

REPORT TO THE LEGISLATURE

**Residential Habilitation Center
Facility-Based Professionals**

Engrossed Substitute Senate Bill 5092 Sec. 203 (k)
Chapter 334, 2021 Laws PV

Engrossed Substitute Senate Bill 5268 Sec. 10 (2)
Chapter 219, 2022 Laws

Engrossed Substitute Senate Bill 5693 Sec. 203 (1)(k)
Chapter 297, 2022 Laws PV

December 1, 2022

DSHS' Developmental Disabilities Administration
Office of the Assistant Secretary

PO Box 45310

Olympia, WA 98504-5310

(360) 407-1500

www.dshs.wa.gov/dda

Table of Contents

EXECUTIVE SUMMARY.....	3
BACKGROUND AND CONTEXT.....	4
IDENTIFIED BARRIERS	8
RECOMMENDATIONS	9
SUMMARY	10

Executive Summary

During the 2022 Legislative Session, the Washington State Legislature directed the Department of Social and Health Services' Developmental Disabilities Administration to work with the Health Care Authority and Apple Health Managed Care Organizations to establish recommendations for clients who live in the community to access DDA's facility-based professionals. DDA and HCA recognize that the Residential Habilitation Center facility-based professionals have important skills, abilities and experiences to effectively provide care to individuals with intellectual and developmental disabilities. Many complexities exist to implement a solution to use the significant skills facility-based professionals offer within the community. However, optimizing this resource with qualified professionals who employ unique and specialized skills would be a benefit to individuals with intellectual and developmental disabilities who live in the community.

Over the course of five months in 2022, DDA composed a workgroup consisting of subject matter experts with extensive knowledge specific to Washington's Medicaid physical and behavioral health system.

Background and Context

In 2019, a stakeholder workgroup facilitated by the William D. Ruckelshaus Center produced a report to the Legislature entitled [Rethinking Intellectual and Developmental Disability Policy to Empower Clients, Develop Providers, and Improve Services](#). The report recognizes the expertise of the professional staff at DDA's Residential Habilitation Centers and recommended expanding access to these professionals. In 2021, the Legislature passed ESSB 5092¹ and ESSB 5268² which directs the Developmental Disabilities Administration to establish recommendations for clients who live in the community to access DDA's facility-based professionals.

Over the course of five months in 2022, DDA composed a workgroup consisting of subject matter experts with extensive knowledge specific to Washington's Medicaid physical and behavioral health system. Representatives from HCA and the MCOs included individuals who specialize in managed care enrollment, provider network, care management, behavioral health, clinical programs and operations. DSHS representatives included individuals who specialize in DDA program and policy, DDA operations and RHC medical specialist staff.

The RHC facility-based professionals referenced in the legislative directive and throughout this report are state employees working at one of the four state-operated Residential Habilitation Centers in Washington state: Lakeland Village in Medical Lake, Fircrest School in Shoreline, Rainier School in Buckley and Yakima Valley School in Selah. For reference, facility-based professionals include the following licensed practitioners: Physician, Physician Assistant, Registered Nurse, Licensed Practical Nurse, Advanced Registered Nurse Practitioner, Psychologist, Psych Associate, Dentist, Occupational Therapist, Physical Therapist, Speech Pathologist/Audiologist, Psychiatrist, and Dietician.

A comprehensive list of all recommendations from the workgroup can be found at the end of this report. The top priority recommendations include:

- In alignment with a Ruckelshaus Workgroup recommendation, and the Legislatures' continued investment in community residential services, increase the number of statewide MCO providers in the specific disciplines with experience supporting individuals with I/DD.
- As the number of individuals receiving Intermediate Care Facility services decreases, explore opportunities for individuals who do not reside at a RHC, access to facility-based professionals such as dentists or physical therapists; and to receive specialty care at the RHC, until there is a more adequate provider network to meet the need.
- Increase the number of facility-based professionals at the RHCs to enter into clinical teaching agreements with residencies, training-based clinics and medical colleges in Washington state to help address the workforce shortage.

¹ Section 203(k), page 137

² Section 10(2), page 8

- Create a Memorandum of Understanding between the MCO, facility-based professionals, and community-based clinics to provide advisory and consultation services to patients with I/DD in their clinics.

Considerations

The workgroup identified categories for consideration related to the delivery of Medicaid benefits necessary to accomplish the legislative intent. The following topics provide the framework for the workgroup's recommendations for RHC facility-based professionals to provide medically necessary services to individuals with I/DD in the community. Subsequent barriers were revealed throughout the workgroups discussions and are also identified below. These categories represent general areas and should not be considered an exhaustive list.

Inpatient vs. Outpatient

RHC professionals provide comprehensive physical and behavioral health services and rehabilitative supports similar to individuals receiving other intensive levels of care, such as inpatient care. Due to federal regulations for Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities, the RHCs must develop each client's habilitation plan so that the client receives continuous aggressive active treatment . A client's habilitation plan is developed by an interdisciplinary team within 30 days of admission to the RHC. The plan includes comprehensive assessments completed by all the professional disciplines. Subsequently, the interdisciplinary team develops a plan rooted in the delivery of active treatment.

Contract and Credentialing

To become a Medicaid provider, RHC licensed health care professionals (either as an independent/solo practitioner or licensed health care group or facility) need to be contracted and credentialed with each MCO. The billing provider must have a Core Provider Agreement to provide Medicaid services to individuals with I/DD in the community. Components impacting the recommendation for contracting and credentialing of RHC professionals include:

- RHC independent practitioners currently do not bill Medicaid for contracted services.
- Inpatient model providers are credentialed differently than those at the RHCs.
- RHC providers do not have the inpatient credentialing model resources.
- Turnover rates are high and fluctuate within the RHC provider pool (Table 1).

The workgroup recommends the RHCs contract with the MCO and the HCA as a provider group. The practicing provider must be enrolled with the HCA and registered under the billing provider group.

³ 42 C.F.R. § 483.440(a)(1)(2)

Billing

Medicaid services must be medically necessary and must meet the medical necessity⁴ definition in Washington Administrative Code to be payable by Medicaid funding. The facility-based professionals at the RHC include covered provider types that are billable to Medicaid. However, services provided by identified facility-based professionals may not be covered provider types such as: Registered Nurses, Licensed Practical Nurses and assistants in the specialty of occupational therapy, physical therapy, medical and dental.

Additionally, the RHCs currently do not use billing codes or file medical claims for clients who are admitted. Additional infrastructure would be needed for facility-based professionals to bill for covered services under the client’s Benefit Service Package and receive payment to provide these services in the community.

Telehealth

Telehealth is an effective element of health care delivery and has become part of the practice in delivering medically necessary physical and behavioral health services. Due to the location of each of the RHCs, making telehealth available could provide individuals with I/DD in the community the ability to access any of the facility-based professionals and create a more equitable resource. The facility-based professionals providing telehealth services would be able to conduct the service from their respective RHC. Services provided through telehealth and the policies governing the delivery of service via this method, continue to be developed by HCA. The standard practice of telehealth would be based on outcomes determined by HCA. The delivery of service via telehealth could positively impact the accessibility and benefit both the individual receiving the service and the RHC professional staff. For successful delivery of telehealth services for the I/DD population, having a knowledgeable advocate to assist the client is a necessity.

Specialized Workforce

The workgroup acknowledged an overall national workforce shortage with an even further need for licensed and certified professionals who specialize in providing healthcare services to individuals with I/DD. Within the MCO provider network system, criteria to select a health care professional with I/DD experience does not currently exist. Statewide need based on geographic availability is uncertain. The consensus of the workgroup was that access to RHC professionals may aid in addressing this specific workforce shortage.

Capacity

Table 1 represents the number of funded and vacant full-time employees among the four RHC professional staff as of May 2022. The RHC facility-based professionals’ primary objective is to effectively meet the needs of the clients admitted to the RHC⁵ (in-patient treatment

⁴ WAC 182-500-0700 ‘Medically Necessary’
⁵ 42 C.F.R. § 483.430 (b)

model). Further analysis is needed to determine whether the RHC facility-based professionals' have capacity beyond their primary responsibilities to serve additional community members. Furthermore, the workgroup recommended creating incentive programs and increasing the general knowledge and comfort of community providers to serve this specific population.

Union and Collective Bargaining

Many of the RHCs facility-based professionals are in positions covered by a collective bargaining agreement. The RHCs would be entering into contracts with MCOs, enrolling with Medicaid and expanding the current work expectations, increasing workload and potentially changing work location to a location outside of the facility's current geographic location. Providers would be required to carry their own malpractice/liability insurance if practicing outside of a facility as a solo practitioner. This may have additional cost implications. The workgroup recognized the need to further examine collective bargaining impacts with the three unions (Washington Federation of State Employees, Service Employees International Union, and the Coalition) to support facility-based professionals providing health care services outside of the RHC and in the community. A universal systematic procedure is needed to determine the facility-based professionals' capacity and evaluation of their workload capacity, to provide community-based services.

Brick and Mortar Community-Based Setting

As cited in the [2019 Ruckelshaus report](#), recommendations were made to improve cross-systems coordination by establishing agreements to enable facility-based professionals to deliver services at mobile or brick-and-mortar clinical settings in the community. The workgroup identified two different options for facility-based professionals to provide Medicaid state plan services to individuals with I/DD in the community in these settings.

Option 1: Leasing space in a clinical setting which contains basic medical and office equipment. This could include contracts with clinics that have available space or professionals alternating days within a specific clinic to provide care.

Option 2: Clinic-to-clinic agreement that formalizes shared services, such as administrative staff to support scheduling and billing, shared equipment and electronic record keeping with an already established clinic for both entities to operate distinct clinics in tandem. Barriers for Option 2 include shared practice liability concerns and potential cost prohibition.

The workgroup recommends leasing office space, equipment and administrative staff to support the work.

The workgroup identified two different options for facility-based professionals.

Table 1 – Statewide RHC Professional Staff⁶

Job Class	Current FTE	# of Vacancies
Physician	5.4	3.4
Physician Assistant	1	2.2
Advanced Registered Nurse Practitioner	7	0
Psychologist	5	4
Psych Associate	17.6	2
Dentist	3.2	0
Occupational Therapist	7	2
Physical Therapist	4.6	0
Speech Pathologist/Audiologist	11.75	3
Psychiatrist	1	0
Dietician	3	3

Table 1 does not include provider types that are not outpatient billable services for Medicaid physical health: RN, LPN and assistants for OT, PT, medical and dental.

Identified Barriers

- Access to facility-based professionals in the community to receive Medicaid benefits in a mobile or brick and mortar setting is equivalent to services provided in an outpatient setting. This does not align with the current model in use by the facility-based professionals at the RHC.
- The services rendered by some of the provider types at the RHC may not correspond to a covered service within the clients Benefits Service Package and would need to parallel the Medicaid Billing Guides.
- Infrastructure and training are needed for RHC professionals to become a billing provider under a Core Provider Agreement with HCA. This will allow the facility-based professionals at the RHCs to bill for covered services under the client's Benefit Service Package and receive payment to provide medically necessary services in the community.

⁶ HRIS Data Warehouse, Position Details Report as of May 1, 2021

- Data is not available to identify the capacity and geographic gaps specific to professionals with an I/DD specialty. Furthermore, there is no data available for which professionals obtain specialized expertise for individuals with I/DD for the community members to seek when they have physical or behavioral healthcare needs.
- There would be additional burden on the RHC provider group administration to credential the professional RHC providers.
- The union and collective bargaining agreements would need to be negotiated for RHC professional staff to work in outpatient settings to deliver community-based services or advise/teach community-based providers.
- Providers would be required to carry their own malpractice/liability insurance if practicing outside of a facility as an independent/solo practitioner. If the provider malpractice is related to inappropriate billing practices resulting in audits, there is additional risk which may negatively impact the entire provider group.

Recommendations

- Based upon the Ruckelshaus Workgroup recommendations, and the Legislatures' continued investment in community residential services, increase the number of statewide MCO providers in the specific disciplines with experience supporting individuals with I/DD.
- Create a system to calculate the ratio between the facility-based professionals' percentage of job responsibilities available to support the provision of services in the community. This ratio should be based on the current number of RHC residents.
- As the number of individuals receiving ICF services decreases, explore opportunities for individuals who do not reside at a RHC to access to facility-based professionals such as dentists or physical therapists. Access should include specialty care at the RHC until there is a more adequate provider network to meet the need.
- Provide support for facility-based professionals to become contracted and credentialed with the MCOs and enroll with the HCA as a provider group.
- Increase the number of facility-based professionals employed by the RHCs to enter into clinical teaching agreements with residencies, training-based clinics and medical colleges in Washington state to help address the workforce shortage.
- Create a Memorandum of Understanding between the MCO, facility-based professionals and community-based clinics to provide advisory and consultation services to patients with I/DD in their clinics.
- Consider the delivery of service via telehealth as an option for facility-based professionals to offer individuals living in the community.
- Conduct an analysis of how many clients could be served in the community by the RHC facility-based professionals within each discipline.
- Conduct a legal analysis regarding malpractice/liability insurance impacts.

Summary

RHC professionals have significant skills, abilities and related experiences to provide effective physical and behavioral health care for individuals with intellectual and developmental disabilities. Optimizing the work of these qualified professionals will aid in addressing the community-based workforce deficiency.

Although there are barriers that require further exploration and may have cost impact to the state, some of the recommendations could have immediate outcomes if supported. The workgroup recommends a short-term and a long-term approach to achieve the identified recommendations.

The workgroup identified categories for consideration related to the delivery of Medicaid benefits necessary to accomplish the legislative intent.