

# Washington's Behavioral Health Workforce Assessment

## Preliminary Recommendations Work Sheet

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**Purpose:** Identify workforce-related actionable recommendations to address barriers identified by stakeholders.

**Background:** Governor Inslee requested the project team gather input and assemble data about workforce supply and demand in order to recommend an action plan to address current and future behavioral health workforce needs in the state. Phase I will assess the range of workforce-related barriers to improving access to behavioral health in Washington, and identify recommendations for short term solutions. Phase II will focus on longer term solutions to the workforce-related barriers identified in Phase I, and will provide the Governor's office and appropriate Legislative committees with a final report and recommendations by December 15, 2017 for the 2018 Legislative Session and beyond.

### High Level Summary of Barriers Identified in Stakeholder Meetings

- **Recruitment and retention:** The behavioral health work environment, especially in settings serving low-income populations, is characterized by heavy caseloads, patients with high acuity of behavioral health care needs, time-consuming documentation requirements, and relatively low pay. As a result, recruiting and especially retaining the workforce across the range of occupations required to deliver behavioral health services is difficult.
- **Skills and training:** The changing behavioral health care environment, including increasing integration of behavioral health and medical care, increases the behavioral health and medical care workforces' need to work effectively in inter-professional teams, be up-to-date with new models of practice and evidence-based skills, have access to and proficiency using current health information technology systems, and efficiently meet documentation requirements. The opportunities and resources to meet these training needs are not adequate to meet demand, both in initial education programs as well as for incumbent workers.
- **Policy/regulation/credentialing:** Numerous policies and regulations influence the number, distribution, and scope of practice of the occupations that comprise the behavioral health workforce. These include what are described as overly burdensome requirements for credentialing some occupations, long timelines to receive credentials, documentation requirements, and challenges created by reimbursement practices.

KEY: Comments received via email are color coded as follows:

Elizabeth K – Blue

Joan M – Purple

Maria Y – Green

Rex R – Orange

Mandy P – Grey

Renee, Nancy, Kathy – Dark red

Mike W. – Brown

Paul F – light blue

Geri – Teal

Brigitte - Pink



## I. Improve access to clinical training for students entering behavioral health occupations (TOPIC 1 for 9/30 MTG)

**Workforce-related barrier:** *Too few resources are available to meet the clinical training needs of the behavioral health workforce - too few internships, residencies, other clinical training, and “real-world” placement opportunities to provide needed experience for behavioral health workforce development. Training in sites that mirror environments where service demand is greatest reinforces the skills needed for future work in those types of practices and can improve students’ interest in working in those practice environments.*

<b>Draft Recommendations</b> (help refine these recommendations to make them clear, specific and actionable)	<b>Which healthcare occupations/sectors benefit most from this recommendation?</b>	<b>What actions are needed to implement this recommendation?</b>	<b>Who needs to be engaged to implement this recommendation?</b>	<b>What impact would implementation create? Are there models to review?</b>
<ul style="list-style-type: none"> <li>Incentivize preceptors at clinical training sites to take on students. (Are there other efforts in the states for other health occupations? If so, can efforts be coordinated?)</li> </ul>	Multiple, including OT	Contacting fieldwork coordinators for OT programs to determine incentives/benefits available	OT as supervisor & fieldwork coordinators	Sites would gain student contributions, & students would gain experience in working in behavioral health
<ul style="list-style-type: none"> <li>Increase number of psychiatric residencies, especially in rural and other underserved communities. (Is there any way to streamline residencies? Incentives to practice in WA after residency?)</li> </ul>				
<ul style="list-style-type: none"> <li>Support coordination among education programs to reduce burden of setting up and carrying out clinical training</li> </ul>			Lake Washington Tech & other local Human Service or social work programs. Community colleges & 4-year colleges. Bellevue College, Seattle Central, Seattle U, Highline, Phoenix, City U, UW, Evergreen, Northwest U.	Lake Washington Tech is currently developing a new Bachelor of Applied Science in Behavioral Healthcare.
<ul style="list-style-type: none"> <li>Incentivize community mental health providers to provide internship programs and be clinical sites</li> </ul>	Community mental health case management programs		Faculty for the above schools + clinical directors at each of the BHOs.	
<ul style="list-style-type: none"> <li>Provide reimbursement to support clinical training (supervisory time, intern’s time)</li> </ul>				
<ul style="list-style-type: none"> <li>Other Actionable Recommendations:</li> </ul>				



## II. Promote team based and integrated (behavioral and physical health) care (TOPIC 2 for 9/30 MTG)

**Workforce-related barrier:** Too little training in team based and integrated (behavioral and physical health) care is available for the incumbent workforce and for students entering clinical occupations – not enough cross training, common language/approaches, or understanding of how to communicate with and work in cross disciplinary teams.

Draft Recommendations (help refine these recommendations to make them clear, specific and actionable)	Which healthcare occupations/sectors benefit most from this recommendation?	What actions are needed to implement this recommendation?	Who needs to be engaged to implement this recommendation?	What impact would implementation create? Are there models to review?
<ul style="list-style-type: none"> <li>Provide more telehealth for both training and BH service delivery</li> </ul>		<p>The department of health is developing rules to support telehealth in various professions</p>		
<ul style="list-style-type: none"> <li>Provide more training in evidence-based practices</li> </ul>	<p>All.</p>	<p>Encourage partnerships between training organizations and BH agencies. Support BH agencies (with both resources and time) to send staff to trainings so they can learn. Encourage BH agencies to support their supervisory staff to provide ongoing support and training to line staff in the delivery of EBPs.</p> <p>Incentivize actually staying and continuing to work at the location that delivered all this start-up training.</p>	<p>BH agencies. Educational institutions. Changes or adjustments in fidelity measures so that agencies aren't punished for trying to support their staff and clients (e.g., the amount of paperwork involved with EBP fidelity measures, etc.).</p>	<p>Better care and outcomes to clients. PACT (Program of Assertive Community Treatment) is an EBP that is delivered throughout the state.</p> <p>This would help the continual problem of training and losing staff.</p>
<ul style="list-style-type: none"> <li>Provide incentives and training for outpatient primary care providers to care for low level behavioral health needs</li> </ul>				
<ul style="list-style-type: none"> <li>Examine applicability of Yale supervision model</li> </ul>				
<ul style="list-style-type: none"> <li>Provide training for school officials on behavioral health issues</li> </ul>				



<ul style="list-style-type: none"> <li>• Create rural-oriented training hub (vis a vis Nebraska BHECN model, for incumbent training)</li> </ul>	<p>Social Workers, Therapists, CDPs, Prescribers</p>			
<ul style="list-style-type: none"> <li>• Develop training specifically to support rural sites with increased integration</li> </ul>				
<ul style="list-style-type: none"> <li>• Make high quality continuing clinical education free and more accessible</li> </ul>	<p>Consider occasional in-services or written descriptions of the various providers' roles</p>	<p>Establish inservice/written materials</p> <p>Contract with existing schools to provide continuing education.</p>	<p>Each occupation could ensure good definition of role</p> <p>Lake WA Tech &amp; other local Human Service or social work programs. Comm. &amp; 4-year colleges. Bellevue College, Seattle Central, Seattle U, City U, UW, Phoenix, Evergreen, Northwest U, Highline,</p>	<p>Accurate knowledge of team members' roles will increase efficiency of services provided</p> <p><b>CCEC - Eastside</b> Cascadia College, Lake Washington Institute of Technology, and Everett Community College have partnered together to offer courses and certificates</p>
<ul style="list-style-type: none"> <li>• Promote behavioral health intervention skills that can be efficiently employed in non-traditional settings (brief, infrequent interventions, collaborative care, triage, co-occurring disorders)</li> </ul>				
<ul style="list-style-type: none"> <li>• Allow OT's to provide BH services</li> </ul>	<p>OTs benefit from recognition &amp; opportunity to share their expertise; other team members benefit from OT's unique perspective &amp; skill set; OTs share some skills with other team members, e.g., OTs can be trained as case managers &amp; can provide cognitive assessments</p> <p>OT, SLP, ABA</p>	<p>Include OT as part of the team</p> <p>Scope of practice review.</p>	<p>Individuals responsible for staffing, budgeting, etc.</p> <p>Associations; professionals; licensees; department of health; Health Care Authority (payment)</p>	<p>Clients would receive more comprehensive services, including assessment for functional abilities &amp; training in life skills</p>



<ul style="list-style-type: none"> <li>Other Actionable Recommendations:</li> </ul>	<p>In outpatient setting: Allow for more “para-professional” service delivery and “practicing to the scope of the license” service delivery. Specialize diagnosing and Tx planning to master’s level, and allow case-management level to do more, with appropriate supervision</p>		<p>Clinical experts, consultants from similar models in other industries: Schools, hospitals (RN – CNA type relationships could exist to deliver care in outpatient mental health/outpatient SUD agencies, with masters level therapists and lower level case managers – with proper training and supervision).</p>	<p>Model: OSPI special education model often used: SLPs test and write IEPS and evaluations, SLPAs deliver service. Or, special education teachers write IEPs and supervise para-professionals, who deliver the service. (When appropriate, higher need would need higher level license, obviously). School Psych’s test and write evaluations and deliver recommendations which are all implemented down the line (teachers/paras).</p>
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### III. Encourage state loan repayment for the behavioral health workforce

**Workforce-related barrier:** *The state loan repayment program does not cover enough behavioral health occupations* - Stakeholders have said there is a lack of open access to loan repayment for non-prescribing occupations and limited opportunities for behavioral health occupations in general. Additionally, there are not enough funds/not for all occupations/not enough worksites and care settings. **Topic to be discussed at 9/30 stakeholder mtg.**

<b>Draft Recommendations (help refine these recommendations to make them clear, specific and actionable)</b>	<b>Which occupations/sectors of healthcare benefit most from this recommendation?</b>	<b>What actions are needed to implement this recommendation?</b>	<b>Who needs to be engaged to implement this recommendation?</b>	<b>What impact would implementation create? Are there models to review?</b>
<ul style="list-style-type: none"> <li>Incentivize loan forgiveness to BH provider applicants serving the public sector, such as those in nonprofit settings.</li> </ul>	<p>Clinical psychologist, LICSWs, LMHs, MFTs have been added to the next program year of the Washington State Loan Repayment Program when working in integrated care settings</p> <p>Social Workers, Therapists, CDPs, Prescribers</p>	<p>No action needed</p>	<p>No action needed unless increased funding desired in order to make more awards</p> <p>CMHCs, BHOs, College recruitment.</p>	<p>Incentivize clinicians with loans to work at high need sites</p> <p>Educational loan forgiveness for teachers in poverty areas exists. That might be a model.</p>
<ul style="list-style-type: none"> <li>Incentive those who serve children with behavioral health needs</li> </ul>	<p>Same</p>	<p>Same</p>	<p>Same</p> <p>CMHCs, BHOs, College recruitment.</p>	<p>Same</p> <p>Educational loan forgiveness for teachers in poverty areas</p>



				exists. That might be a model.
<ul style="list-style-type: none"> <li>• Increase incentives for those without debt</li> </ul>	<p>Could affect variety of professions depending on eligibility</p> <p>Social Workers, Therapists, CDPs, Prescribers</p>	<p>Would need new legislation to allow direct payments rather than loan repayment awards</p> <p>Signing bonus and moving incentives</p>	<p>Associations, Legislature, WSAC</p>	<p>Increase number of clinicians eligible for incentives, encourage retention</p> <p>Alaska SHARP-II program includes direct incentive program</p>
<ul style="list-style-type: none"> <li>• Other Actionable Recommendations: <ul style="list-style-type: none"> <li>Scholarship programs for students wishing to enter the BH field (i.e., how can we help them graduate without any debt in the first place?)</li> </ul> </li> </ul>				

#### IV. Expand the workforce available to deliver medically-assisted behavioral health treatments (TOPIC 3 for 9/30 MTG)

**Workforce-related barrier:** *Too few providers have the prescribing authority needed to deliver evidence-based behavioral health treatment.* At present, psychiatrists, psychiatric NPs, general primary care physicians, [and pharmacists?] can prescribe medications for behavioral health conditions. There are too few of these professionals available to efficiently serve the needs of all behavioral health service sites in the state. [Is this a supply shortage issue, or a recruitment/retention issue? Recommended solutions differ depending on how much the problem is one vs. the other]

Draft Recommendations (help refine these recommendations to make them clear, specific and actionable)	Which healthcare occupations/sectors benefit most from this recommendation?	What actions are needed to implement this recommendation?	Who needs to be engaged to implement this recommendation?	What impact would implementation create? Are there models to review?
<ul style="list-style-type: none"> <li>• Integrate behavioral health certificate(s) into training for MPH, MD, Mid-level, RNs</li> </ul>				



<ul style="list-style-type: none"> <li>• Provide prescriptive training/examination/credentialing to broader range of BH practitioners</li> </ul>		<p>Legislative change required; research what other states are doing</p> <p>Because medical complications can arise from the administration of medications, and medical training currently consists of four years, please keep in mind any adverse outcomes that might arise if the approaches are not thoughtful.)</p>		
<ul style="list-style-type: none"> <li>• Provide dual credentialing MH &amp; CDP, CDP &amp; other occupations</li> </ul>			Schools offering CD education: Bellevue, EWU, and Lake Washington Tech	<i>Not sure the rest of this section fits here.</i>
<ul style="list-style-type: none"> <li>• Fast track masters level endorsements</li> </ul>				
<ul style="list-style-type: none"> <li>• Provide integrated health credentialing</li> </ul>				
<ul style="list-style-type: none"> <li>• Create dual licensure</li> </ul>				
<ul style="list-style-type: none"> <li>• Other Actionable Recommendations:</li> </ul>	<p>All BH agencies.</p> <p>Counselors</p>	<p>Provide incentives to BH agencies to recruit RNs. Work with RN programs (universities and community colleges) to expose nursing students to the value and importance of BH work.</p> <p>Payment models</p>	<p>BH agencies, nursing schools.</p> <p>Insurance</p>	<p>RNs serve a vital function in serving as a “holistic” hub. They can screen for medical conditions, help triage who requires more acute services due to medical reasons, and can help differentiate between more medical versus more psychological conditions.</p> <p>Rural Health Clinics cannot get paid for counseling services – counselors are not considered a “provider” – Imagine the impact of carving off the lower level mental health needs to integrated –care medical clinics, so they could get</p>



				<p>paid. Right now there is a gap in services (at least in our rural county) that if a Medicaid client does NOT meet the ACS for mental health, there is no where else for them to go for counseling. They have to “wait/get sicker” then meet ACS to come to CMHC. (Now, our CMHC could decided to negotiate extra non-ACS contracts with the state Medicaid MCOs, but – given that we cannot even staff enough people to cover our BHO required ACS contract services, how could we successfully take on more non-ACS unless there’s either more BH staff out there, or – perhaps that population can go to medical clinics instead for their services.</p>
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## V. Increase the number of dually certified behavioral health care providers (TOPIC 4 for 9/30 MTG)

**Workforce-related barrier:** *Not enough providers have dual training and certification in mental health and chemical dependency treatment to meet system needs. Providing opportunities for dual certification, or “add-on” certifications would allow existing staff to work to the tops of their licenses and have the skills to work in integrated settings, while potentially reducing shortages or relieving stress on current staff.*

<b>Draft Recommendations</b> <b>(help refine these recommendations to make them clear, specific and actionable)</b>	<b>Which healthcare occupations/sectors benefit most from this recommendation?</b>	<b>What actions are needed to implement this recommendation?</b>	<b>Who needs to be engaged to implement this recommendation?</b>	<b>What impact would implementation create? Are there models to review?</b>
<ul style="list-style-type: none"> <li>Integrate behavioral health certificate(s) into training for MPH, MD, Mid-level, RNs</li> </ul>				
<ul style="list-style-type: none"> <li>Fast track CDP certificate as part of MHP education programming. [In which training programs? MSW? Others?]</li> </ul>				<p>Lake Washington Tech is developing an online short-certificate program in Substance Use Disorder Counseling for licensed providers and those in graduate training.</p>
<ul style="list-style-type: none"> <li>Provide dual credentialing MH &amp; CDP, CDP &amp; other occupations</li> </ul>		<p>Educate providers/educators on the recently implemented WAC that allows for expedited CDP credential</p>		
<ul style="list-style-type: none"> <li>Fast track CDP certificate for experienced masters level practitioners [How? for which occupations?]</li> </ul>		<p>DOH WAC changes</p> <p>Educate providers on the recently implemented WAC that allows for expedited CDP credential</p>	<p>Providers.</p>	<p>DOH recently proposed new rules to reduce the education and supervised hours requirements for a master’s level MHP earning a CDP credential. The new WACs were the culmination of a years-long rulemaking process to create an alternative CDP track, so if these agency ends up adopting the new rules, I’m not sure if the agency will want to open this issue up again.</p>
<ul style="list-style-type: none"> <li>Create more programs like the HEET pilot at Whatcom and Spokane Falls Colleges (is that a joint program?) to add CDP training for Master’s level mental health counselors</li> </ul>				



<ul style="list-style-type: none"> <li>• Provide integrated health credentialing</li> </ul>		<p>"Expand the scope of practice through licensing definition guidelines for LMHCs and LICSWs to include SUD treatment. Currently, their licenses cover mental disorders and SUD dx are included in the DSM-V. This would allow for assessment, treatment planning in the SUD area. WA state is one of the few states in the nation that gives exclusive SUD tx scope to a paraprofessional CDP certificate that is not accepted by CMS except under waiver. This would allow for greater penetration of assessment and brief intervention in the much needed SUD treatment area."</p>		
<ul style="list-style-type: none"> <li>• Create dual licensure</li> </ul>	<p>All BH agencies</p>	<p>Work with DOH to create a new license or process where someone can obtain a combined CDP and MHP credential. This may also require work with CDP-only organizations and MHP-only organizations, who may balk at the creation of a separate credential.</p>	<p>DOH, CDP associations, any MHP associations who may resist. Education institutions (universities, community colleges).</p>	<p>There are individuals who currently have both MHP and CDP credentials. They can provide feedback about how they have been able to use both, what parts of the curricula can combine, etc. Agencies that have staff with dual credentials can also speak to any efficiencies and effectiveness that have resulted from dual licensure.</p>



<ul style="list-style-type: none"> <li>Have employers train professionals with Master’s degrees or higher in substance use disorder treatment (see new DOH rules and new WAC)</li> </ul>	Define which “professionals” applicable	Scope of practice review; curriculum development;	Legislation; associations; professionals; licensees; department of health;	
<ul style="list-style-type: none"> <li>Include substance use disorder treatment in the scope of practice for licensed clinical social workers and licensed mental health counselors</li> </ul>	LCSW; LMHC; CDP	Scope of practice review	Legislation; associations; professionals; licensees; department of health; schools	
<ul style="list-style-type: none"> <li>Include behavioral health in the scope of work for OTs</li> </ul>	Determine whether certification/credentialing may be obtained by OTs Counselor series credential holders; OTs	Research WACs, contact state & national OT associations Scope of practice review	Legislation; associations; professionals; licensees; department of health	
<ul style="list-style-type: none"> <li>Other Actionable Recommendations:</li> </ul>				

## V. Reduce license processing time

**Workforce-related barrier:** *It takes too long for behavioral health licensing requests to be reviewed and processed.* The result is lost opportunities to employ interns and others while they are awaiting their licenses, inability to retain skilled staff in the absence of approval of licenses in a timely fashion.

Draft Recommendations (help refine these recommendations to make them clear, specific and actionable)	Which healthcare occupations/sectors benefit most from this recommendation?	What actions are needed to implement this recommendation?	Who needs to be engaged to implement this recommendation?	What impact would implementation create? Are there models to review?
<ul style="list-style-type: none"> <li>Identify and address staffing or process limits at licensing (DOH) to develop solutions</li> </ul>	Entry level credential applicants	DOH processes complete applications w/in 14 days. Can the process/application be simplified to get a complete application the 1 <sup>st</sup> time? Guidebook?	Professional associations; licensees; DOH staff;	Improve access to care
<ul style="list-style-type: none"> <li>Find ways to effectively and efficiently license out of state professionals</li> </ul> <p>Support those with foreign credentials in this area receiving any assistance they can to enter the profession here.</p>	Potentially all professions licensed by DOH where there is an identified shortage	Analyze and determination if legislation is necessary to align WA requirements w/others while not compromising client /patient safety. <a href="#">See the work of the Puget Sound Welcome Back Center at Highline.</a>	Legislature; National Organizations; Professional associations; licensees; DOH staff;	Improve access to care; identify other state and national best practices



<ul style="list-style-type: none"> <li>Find ways to effectively and efficiently credential professionals who are licensed in other states/countries</li> </ul>	Potentially all professions licensed by DOH where there is an identified shortage	Ditto Interstate compacts	Legislature; National Organizations; Professional associations; licensees; DOH staff;	Improve access to care; identify other state and national best practices
<ul style="list-style-type: none"> <li>Other actionable recommendations:</li> </ul>				

## VI. Increase Diversity in the BH workforce (TOPIC 5 for 9/30 MTG)

**Workforce-related barrier:** *The BH workforce does not reflect the diversity of the population wanting to access services.* As a result, it is difficult to provide culturally appropriate care early and in a proactive way that reduces the need for dealing with behavioral and physical healthcare issues when they become more acute.

Draft Recommendations (help refine these recommendations to make them clear, specific and actionable)	Which healthcare occupations/sectors benefit most from this recommendation?	What actions are needed to implement this recommendation?	Who needs to be engaged to implement this recommendation?	What impact would implementation create? Are there models to review?
Expose more youth to a greater variety of BH occupations and settings ( <b>NOTE from Mandy Paradise:</b> I'm offering that the drafted recommendation is close, but not quite right. It's not simply exposure to services and settings, but truly working to improve mental health literacy as a foundation for healthcare.)	All occupations and sectors	1) mental health literacy content in schools; 2) Pre-vocational courses on behavioral health,	OSPI – Career and Technical Education OSPI – Project AWARE	Earlier mastery of behavioral health concepts and literacy; early opportunities to explore career paths related to behavioral health services leading to targeted post-secondary education and credentialing. Nevada has a high school pre-vocational behavioral health course being piloted. Washington is currently piloting a mental health & high schools curriculum resource to improve MH literacy
<ul style="list-style-type: none"> <li>Increase the use of peers/other community based workers</li> </ul>		Use of Community College		
<ul style="list-style-type: none"> <li>Increase diversity at the top of the field, not just in the front line occupations</li> </ul>				
<ul style="list-style-type: none"> <li>Increase internship opportunities</li> </ul>				
<ul style="list-style-type: none"> <li>Create effective pathways to support diverse workers to become credentialed</li> </ul>				
<ul style="list-style-type: none"> <li>Other Actionable Recommendations</li> </ul>				



## VII. Encourage state loan repayment for the behavioral health workforce (Large Group Discussion for 9/30 MTG)

**Workforce-related barrier:** *The state loan repayment program does not cover enough behavioral health occupations - Stakeholders have said there is a lack of open access to loan repayment for non-prescribing occupations and limited opportunities for behavioral health occupations in general. Additionally, there are not enough funds/not for all occupations/not enough worksites and care settings.*

<b>Draft Recommendations</b> <b>(help refine these recommendations to make them clear, specific and actionable)</b>	<b>Which healthcare occupations/sectors benefit most from this recommendation?</b>	<b>What actions are needed to implement this recommendation?</b>	<b>Who needs to be engaged to implement t(his recommendation?</b>	<b>What impact would implementation create? Are there models to review?</b>
Incentivize loan forgiveness to BH provider applicants serving the public sector, such as those in nonprofit settings. <b>(NOTE FROM Paul Francis: I would just add from a higher ed perspective that we support any financial assistance to our students, including loan repayment/forgiveness.)</b>	Clinical psychologist, LICSWs, LMHs, MFTs have been added to the next program year of the Washington State Loan Repayment Program when working in integrated care settings	No action needed	No action needed unless increased funding desired in order to make more awards	Incentivize clinicians with loans to work at high need sites
<ul style="list-style-type: none"> <li>• Incentive those who serve children with behavioral health needs</li> </ul>	Same	Same	Same	Same
<ul style="list-style-type: none"> <li>• Increase incentives for those without debt</li> </ul>	Could affect variety of professions depending on eligibility	Would need new legislation to allow direct payments rather than loan repayment awards	Associations, Legislature, WSAC	Increase number of clinicians eligible for incentives, encourage retention Alaska SHARP-II program includes direct incentive program
<ul style="list-style-type: none"> <li>• Other Actionable Recommendations:               <ul style="list-style-type: none"> <li>- Scholarship programs for students wishing to enter the BH field (i.e., how can we help them graduate without any debt in the first place?)</li> <li>- Expand State Work Study program - the one state student financial aid program that includes graduate and professional students. At one time WA had the largest SWS program in the country; however, it's been cut by 2/3's since the Great Recession. The Washington Student Achievement Council is requesting an additional \$10 million for the program next session and I'd love to see support for that in our final recommendations.</li> </ul> </li> </ul>				



## VIII. Increase Medicaid reimbursement rates to support competitive behavioral health workforce salaries and wages

### (TOPIC DISCUSSION AT 10/18 MTG)

**Workforce-related barrier:** *Low salaries and wages at facilities that serve primarily publicly-insured clients are not competitive with other employers, hindering recruitment and retention. Medicaid rates paid to behavioral health providers, for both mental health and substance use disorder treatment, are at the bottom of the rate bands (at the 25<sup>th</sup> percentile of the reasonable range for licensed professionals).* Medicaid rates paid to providers vary across the state, depending on the contracts between providers and BHOs or MCOs. The MH rates paid to BHOs for Medicaid capitation, for the four traditional rate cells, were cut by \$32 million for the biennium, and that effectively puts them at the bottom of the rate band, and that corresponds with 25<sup>th</sup> percentile clinician salaries. SUD rates were not built up from costs, so it is unclear how the range of the SUD rate band was set. Bottom of the rate band MH was combined with SUD rates to form a combined rate. For the Medicaid expansion population, the newly eligibles, rates are not at the bottom of the rate band. **NOTE FROM Joan Miller:** This sentence (above) is not entirely accurate. I have included some language with a more detailed explanation about rates. As a side note, if it is essential for political reasons to talk about both MH and SUD rates and salaries at the same time, I would drop the 25th percentile reference and focus on inadequate state funding and the impact of that on being able to pay competitive salaries. And not talk about rates paid to providers.

**Note from Maria Yang:** Medicaid rates aren't directly paid to BH providers. The state sets the Medicaid rate band. The BHOs set a case rate (per member per month payment) based off of the Medicaid rate band that the state sets. The state has argued that the BHOs and agencies have a lot more Medicaid money because of the number of people who have enrolled through the Affordable Care Act (more enrollees seems like it would mean more dollars). If the rate band is set low, however, it still means not enough money per person who gets enrolled. If you want more information on this, any of the BHO administrators can offer more information.

These rates are tied to low salaries, which makes facilities with high percentages of Medicaid clients less able to compete for staff compared to the VA, state hospitals, and facilities with more privately insured clients. The recruitment and retention difficulties that result from having too few resources for salaries/wages and for staff training and professional development was described as among the most significant workforce-related barriers to delivering behavioral health services by this project's stakeholders and key informants.

The inability to pay competitive wages in some facilities may also impede their eligibility to participate in federal loan repayment through the National Health Service Corps (NHSC)<sup>1</sup>. FQHCs and community mental health centers that are heavily dependent on Medicaid reimbursement may not be able to meet these NHSC requirements (e.g., \$47,923 annual salary for a marriage and family therapists, \$57,982 for a licensed clinical social worker).

**NOTE:** there was a comment that in 2020 everyone will be paid from one fund and this distinction will not be as relevant. Is that completely true?

**NOTE:** There are a number of efforts underway looking at issues related to reimbursement and Washington's Medicaid waivers. A task force of the BH Stakeholder Group is working to further define the issue and its impacts on increasing access to BH services in Washington.

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<sup>1</sup> <http://nhsc.hrsa.gov/currentmembers/loanrepaymentrecipients/faqs/participantsalaryreferenceguide.pdf> accessed 9-7-16



<b>Draft Recommendations</b> <b>(help refine these recommendations to make them clear, specific and actionable)</b>	<b>Which occupations/sectors of healthcare benefit most from this recommendation?</b>	<b>What actions are needed to implement this recommendation?</b>	<b>Who needs to be engaged to implement this recommendation?</b>	<b>What impact would implementation create? Are there models to review?</b>
<ul style="list-style-type: none"> <li>incentivize providers, esp. psychiatrists and child psychiatrists, to take Medicaid-insured clients <b>(NOTE FROM Maria Yang: It is not entirely clear to me how this is related to the overall theme of Medicaid rates. Regardless, it is illegal to use Medicaid funds as incentives.)</b></li> </ul>				
<ul style="list-style-type: none"> <li>increase Medicaid reimbursable practitioners (not just Master's level practitioners) <b>(NOTE FROM Maria Yang: I'm sorry that I can't offer more explanation for the following comment, but apparently you can only increase Medicaid reimbursable practitioners under Medicare and NOT Medicaid. Second, if Washington keeps its Medicaid rate band where it is, increasing the number of practitioners who can bill for services will not help with wages or salaries.)</b></li> </ul>	<p>Case Managers</p>	<p>Engage private as well as Medicaid insurance (because currently CM is covered under BHO contracting Medicaid model – however, many private insurance, and again, Medicare, will NOT pay for case management for MH svcs)</p>	<p>Health Care Authority;  Insurance commissioner, state offices</p>	<p>Clinical medical models in for example a Rural Health Clinic – they can bill Code 99211 for a nurse-office visit for certain services.</p>



<p>• Other Actionable Recommendations:</p> <ul style="list-style-type: none"> <li>- Encourage the legislature to move Washington “up” the rate band.</li> <li>- Increase Medicaid rates</li> <li>- Reduce the amount of required paper work so that staff can provide more services to our clients.</li> </ul>	<p>All BH agencies and staff will benefit.</p> <p>Agency affiliate counselors – the bulk of community behavioral health center therapists</p>	<p>Provide education and concrete examples to legislators about how the current low rate band adversely affects all aspects of BH care.</p> <p>Work with office of insurance commissioner – many insurance companies will only allow services to be provided by LICENSED MHPs – our agencies have very few of those. If we had the ability to serve more private pay – it would also help.</p>	<p>Any parties who have any relationships with legislators.</p> <p>Insurance commissioner, state offices</p>	<p>So that we can hire experienced staff instead of most of the time hiring new staff right out of college. The cost of training staff is very expensive and with the turnover bh providers are continually training new staff which is a substantial cost to the provider.</p> <p>The only way I can address the question in this column is with another question: Why is it ok that “Agency Affiliates” licensed counselors are “good enough” to service the highest need clients (those who meet ACS in a CMHC) – yet, many people with private insurance are often less impacted. In addition, this same concept applies to Social Workers – why are they the only ones “good enough” to service therapy for Medicare (a federal problem, I’m aware), when the same thing: Agency Affiliates, are able to do ACS clients? This makes NO SENSE --- it’s payment driven. It’s not service and client driven – and that’s the problem.</p>
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