Notes

Children and Youth Behavioral Health Work Group – Workforce & Rates (W&R) Subgroup

October 24, 2024

Glossary of Terms

ABA: Applied Behavior Analysis
BHI: Behavioral Health Integration
BHSS: Behavioral Health Support Specialist
CCBHC: Certified Community Behavioral Health Clinic
CYBHWG: Children and Youth Behavioral Health Work Group
DOH: WA Department of Health
HCA: WA Health Care Authority
NAMI: National Alliance on Mental Illness
OT: Occupational Therapy
PAL: Partnership Access Line
UBH: United Behavioral Health
UW: University of Washington
WSMA: Washington State Medical Association

Meeting Topics

Recap of 10/14 Children and Youth Behavioral Health Work Group (CYBHWG) Meeting & Vote
2025 Potential Statements of Support – presentations & Q&A
Open Call for Additional Potential Support Items

Discussion Summary

Recap of 10/14 CYBHWG Meeting & Vote

1. The Work Group will submit the first draft report to the legislature in November.
2. Overarching recommendations included the Partnership Access Line (PAL) and Certified Community Behavioral Health Clinics (CCBHCs).
3. Legacy items from the W&R subgroup included the following:
    a. Behavioral Health Teaching Clinic designation and enhancement rate.
    b. Conditional Scholarships.
    c. Fund the supervisor stipend program (in an altered format – this recommendation is now just 'to monitor', because funding was included in the Department of Health's (DOH) maintenance level budget).
4. New recommendations from the W&R subgroup that were prioritized and voted upon included the following:
    a. Advanced by the Work Group: Behavioral Health Support Specialist (BHSS) (providing funding to develop an adolescent curriculum).
    b. Not advanced by the Work Group: The Well Being Specialist designation.

5. Discussion surrounding the 10/14 vote included the following:
    a. The cover letter of the report to the legislature will include a statement that references the current budget picture, and relays the sentiment that first and foremost, the Work Group's objective is to protect and maintain the gains that have been made since this Work Group began (e.g. legacy items).
    b. The meeting on 10/14 included a lot of discussion about how to position workforce in the future, given everything along the continuum of care involves workforce.

2025 Potential Statements of Support – presentations & Q&A

1. Medical necessity proposal (David Lloyd, Inseperable):
    a. Inseparable is a national mental health policy and advocacy organization that works to enact policy at the state and federal level.
        i. Inseparable is beginning to deepen their engagement in Washington and are meeting with groups (such as this subgroup, National Alliance on Mental Illness (NAMI) Washington, and the state psychological association) to improve health coverage.
    b. <u>Overall issue</u>: Often in commercial and Medicaid coverage, services are promised and people think they have coverage, and then when services are recommended by a clinician, the health plan makes the determination that the services are not medically necessary.
        i. Often, the health plan cites non-transparent criteria or guidelines that have not been peer reviewed, aren't externally validated, and aren't consistent with the standards of mental health and substance use care.
    c. There have been some notable federal court cases related to this issue, including Wit vs. United Behavioral Health (UBH).
        i. Since some of these federal court cases, Inseparable has been working in several states to pass legislation with the goal of increasing access to care.
    d. Representative Simmons introduced HB 2145 (2024), and Inseparable has been working with her and other stakeholders and advocates to push for medical necessity next session.
    e. Washington currently has a Mental Health Parity Act that predates the Federal Parity Act.
        i. Inseparable plans to update this act and put in place a definition of medical necessity that aligns around generally accepted standards of care and high quality criteria and guidelines and consensus recommendations from nonprofit clinical specialty associations, such as the American Academy of Child and Adolescent Psychiatry.
    f. Inseparable is also looking to address other barriers that both families and providers face, such as callbacks of payment after receipt of payment, which is forcing people out of network.
    g. Discussion surrounding this item included the following:
        i. California was the first state to enact medical necessity legislation and there have been some major improvements, including:
            1. A reduction in the number of requests for independent medical reviews for mental health and substance use disorders by nearly 30%, which the chief regulator attributed to fewer denials in the first place.

2. Inseparable is hoping to reduce these audits in Washington, where there are already decent provisions written into law that need better enforcement.
3. New York State is trying to enact legislation to clamp down on these audits as well.

ii. Inseparable is hoping to give the insurance commissioner better powers to address reimbursement rates that are inadequate across mental health clinicians, which are not at parity with physical health.

iii. This work does not impact all types of insurance plans because only some are subject to federal regulation – the states oversee Medicaid plans, as well as individual marketplace plans and small group employer plans, whereas larger employer-based plans are subject to federal regulation.

1. Inseparable thinks that over time there must be success in the states as proof of concept, in order to be successful federally.

iv. Inseparable would love for the standards to apply to both commercial and Medicaid plans; however, they need to consider what is politically possible given the challenging state budget context and consider step-wise approaches.

v. Inseparable will have to wait for the new administration is in place to have more detailed conversations about implementation.

h. Folks can reach out to david@inseparable.us for more information.

2. Applied Behavior Analysis (ABA) Rate Increase (Amber D. Lewis & Carla Myers)

a. ABA is a science-based therapeutic behavioral practice that helps to support those diagnosed with autism, as well as other diagnoses such as Down syndrome, cerebral palsy and feeding disorders, and also provides parent training and support.

i. This service can be provided in the home, in a clinic and within the school setting, and among other settings.

ii. It is a tiered level delivery, where PhD and Master's level clinicians are at the top of the pyramid, there are mid-level supervisors, and then 80% of the workforce is comprised of high school and early college level individuals.

1. The “lower tier” workforce typically work one-to-one with the individuals.
2. The top tier folks provide case management and complete assessments.

b. ABA is a proactive service, focused on early intervention and important skills such as communication, social skills, self-help skills, and decreasing behaviors such as aggression, property destruction, and self-injurious behaviors.

c. There is research that shows investing in ABA early helps save costs across the lifespan.

i. When folks end up in emergency services and inpatient or out of state placements, the costs, time and community services put a strain on the budget.

d. There are two things that the Washington Association for Behavior Analysis are focused on:

i. Advocating for higher increased Medicaid reimbursement rates to sustain this early intervention and thorough adolescent and young adulthood services and prevent the need for emergency services, law enforcement involvement, and out of state care.

1. Washington State has one of the lowest reimbursement rates across the country, even with a small increase received at the start of this year.

2. Across the state, providers are either not accepting Medicaid altogether, or they are just leaving the workforce because they cannot afford to continue services.
3. There is not an adequate Medicaid provider network capacity anywhere in the state.

ii. The Health Care Authority (HCA) has implemented a credentialing requirement timeline starting next year, that involves the credentialing of each level of the workforce pyramid (described above), including the high school or minimal college level folks, which may place a burden on the field.

1. Services are all billed under the Master's or PhD level clinician, rather than the entry level staff, which is conceptually atypical from the rest of the country and also burdensome.
2. HCA credentialing already takes 30 to 60 days (or more) to complete,
3. Businesses cannot sustain to float payroll for 60+ days – which may lead to a decrease in the Medicaid population services
4. The advocacy work is to work with HCA to find a compliance regulation that can accomplish sustaining compliance, but not at the expense of everyone else in the state.

e. You can reach out to Amber D. Lewis at amber@lewisconsulting.us and Carla Myers at publicpolicy@washingtonaba.org for more information.

f. Discussion surrounding this item included the following:

i. Affirmation from a parent with lived experience that without early intervention, involvement with law enforcement, hospitalizations, inpatient out of state care, all can (and did, for her daughter) occur.

ii. ABA is billed under physical health, rather than behavioral or mental health, and thus is likely not included in the Washington State Medical Association (WSMA) covered lives assessment proposal.

iii. They are still assessing the feasibility of what rate increase could be obtained.

3. Psychologists Prescribing Authority (Melanie Smith & Dr. Steven Curtis) – See slides for more details.

a. There is a massive gap between outpatient pediatric prescribing that can be done by primary care providers (PCPs) versus the psychiatric care that can be provided by psychiatrists in places such as University of Washington or Seattle Children's – there are many pediatric patients with medication needs, but few places to refer them for medication evaluations.

b. Prescriptive authority for psychologists is not legal in Washington state.

c. Prescriptive authority for psychologists is a small but growing profession.

i. There are seven states that have legalized prescriptive authority for psychologists and three federal agencies.

ii. There are over 300 prescribing psychologists at the present time, and there are over seven training programs in existence.

d. Prescribing psychologists are licensed psychologists with doctorates who have earned a postdoctoral master's degree in clinical psychopharmacology, and who've passed national psychopharmacology exams and completed didactic training and supervised hours similar to non-physician prescribers.

e. Many people are concerned that prescribing psychologists post a public health hazard; however, data has been accumulated over the past few years to create an extensive database of evidence that refutes this.
f. Additionally, states that have implemented prescriptive authority for psychologists have a lower probability of unmet mental health need compared to other states, and the probability of a child receiving psychotropic medication is slightly higher.
g. Discussion surrounding this item included the following:
    i. The length of training for the prescribing curriculum – the specialized Master's typically takes a couple of years, followed by supervised practice.
    ii. The DOH rulemaking process typically takes about 18 months unless there is a faster requirement.
    iii. Prescribing psychologists in other states have a limited formulary where they can only prescribe medications for behavioral health conditions.
    iv. Collaboration is embedded into the licensure, such that prescribing psychologists are required to collaborate with primary care and keep them updated on changes with their mutual patient.
    v. Washington DOH did a Sunrise Review of psychologist prescribing in 2021.
        1. The DOH identified a number of places for improvement, and those changes have been made to the bill over the last two years.
        2. There have been hearings in the legislature where the DOH has testified in support of this legislation multiple times.
        3. There is also support from HCA through testifying that this would expand access to those who get prescribing through Medicaid.
    vi. The lead sponsors for this are Representative Simmons and Senator Bateman.
    vii. The opposition to this comes mainly from the American Medical Association and the Psychiatric Association; however, on the ground there is rarely pushback from providers or hospitals.

4. Occupational Therapists (David Cacanindin)
    a. Occupational therapy (OT) is a profession that started in behavioral health and was exclusively working in behavioral health for the first 40-45 years of the profession.
    b. This work group enabled the passing of SB 5228 (2023), which is an attempt to rebuild the OT workforce that has sort been whittled down as a result of reimbursement issues and lack of understanding of the role.
    c. SB 5228 (2023) provides funding to help get occupational therapists into four different agencies across the state to solidify a position, to start bringing in students, and to rebuild the workforce in the behavioral health practice setting, specifically in community behavioral health.
    d. The next phase of funding that is being requested is for a second year to help students begin progressing through the existing program.
        i. There was always expected to be a second year, and so the request is for help getting funding streamlined in behavioral health settings.
    e. Occupational therapists are the only profession that looks at all of the ways that someone's physiological, mental, emotional, and neurological health meets the capacity of their activities.

    i. Occupational therapists work with patients to self-regulate, and develop routines and habits that are long-lasting, in order to perform at their very best.
    ii. Occupational therapists also modify the specific activities that a patient is doing along with the environment in which they do them, to maximize their life performance.
    iii. Occupational therapists can perform their work in the office, as well as in living contexts, such as the grocery store, workplaces, schools, and more.
  f. There are a large portion of occupational therapists working within school settings, and the Washington Occupational Therapy Association envisions expanding their reach beyond community behavioral health settings in ways such as:
    i. Creating a separate behavioral health centered team working in schools, or
    ii. Finding ways to maximize the amount of time that therapists have with clients in the schools while decreasing their case load, to allow occupational therapists to continue working on behavioral health issues, not just developmental issues, while already in the school setting where occupational therapists already exist.

5. Workforce Board recommendations (Renee Fullerton) – See slides for more details.
  a. This is a decision package request for some additional investment in healthcare and behavioral health workforce policy infrastructure within Washington state.
  b. The Workforce Board convenes the Health Workforce Council as required under RCW 28C.18.120 and the proviso that funds the Health Workforce Council overall.
  c. The Health Workforce Council brings together folks across the entire healthcare spectrum, including behavioral health, oral health, primary care, hospital care, government payers, K-12 and post-secondary.
  d. The Council also is the funding line for the Health Workforce Sentinel Network, a partnership between the Health Workforce Council and the University of Washington (UW) Center for Health Workforce studies.
  e. Currently, this work is funded with a $240k proviso, which began in 2019 and has continued unchanged since then.
    i. During that same time frame, the workforce board had separate funding lines that came to support behavioral health work, with the last of those expiring in June of 2025.
    ii. Starting in July 2025, the current funding will be enough to cover 0.85 FTE of staff time for the Council, $1k for conference, travel and meeting costs, and $100k contract with UW to support the Sentinel Network.
  f. The Workforce Board has submitted an agency budget request for $345k in FY26 and $327k ongoing beginning in FY27 to the Governor and Legislature to maintain work on healthcare and behavioral health workforce.
    i. This includes 2.5 FTE (1.65 new FTE) for healthcare and behavioral health workforce research and policy development.
    ii. $115k annually to support increased annual costs to operate Health Workforce Sentinel Network (an increase of $15k per year). per year to also address their inflationary cost increases.
  g. In addition to the basic convening role the Council and Workforce Board have, they have key projects for the following:

i. Increasing collection, ensuring access and resource resourcing, ongoing analysis of behavioral health and health workforce data, including evolution of Sentinel Network.
ii. Developing rural-specific behavioral health and healthcare workforce strategies and adoption of those strategies.

Open call for additional potential support items

1. At the next meeting, the subgroup can take up additional support items, as well as voting on those to advance to the full work group for a final decision.
2. The subgroup is hoping to have short proposals for each support item by November 6th for consideration.

Look Ahead: 24/25 Schedule

**(April-August) All meetings will take place on the first and third Wednesdays of the month, unless otherwise indicated.*
(September-October) All meetings will take place on the first and third Thursday of the month, unless otherwise indicated.

- November 6* – 10-11am
- December 5 – 10-11am