconsistent access to training throughout the state, which also leads to higher provider burnout and attrition.

c. This funding will support a comprehensive capacity building plan for training home visitors serving this population focused on behavioral health support for the family unit.
d. The changes to the recommendation from earlier versions include:
    i. It is more concise.
    ii. The issue leads have adjusted terminology.
    iii. The recommendation highlights the population being served, addressing invisible needs.
e. The recommendation will have a large impact on this workforce, and has a proven track record and infrastructure in place.
f. There are a variety of training opportunities that could be offered to take into account the fiscal cost of building workforce capacity.
g. This is a proactive recommendation, by addressing an at-risk population, and is not overburdening state resources.
h. Discussion surrounding this item included the following:
    i. This could potentially be supported with the existing professional development funding for DCYF to support home visitors and Early Support for Infants and Toddlers (ESIT) providers, but it has been difficult to reach this detail due to the tight timeframe.
    ii. There is conversation outside of the subgroup surrounding this type of support with the hospital staff.

3. **Alternative-payment model for Infant and Early Childhood Mental Health (IECMH) pilot**
    a. This is for *treatment*, not consultation, as previous title iterations have suggested.
    b. The recommendation is to develop an alternative payment model with the goal of supporting equitable access across Washington for families with young children who are in need of treatment through financially sustainable programs to provide that treatment.
    c. This recommendation builds upon the previous success of MHAYC.
    d. The issue: Currently there are not a lot of community-based infant and early childhood mental health programs in the public behavioral health system, largely because this work requires specialty providers.
        i. The work involves training requirements, reflective supervision and consultation requirements, a dyadic focus and home-based care, as well as an immense mental and emotional toll.
        ii. With the current reimbursement model, this work is essentially treated the same as if therapy was provided in an office.
    e. The alternative payment model would create a value-based case rate model that would support the home-based dyadic work, the training required, and the time for ongoing reflective supervision and consultation.
4. **Expand Maternity Support Services (MSS) regional coverage and provision of wraparound supports**
    a. This recommendation has been reframed a bit from the last iteration.

b. The recommendation is to expand MSS, a program that very few Medicaid birthing people are able to currently benefit from.
c. This program has had multiple major cutbacks in the past, and currently is only offered in 25 counties, which leaves many counties untouched.
d. Currently, MSS supports birthing people up to two months postpartum, but there is a lot of interest in people benefitting from MSS for a full 12 months postpartum
    i. Medicaid has been extended to be up to 12 months postpartum.
    ii. The issue leads are not sure the program could get Federal Medical Assistance Percentage (FMAP) for the entire expansion, though there has been federal matching for other MSS-related items.
    iii. The "dream" program would extend to 12 months postpartum.
e. The issue leads took out language about Wraparound with Intensive Services (WISe).
    i. There is consideration of the possibility of creating a pilot for this model.
f. There were three enhancements made last year under SB 5580 (2023), totaling $5 million, but it is unclear how much of that is specifically for MSS.
    i. There are going to be changes to increase rates and to change the number of service hours that people can get if they are receiving MSS.
    ii. However, it is unclear how many providers are going to jump at this rate increase and none of these changes go into effect until January of 2026.
    iii. Even with this increase, the amount of funding is still nowhere near the amount that the state used to give to MSS.
g. There is an HCA DP related to MSS.
    i. HCA was directed to change the screening tool for MSS services; however, they did not get any FTE to support and evaluate that process.
    ii. HCA put forward a DP for $1.6 million.
    iii. The issue leads think that an additional $5 million would be warranted.

5. **Explore sustainable funding mechanisms for childcare- and IECMH-related initiatives**
    a. The language of this recommendation has been refined based on engagement with six stakeholders.
    b. The issue: Last year, Washington lost $6.9 billion for three main reasons: 1) employee turnover, 2) absenteeism, and 3) lost family income.
        i. The issue lead identified that employment disruptions are associated with childcare challenges, where 1 in 10 parents are leaving the workforce because of childcare issues.
        ii. 77% of parents whose child needed a mental health treatment reported missing more than three days of work, and also reported a reduction of work performance.
        iii. Washington doesn't have a sustainable funding mechanism to support childcare and IECMH-related initiatives.
    c. The recommendation is to ask the larger work group to develop a Legislative Task Force to:
        i. Explore consumer tax models and additional financing strategies.
        ii. Complete a statewide assessment to estimate a budget for childcare and IECMH initiatives.
        iii. Create a tax policy and smoking products specifically for tobacco and marijuana and propose other funding sources.

iv. Design infrastructures to implement equitable access to funds, specifically for three things:
    1. Childcare stipends for low and lower-middle-income families.
    2. Childcare workforce and development.
    3. IECMH workforce and development.
v. Examine short- and long-term outcomes.

d. The issue lead edited the framework to include childcare, due to research that suggests that workforce and childcare are interdependent.
e. Discussion surrounding this item included the following:
    i. The issue lead is envisioning that this would add on top of existing taxes on tobacco and marijuana sales, but this is something that the task force would work on.
    ii. The task force would need to collaborate with existing groups and agencies, such as the Child Care Partnership table and others, to avoid duplicating work.

New item priority order vote:

1. The subgroup is *not* at consensus for the following recommendations:
    a. Exploring sustainable funding mechanisms recommendation
    b. Sustainable funding for BH capacity for home visiting
2. All other items received consensus.
3. Priority order:
    a. #1 - Alternative payment model
    b. #2 - Enhancing family provider therapy rates
    c. #3 - MSS
    d. #4 - Sustainable funding for behavioral health capacity home visiting
    e. #5 - Sustainable funding mechanisms for childcare and IECMH initiatives

Group Discussion of Prioritization Results & Consensus for Advancement

1. Discussion of priority order included the following:
    a. The subgroup leads and support staff will look at the results in more detail and send out digestible data and recommendations for a pathway forward.
    b. All items that are moved forward to the work group will be voted on as independent recommendations within the pool of all new subgroup recommendations that have been advanced to the work group.
    c. Related to the future of some of these recommendations, family therapy rates can be implemented within a year (with Centers for Medicare and Medicaid Services (CMS) approval) and alternative payment models would be a longer-term process.
    d. *Only 1 person per organization can vote.*