Washington State
Joint Legislative and Executive Committee on Behavioral Health

February 10, 2025
2 - 5 pm

Reminders

- Public meeting
- Meeting is being streamed and recorded by TVW
- Comments in meeting chat are public record (Committee only – NEW)
- Cameras off for non-Committee members (NEW)

Welcome
& Introductions

Today's Agenda

1. Welcome & Introductions
2. Reports from subcommittees
3. Governor Inslee’s behavioral health budget proposal
4. Moving Forward
5. Public comment
6. Wrap up/Adjourn

JLEC Subcommittees

Subcommittee Process, Purpose, Outcomes

Process

- JLEC identified top 5 priority areas.
- Individuals "nominated" by JLEC members.
- 3- 90 min meetings - "sprints".
- Materials sent ahead: JLEC proviso, other BH workgroups.
- Discussion based meetings.

Purpose

- To dig deeper into each subject area and propose strategic, actionable priorities to the full JLEC so the committee can recommend steps to strengthen access to behavioral health services in Washington State.
- Review and discuss past and existing work being done in this area - prior recommendations, current efforts and/or investments, etc.
- Identify current challenges, barriers, or unmet needs being experienced in the subject area.
- Identify the key underlying causes for these challenges.
- Propose strategic priorities and actions JLEC could recommend for inclusion in a strategic plan.

Outcomes

- Develop Issues/themes; recommendations

Themes Identified in Multiple Subcommittees

1. More coordination/collaboration amongst agencies and partners that plan and deliver behavioral health programs.

2. Address workforce barriers and challenges.
   - Cost of entering the BH field is too high.
   - Compensation is too low.
   - Licensing/credentialing issues are barriers to providing services.
   - More diversity needed.

3. Strengthen primary prevention and early intervention programs and ensure payment/coverage for these programs.

4. Equity in programs, access, and funding for all populations.

Community Based Healthcare & Strengthening Workforce

Sarah Mariani,
Washington Health Care Authority

Kristen Wells,
Community Member

Community Based Healthcare & Strengthening Workforce

Overarching Themes:

1. Invest in community-based prevention and early intervention services and programs as key elements of Behavioral Health for individuals. Support through policy changes.
2. Invest in the full continuum of professionals that serve community behavioral health.

Community-Based Prevention

- **Establish policies and increase funding** and services for **primary prevention** and wellness promotion.
- Increase investment in **evidence-based programs to address social determinants of health** in communities – i.e., housing, independent living and social connections.
- Ensure **funding/payment for prevention and treatment services** - *both* are critical parts of continuum of care.
- Develop statewide policy to **require universal behavioral health care screening** in primary care.
- Increase funding for **school-based behavioral health resources**.
- **Expand mental health school counseling and resources for children and youth**, college students, and parents (I.e., screening/support classes for parents). Prioritize rural areas and marginalized populations.
- Fund **state-wide implementation of social emotional learning curriculum** for all ages.
- **Continue funding community organizations** who provide community-based prevention programs.

Community-Based *Early Intervention*

- **Increase investment and access to Early Intervention services** to help prevent mental health or SU crises and worsening of a condition.
- Improve ability to **fund and provide services pre-diagnosis**.
- Strengthen and expand programs that **intervene following the first crisis.** e.g., New Journeys for psychosis and programs that intervene to prevent a second overdose or suicide attempt.
- **Fund BH education and services for families/parents** (e.g., Family Initiated Treatment, FIT). Insurance either doesn't cover family-centered care or **reimbursement rates are too low**.
- **Address NIMBYism to ease placement of treatment facilities**: education, outreach, planning and zoning requirements.

Workforce

- Increase investment in **prevention workforce** (i.e. certified prevention professionals).
- Increase **availability of community-based health care providers**.
- Invest in **peer support programs** to strengthen workforce, work towards equity within workforce and destigmatize behavioral health.
- **Streamline licensure pipeline for Community Health Workers**: use more apprenticeships, compensate supervisors to train students.
- Develop **policy to allow more flexible hiring requirements for Peer Specialists**. Reduce the burden of collecting court documentation.
- Address **financial burden of entering the behavioral health field** (E.g., cost of graduate degrees, expand paid practicums/reduce length of unpaid practicums, relieve debt burden).
- Secure funding for **Conditional Scholarships** – reduce debt burden, strengthen workforce, diversify workforce.
- Advocate for **financial aid and federal funding for Pell grants** (students pursuing behavioral health fields).

Prevention & Early Intervention Subcommittee

Hope Baker, ESD 105

Brian Estes, NAMI Washington

Prevention & Early Intervention Subcommittee

Overarching issue

Increase and improve collaboration & coordination between local and state public health, HCA, OSPI and integration of the multiple, overlapping strategic plans: WA Thriving (children and youth), State Prevention Enhancement Policy Consortium, CRIS, etc.

Develop working definitions

- **Prevention:** *Reduce the risk of mental health problems or substance use disorder by addressing factors that contribute to them. Increase protective factors and reduce risk factors.*
- **Early intervention:** *Intervening at earliest sign of struggle, to prevent the need for more intensive care or crisis services.*

Prevention & Early Intervention Subcommittee

Prevention-related recommendations

- Strengthen public policy to increase funding and resources for prevention and health promotion.
- Focus on destigmatization and normalizing conversations of behavioral health.
- Improve access to data and information on risks and needs: Enhance work related to the Healthy Youth and Young Adult Survey; Also need a similar survey for adults
- Support for social determinants of health (housing, food security, health, education, etc.) **and social services that support connection**
- Increased use of/promotion of EPSTD (Early and Periodic Screening, Diagnostic, and Treatment) and SBIRT (Screening, Brief Intervention, and Referral to Treatment).
- Increase mental health awareness and prevention in schools. Consider cell phone ban and/or restricted use of social media. Reintroduce bill to ban cell phone use in schools.

Prevention & Early Intervention Subcommittee

Early Intervention-related recommendations

- Increased and improved mental health/primary care integration.
- Improve community-level coordination of Mental Health and Public Health.
- Use of a validated screening tool that can be used to routinely screen for BH problems.
- Reconsider the use of the term 'Behavioral Health'. Mental Illness is not behavioral, it is an illness.
- Workforce supply and development for early intervention services to prevent crises: Need more BS/BA professional career paths to do therapy; more prescribing psychologists.
- Promote 988 and the services it provides more widely; Improved language access (988).
- Develop and deliver services before a diagnosis; ensure they are funded and/or covered by private insurance.
- Strengthen/leverage ability of Medicaid (and all insurance) to fund screening and early intervention.
- Work with providers and MCOs to ensure they are aware of the flexibility Medicaid to cover early intervention before a diagnosis, and that they are using consistent interpretations.

Eliminate Disparities & Inequities Subcommittee

Dakota Steel,
Washington Health Care Authority

Alondra Torres,
Community Member, NAMI Washington

Eliminate Disparities & Inequities Subcommittee

Recommendations

- Strengthen and diversify the behavioral health workforce
- Increase investment in Primary Prevention
- Increase investment in Mental Health supports for children

Eliminate Disparities & Inequities Subcommittee

- Address issues of safety that deter people from seeking and receiving appropriate help.

- Address law enforcement response to Behavioral Health crises.
  - Many people feel unsafe calling 988 or 911 (fear of law enforcement involvement and health system responses), impeding access to needed Behavioral Healthcare and resulting in inappropriate incarceration.

- Strengthen coverage and insurance for Behavioral Healthcare.

Administrative & Structural Issues Subcommittee

Teresa Claycamp, Washington Health Care Authority

Scott Munson, Treatment Provider

Administrative burden: Multiple regulatory requirements

Issue: Licensed Behavioral Health Agencies (BHAs) are faced with complying with multiple regulatory requirements that may require:

- Annual audits
- On-site reviews
- Data collection and reporting
- Policies and procedures
- Other deliverables and reporting

- Requirements result in BHA's duplicating work and compounding administrative burden.
- Contract requirements or program oversight is often developed without realizing impacts to providers or systems and as a result often does not measure what is intended.

Recommendation:

- A technical advisory panel of MCOs / ASOs / Providers to identify sources of regulatory burden through
  - Conducting an analysis to identify where duplications exist and determine actions to appropriately reduce duplicative requirements while ensuring quality oversight/monitoring.
  - Note: Within current resources, this would not be feasible.

Administrative Burden: BHAs must credential with numerous payors.

Issue: Credentialing and re-credentialing processes

- To bill with an insurance payor, BHA's need to be credentialed, and re-certify credentials regularly.
- Medical insurance credentialing is a complex, administratively burdensome process that verifies BHA's are legitimate and qualified to receive reimbursement for the services they are providing.

Recommendation:

- Establish a work team to support developing streamlined recommendations or other solutions.
    - Start with payors to identify all requirements and processes.
    - Bring in provider perspectives and develop licensing and credentialing recommendations.
    - Understand history, what is working, what is not working and how the process works now.
    - A single credentialing process is directed by RCW 48.43.750
        - Previously administered through OneHealthPort and currently using the CAQH.
    - There is a Washington Practitioner Application (WPA) and a Washington Credentialing Standardization Group (WCSG) responsible for the WPA.

Administrative burden

Issue: Paper-based documentation, inefficient Electronic Health Records, manual information retrieval for data submission, and lack of efficient information exchange/care coordination.

Recommendation:

Ensure all Behavioral Health Agencies (BHAs) have adequate Electronic Health Records (EHR) funding and capabilities.

- Support work that is already underway - Health Care Management and Coordination System (HCMACS) is a statewide EHR service funded by HCA that all facilities, regardless of type, may be able to access.
- Note: While valuable and aimed at reducing burden, EHRs may also add administrative burden to providers related to data entry, coding for billing, etc. This should be acknowledged when thinking about this in the context of reducing admin burden.

Administrative burden

Issue: Inconsistent, overlapping, or duplicative requirements across health plans and payors.

Recommendation: Apply similar policies across private health plans, Medicaid and PEBB/SEBB. Seek opportunities for consistency.

- HCA/OIC efforts on coverage of crisis services (MCR and crisis stabilization) – what have we learned by trying to import Medicaid payment/service delivery mechanisms into private health plans. Leverage information gleaned from the upcoming "Address Crisis Services Funding Gaps" report (proviso 19).
- HB 1357 (2023) and SB 6228 (Prior authorization for inpatient/residential SUD care) – changes to prior auth policy apply across commercial health plans, Medicaid, PEBB/SEBB. More bills to come this session.

Other issues and recommendations

Compensation and reimbursement rates

- Medicaid and private reimbursement rates have not kept up with inflation and payroll cost resulting in restricting providers ability to hire.
- Integrated care is expensive. Providers cannot afford to hire and fully build out the system of care.

Current Initiatives, Plans, and Deficits

- **Capacity:** there is a need for capacity along the continuum of behavioral health care.
  - Support for Crisis service expansion. Relying on the treatment system to provide crisis beds perpetuates a burden on providers.
    - Continue to strengthen mobile crisis teams and response capacity.
    - Support Endorsement Teams for crisis response teams and 23-hr Crisis relief centers (CRCs) for adults and youth.
    - Communication on current and planned expansion of crisis facilities
  - Invest in Intensive Behavioral Health Treatment Facilities (IBHTF) and Intensive Residential Treatment (IRT).
- **Funding streams**: Identify all funding streams and opportunities for alignment.

- **Collaboration and Community Voice:** Support cross-agency collaboration embedded in community. Ensure community voice in decisions.

Discussion Questions

1. What are your reactions to these recommendations? Is anything missing?
2. JLEC's purpose is ..."*to identify key strategic actions to improve access to behavioral health service*".
   - Do these recommendations *generally* meet this purpose?
3. If not, how can they be more action oriented?
4. Are there any specific recommendations we can push forward or be more aggressive on?

February 2025

Gov. Inslees's Proposed 2025-27 Behavioral Health Budget

Arnel Blancas | Budget Advisor
Budget Division

WASHINGTON STATE OFM Office of Financial Management

The approach

How items were prioritized

- Do as little harm as possible.
- Minimize impacts to vulnerable populations
- Protect core services
- End programs no longer needed
- Reduce where conditions or needs have changed
- Delay implementation of programs

Behavioral health investments

OFM

Investments in behavioral health

- Expand access for individuals who have a significant behavioral health diagnosis and need additional support living in a community setting. ($237 million)
- Continue development of Certified Community Behavioral Health Clinics ($2 million)
- Implement fourth phase of the Trueblood v. DSHS settlement agreement ($122 million)
- Support Tribes with opioid prevention and treatment ($32 million)
- Expand the program that provides referral and follow-up for individuals that show up in emergency rooms from an opioid overdose ($1.5 million)
- Increase opioid use disorder treatment and education at juvenile rehabilitation facilities ($2.6 million)

Cost-savings

Reductions in behavioral health

- Facility delays
  - Brockmann ($14 million)
  - Maple Lane ($36 million)
  - Olympic Heritage Behavioral Health ($32 million)
- Reduced forecast in long-term civil commitment bed utilization ($13 million)
- Administrative savings ($8.7 million)


Questions?

For more information

Contact:

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Scan the QR code to visit ofm.wa.gov or find us on social media.

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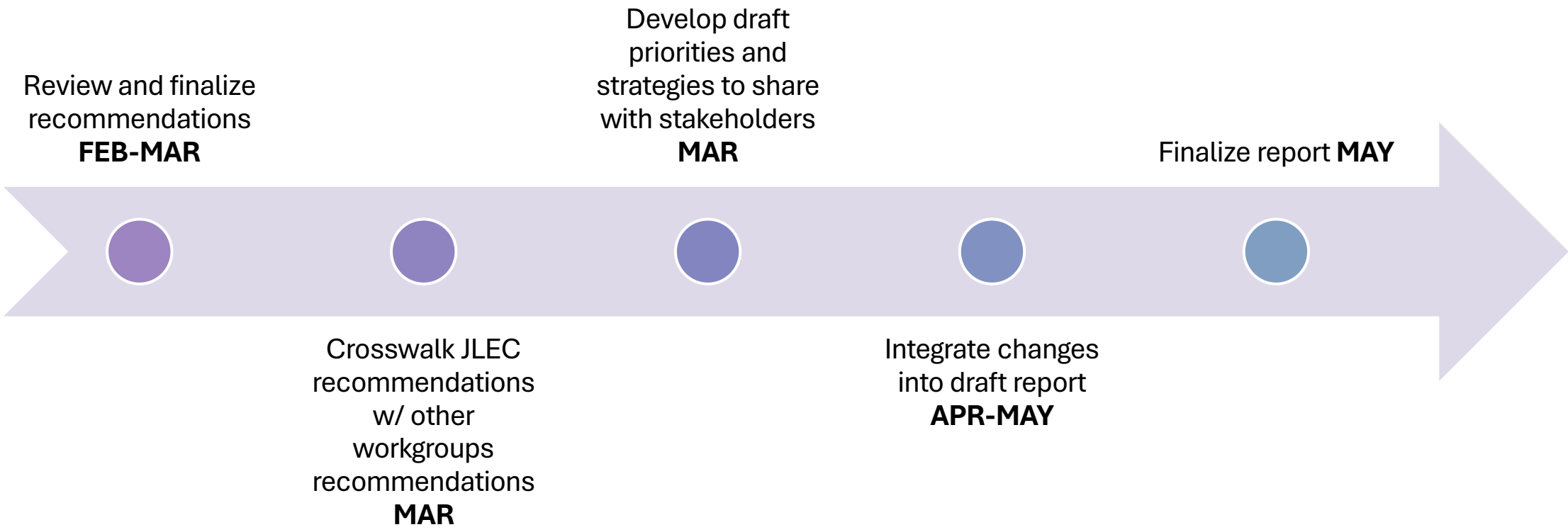
JLEC Timeline



Public Comment

Upcoming meetings

March 17th, 10 am – Noon

April 21st, 10 am – Noon

May 19th, 10 am – Noon (final currently scheduled JLEC meeting)

All meetings will be virtual.