

Children and Youth Behavioral Health Work Group Recommendations

2016 - 2020

Engrossed Second Substitute House Bill 2439, Chapter 96, Laws of 2016

Engrossed Second Substitute House Bill 2779, Chapter 175, Laws of 2018

Second Substitute House Bill 2737, Chapter 130, Laws of 2020

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**Division of Behavioral Health
and Recovery -
Children, Youth and Families**

P.O. Box 45502
Olympia, WA 98504

Contact: Rachel Burke
Phone: (360) 725-5276
Fax: (360) 586-9551

hca.wa.gov

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Acknowledgements

This report describes progress made in improving access to, and quality of, behavioral health services for children, youth and families. Thank you to the many people in the work group and its advisory groups from 2016 to today who contributed their hearts, hands, and minds to this work – with special thanks to the youth, and parents of children and youth, whose experiences and perspectives informed this work.

Executive summary

In 2016, [Engrossed Second Substitute House Bill 2439](#) (House Bill 2439) established the Children’s Mental Health Work Group (renamed the Children and Youth Behavioral Health Work Group [CYBHWG]), bringing together legislators, state agencies, health care providers, tribal governments, and other stakeholders to identify and address issues related to mental health access for children, youth, and families. In December 2016, the work group submitted a report to the Legislature with a range of recommendations addressing access issues. This report is an update to the 2016 report, [The Children’s Mental Health Work Group Final Report and Recommendations](#), highlighting progress made on the original 2016 recommendations, as well as recommendations the work group has made in the years since then.

While the original work group was authorized only through December 2017, two additional bills have extended its work:

- [Engrossed Second Substitute House Bill 2779](#) (House Bill 2779), passed in 2018, extended the work group through December 2020.
- [Second Substitute House Bill 2737](#) (House Bill 2737), passed in 2020, renamed the work group and reauthorized it through December 2026.

The work group’s original recommendations fell into a number of different categories:

- Medicaid rates for behavioral health services;
- Screening and assessment;
- Workforce;
- Behavioral health service delivery and care coordination;
- Network adequacy;
- Paperwork reduction;
- Child care services; and
- Behavioral health training and education.

Much of the legislation enacted in response to the original 2016 recommendations and those from subsequent years can be found in a series of bills related to children’s mental health, including the two bills mentioned above. The table on the following page shows the bills and the 2016 recommendations they addressed.

Other recommendations were enacted through budget provisos.¹ Additional legislative action on these recommendations, as well as recommendations the work group made in subsequent years are detailed later in this report.

The most constant recommendation has been to raise the Medicaid rates for behavioral health providers. This recommendation passed in 2020, but was vetoed as part of the Governor’s COVID-19 response. The 2020 CYBHWG sees rate increases as foundational to addressing the behavioral health workforce crisis and access issues. A sufficient workforce is a prerequisite for providing adequate access to all children, youth, and families who need these services.

¹ A proviso is language in a budget bill that places conditions on the use of appropriated funds. Budget provisos often fund new work or services that are legislated in another bill. In some cases, a proviso can direct an agency to do new work that is not included in another bill.

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Bill	Year	Enacted 2016 recommendations
Engrossed Second Substitute House Bill 1713 (House Bill 1713)	2017	<ul style="list-style-type: none"> Requires each managed care organization (MCO) and behavioral health organization (BHO)² to develop adequate capacity to provide children’s mental health treatment services and ensure it is meeting care coordination requirements. The Health Care Authority (HCA) must reimburse providers for depression screening for mothers of children from birth to six months, and adolescents (ages 12-18) and for behavioral health services delivered through telemedicine. The Office of the Superintendent of Public Instruction (OSPI) must pilot a lead staff person for children’s behavioral health in two Educational Service Districts (ESDs). The Department of Early Learning (DEL)³ must establish a consultation program to offer behavioral health resources to child care providers. Washington State University (WSU) must offer a child and adolescent psychiatry residency.
Engrossed Second Substitute House Bill 1819 (House Bill 1819)	2017	<ul style="list-style-type: none"> Directs the Department of Social and Health Services (DSHS) to streamline providers’ documentation requirements. This work was later transitioned to the Department of Health (DOH).
Substitute House Bill 1624 (House Bill 1624)	2017	<ul style="list-style-type: none"> Made families with children receiving child protective services or welfare services eligible for Working Connections Child Care.
House Bill 2779	2018	<ul style="list-style-type: none"> HCA’s annual report on network adequacy for children’s mental health services must include data on mental health and medical services provided for eating disorder treatment. The University of Washington (UW) must offer a child and adolescent psychiatry residency. The lead staff person in each ESD behavioral health pilot site must offer a mental health curriculum to students in one high school. School districts must use one professional learning day each year for social-emotional learning, cultural sensitivity, and related training.
Second Substitute House Bill 1668 (House Bill 1668)	2019	<ul style="list-style-type: none"> Created a tuition loan repayment program for behavioral health professionals working at community health clinics in underserved areas.
Second Substitute Senate Bill 5903 (Senate Bill 5903)	2019	<ul style="list-style-type: none"> WSU and UW to each offer an additional child and adolescent psychiatry residency. HCA to expand the Coordinated Specialty Care program for early identification and treatment of psychosis to make its services available statewide and then to increase programming based on incidence and population. (The program was funded the following year.) The Department of Children, Youth and Families (DCYF) must contract to provide six regional consultants to support the work of coaches and child care providers in the child care consultation program, now called Early Achievers.
Substitute House Bill 2456 (House Bill 2456)	2020	<ul style="list-style-type: none"> Extended grace period to 12 months for homeless families in Working Connections Child Care program.

² Prior to behavioral health integration, BHOs purchased and administered public mental health and substance use disorder treatment on a regional basis for individuals enrolled in Medicaid. MCOs now fill this role.

³ Since 2016, DEL has been reorganized into a new agency, the Department of Children, Youth and Families (DCYF).

Background

History

In 2016, House Bill 2439 established the Children’s Mental Health Work Group. The original work group was authorized through December 2017 and brought together representatives from the Legislature, state agencies, health care providers, tribal governments, community health services, and other organizations, as well as parents of children and youth who had received behavioral health services.

The work group was tasked with reviewing barriers to identifying and treating children and youth with mental health issues, with a particular focus on birth through age five.

House Bill 2439 directed the group to:

- Review and recommend developmentally, culturally, and linguistically appropriate assessment tools and diagnostic approaches to establish eligibility for services;
- Identify billing issues related to providing services, including parent-child treatment dyads⁴;
- Identify and evaluate barriers to billing and payment for behavioral health services provided in primary care settings;
- Review workforce issues, and recommend strategies for increasing diversity and numbers;
- Make recommendations on training and endorsement standards for professionals serving children from birth to age five and their parents or caregivers;
- Analyze mental health supports for child care providers to reduce expulsions of children in child care and preschool; and
- Identify outreach strategies to parents, providers, schools, and others who work with children and youth on available mental health services.

The work group reported its findings to the Legislature on December 1, 2016. It proposed additional recommendations at its December 2017 meeting, including continuation of the work group.

In 2018, the Legislature passed House Bill 2779, reestablishing the Children’s Mental Health Work Group and extending it through December 2020. The emphasis on the birth to age 5 population was not included in the 2018 legislation and the work group was directed to:

(a) Monitor the implementation of enacted legislation, programs, and policies related to children’s mental health, including provider payment for depression screenings for youth and new mothers, consultation services for child care providers caring for children with symptoms of trauma, home visiting services, and streamlining agency rules for behavioral health providers;

(b) Consider system strategies to improve coordination and remove barriers between the early learning, K-12 education, and health care systems; and

(c) Identify opportunities to remove barriers to treatment and strengthen mental health service delivery for children and youth.

⁴ A dyad is something that consists of two elements or parts. For infants and young children, therapy is often best provided through treating the parent and child together as a parent-child dyad.

In 2020, the Legislature passed House Bill 2737, reauthorizing the work group through December 2026. The work group was renamed the Children and Youth Behavioral Health Work Group (CYBHWG), using the term “behavioral health” to encompass substance use treatment as well as mental health, and calling out youth in the title as a group with unique characteristics and needs that differ from children.

Its duties were amended to require:

- Monitoring mood, anxiety, and substance use disorder prevention, screening, diagnosis, and treatment for children and young mothers;
- Determining strategies and resources needed to:
 - Improve inpatient and outpatient access to behavioral health services;
 - Support the unique needs of young children prenatally through age 5;
 - Develop system improvements to support the behavioral health needs of children and youth; and
- Considering issues and recommendations put forward by the statewide Family, Youth and System Partner Roundtable (FYSPRT).⁵

While the co-chairs are empowered to convene as many advisory groups, or subgroups, as they find necessary, House Bill 2737 also requires the work group to convene a continuing advisory group on school-based behavioral health and suicide prevention to:

...advise the full work group on creating and maintaining an integrated system of care through a tiered support framework for kindergarten through twelfth grade school systems defined by the Office of the Superintendent of Public Instruction and behavioral health care systems that can rapidly identify students in need of care and effectively link these students to appropriate services, provide age-appropriate education on behavioral health and other universal supports for social-emotional wellness for all students, and improve both education and behavioral health outcomes for students...

House Bill 2737 amended membership to include:

- A parent of a child under the age of six who has received behavioral health services;
- Two youth representatives who have received behavioral health services;
- A substance use disorder professional; and
- One representative each from a private insurance organization, an organization representing the interests of individuals with developmental disabilities, and the statewide FYSPRT.

(See Appendix C for a complete list of 2020 CYBHWG members.)

⁵ In 2009, the *T.R. et al. v. Kevin Quigley and Dorothy Teeter* lawsuit was filed against the state based on federal laws that require states to provide mental health services and treatment to children covered by Medicaid. As part of the settlement, FYSPRTs— regional groups of parents, youth, providers, and others within the community – were created to address challenges and barriers to behavioral health services for children, youth, and families in Washington State. If a regional group cannot resolve issues it identifies at the local or regional level, they bring it to the statewide group. With House Bill 2737, if issues cannot be resolved at the statewide FYSPRT level, they are brought to the CYBHWG.

2020's Children and Youth Behavioral Work Group

The mission of today's work group follows the initial intent of the 2016 authorizing legislation – to increase access to developmentally and culturally appropriate behavioral health services for children, youth, and families, and acknowledges that the lifespan for this population extends into young adulthood:

[To] identify barriers to and opportunities for accessing behavioral health services for children, youth and young adults (prenatal to 25 years old) and their families that are accessible, effective, timely, culturally and linguistically relevant, supported by evidence, and incorporate tailored innovations as needed; and to advise the Legislature on statewide behavioral health services and supports for this population.

In 2020, the CYBHWG had four subgroups:

- Prenatal through Five Relational Health;
- School-based Behavioral Health and Suicide Prevention (legislatively mandated);
- Youth and Young Adult Continuum of Care; and
- Workforce and Rates.

In 2021, the work group will have an additional subgroup focused on behavioral health integration as it relates to services for children, youth, young adults, and their families.

Each of these subgroups' members represent a broad range of individuals, including:

- Legislators;
- Advocates;
- Counselors and social workers;
- Physicians;
- Representatives from state agencies, public health departments, hospitals, community-based health clinics, Medicaid MCOs, and commercial insurers;
- Youth who have received services; and
- Parents of children and youth who have received services.

In 2020, these groups met throughout the spring, summer, and fall to evaluate access, barriers, and opportunities through their particular lenses and develop recommendations.

The work group submitted its preliminary recommendations for the 2021 legislative session to the Legislature and the Governor on November 2, 2020, and its final recommendations ([Appendix B](#)) on December 11, 2020.

Between the work group members and those involved in the subgroups, around 200 people contributed to the recommendations.

Update: 2016 recommendations and beyond

This section describes the current status of the recommendations the CYBHWG submitted in December 2016, as well as additional recommendations from the work group since that time. Original recommendations, from the 2016 Children’s Mental Health Work Group report, are formatted as quotations at the beginning of each section.

Those that have resulted in legislation or other policy changes have a red checkmark next to the original recommendation. For those that have not been fully realized, but have seen progress, as well as those which have progressed beyond the original recommendation, a graphic shows the progression.

Rates

Prioritized recommendations

Increase Medicaid rates

The Legislature should provide funding to increase Medicaid rates to achieve equity with Medicare rates, in order to increase the number of providers who will serve children and families on Medicaid.

After the rate increases have been implemented for two years, the Legislature should require an outcome-based study on providers, analyzing the impact on the workforce and the number of providers who serve children and families on Medicaid.

The work group has recommended an increase in Medicaid rates for behavioral health services as a priority every year since 2016, as its members see increased rates as a necessary first step to address the behavioral health workforce shortages in Washington State. The 2019 recommendation added specificity, recommending that rates be raised by eight percent or to the Medicare reimbursement rate.

In 2020, as part of the state’s supplemental operating budget – [Engrossed Substitute Senate Bill 6168](#) (Senate Bill 6168), Sec. 215 [78] – the Legislature passed a rate increase for selected behavioral health services, including psychotherapy and care coordination, of 15 percent or the Medicare rate, whichever is lower. The Governor vetoed the increase as part of the cost-cutting measures to address the impacts of the COVID-19 pandemic.

The CYBHWG has again prioritized this recommendation for 2021, using the language contained in Senate Bill 6168, which increases rates by 15 percent and makes technical corrections necessary to implement the rate increases. This year, the work group found rate increases for behavioral health providers to be foundational for maintaining the delivery system and ensuring access.

Progress on rate increases



Additional 2016 recommendations

- ✓ State agencies should remove limitations on treatment options focused on treating the family dyad or a particular familial relationship.

Limitations on providing treatment for a family dyad (critical for treatment of infants and young children) and other family relationships were effectively removed with the passage of House Bill 2779 (2018), which added “family supports” as an allowable outpatient service.

The Legislature should provide increased funding for specialized children’s mental health services and training, including, but not limited to:

- Infant mental health services and training;
- ✓ Wraparound with Intensive Services (WISe);
- Treatment for eating disorders;
- ✓ Early interventions for treating psychosis; and
- Interventions that are culturally and linguistically appropriate.

Infant mental health services and training

Funding for infant mental health services and training continues to be an area of concern for the CYBHWG. Key concerns are the lack of billing authorization and funding for the special services required for infant and early childhood mental health assessment, and an extremely small number of clinicians statewide that provide specialized infant and early childhood behavioral health services.

In 2020, the Legislature included a budget proviso (Senate Bill 6168, Sec. 215 [56]) for HCA to develop and implement grants to provide flexible funding for training and mentoring of clinicians serving children, including those that serve the birth to age 5 population. This proviso was vetoed as part of the Governor’s pandemic response.

The work group currently has a priority recommendation for the 2021 legislative session to change Medicaid policy to allow three to five sessions (including in natural settings) utilizing the *DC:0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*. This change in policy is accompanied by a budget request to fund the additional sessions and services provided. (See Prioritized recommendations in the Screening and assessment section for more information.)

Wraparound with Intensive Services (WISe)

Wraparound with Intensive Services, or WISe, is a new approach to helping Medicaid-eligible children, youth, and their families with intensive mental health care. Children, youth, and families receive services in their home or other community settings and have a team of people to support them (including family members, friends, counselors, youth and family peers, and others). The individual and their family set goals that meet their needs and develop an individualized care plan.

With WISe, MCOs receive a monthly case rate that covers all WISe-related behavioral health costs, in addition to the regular amount they receive per member per month. Since 2014, a review of the WISe case rate has been part of the annual rate review conducted by the actuaries as part of HCA’s rate-setting process. The WISe case rate has been adjusted seven times since July 2014 with another annual update

anticipated in early January 2021. The original WISe case rate was \$2,070.12 per youth per month; the rate is currently \$3,371.43. In July 2018, the WISe Fee-For-Service (FFS) case rate for American Indian and Alaska Native youth was \$1,388.38 per youth per month; it is currently \$3,304.00. In addition to the WISe FFS case rate, agencies receive the FFS reimbursement for each service provided.

Treatment for eating disorders

While funding for treatment for eating disorders has not been increased, House Bill 2779 (2018) added a requirement that HCA report annually on mental health and medical services for eating disorder treatment.

Early interventions for treating psychosis

The recommendation for increased funding for treating psychosis was realized in 2019, following a recommendation by the work group to create a statewide implementation plan to expand Washington State’s first episode psychosis program for adolescents and young adults. Senate Bill 5903 directed HCA to develop a statewide plan to implement evidence-based Coordinated Specialty Care programs that provide early identification and intervention for psychosis statewide and to work with an actuary to determine a case rate in order for the programs to be sustainable. The program, New Journeys, will be in each region by January 2021, and will expand based on incidence and population to result in statewide access. The implementation plan and case rate recommendations will be in the Senate Bill 5903 Legislative report, New Journeys: Coordinated Specialty Care for First Episode Psychosis, to be submitted to the Legislature on January 28, 2021.

Interventions and services that are culturally and linguistically appropriate.

While the Legislature has not increased funding for culturally appropriate interventions, it has passed legislation to improve families’ ability to find culturally and linguistically compatible providers.

In 2017, House Bill 1713 required MCOs (and previously BHOs) to better support children’s timely access to mental health treatment (Chapter 74.09.337 RCW). The legislation aimed to increase transparency and accessibility of cultural and linguistic information about behavioral health providers participating in the MCO’s network with capacity to serve children and youth. As a result, families have easier access to information about providers on the MCOs’ websites, including information about whether available providers have completed cultural competence training and/or have specific expertise to support the enrollee’s needs, e.g., “served in Peace Corps, Tanzania; speaks fluent Swahili.” This legislation expired in 2020, but HCA continues to require MCOs to share this information on their websites.

New recommendations since 2016

Year Recommended	Recommendation	Legislation
2017	Direct HCA to contract with an outside facilitator to build on the 2017 home visiting and Medicaid financing strategies recommendations and develop an implementation plan for Medicaid coverage of home visits.	House Bill 2779 (2018) requires DCYF and HCA to develop a strategy for Medicaid funding for home visiting. (See January 2019 report for details.)

Year Recommended	Recommendation	Legislation
2017	Create Medicaid codes for supervision of mental health practitioners and partial hospitalization treatment and services.	House Bill 2779 (2018) allows reimbursement of providers for partial hospitalization or intensive outpatient treatment.
2019	Require that proposals related to increasing Medicaid rates must be grounded within the rate-setting process for the provider type or practice setting, incentivize preventive care, and recognize the shift toward value-based purchasing. Any increase in Medicaid rates for behavioral health services must include a proportional increase to services with a case rate, with a priority on WISE.	Engrossed House Bill 2584 (House Bill 2584, 2020) requires HCA to work with actuaries and MCOs in implementing funded behavioral health rate increases to ensure appropriate adjustments are made to the WISE case rate.
2019	Require HCA, with respect to funds appropriated by the Legislature with the intent of increasing Medicaid rates paid to providers, to establish mechanisms that ensure these funds are passed on by MCOs directly to behavioral health providers.	House Bill 2584 requires HCA to establish a process for verifying that funding appropriated for behavioral health provider increases, including rate increases provided through MCOs, is used for the objectives stated in the appropriation.
2019	Enhance transparency and accountability mechanisms utilized by HCA and MCOs to ensure that appropriated community behavioral health funds are used by HCA and MCOs for their intended purpose.	House Bill 2584 requires HCA to provide annual reports to the Legislature regarding the implementation processes and results of targeted behavioral health provider rate increases.

Screening and assessment

Prioritized recommendations

The Legislature should require HCA and the Division of Behavioral Health and Recovery (DBHR) to assemble a work group or work groups to:

- ✓ Identify a standardized list of culturally and developmentally appropriate screening tools for children ages 0-20 for use by all primary care practitioners whether covered by Medicaid or commercial insurance.
- Identify standardized mental health assessment, outcome, and diagnostic tools that are culturally and developmentally appropriate for children ages 0-5 that support access to services, and clearly identify what substantive mental health challenges look like in young children.
- Identify billing options and propose coverage with an adequate reimbursement rate for these services during an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visit, or other primary care visit:
 - Maternal depression screening, for children ages 0-5; and

- Behavioral health screening, including depression screening, for children ages 0-20.

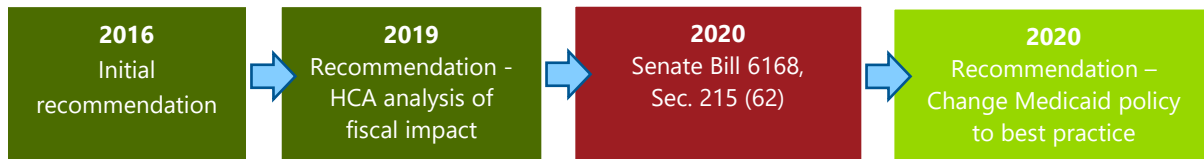
Standardized list of appropriate screening tools

HCA has included a list of behavioral health screening tools for well-child visits, recommended by the work group described in the 2016 recommendation, in its EPSDT Program Billing Guide since 2018. (See [Appendix A](#) for additional details.)

Developmentally appropriate mental health assessment tools for 0-5

While the full realization of recommendations for mental health assessments for infants and young children has not come to fruition, progress is being made. In 2020, the Legislature included a proviso directing HCA to conduct an analysis on the impact of changing Medicaid policy to best practices for mental health assessment and diagnosis for children ages 0-5. A report on the analysis will be submitted to the Legislature in early 2021. Meanwhile, the work group has recommended, for 2021, changing Medicaid policy to match best practices for children ages 0-5, including allowing three to five sessions in natural settings.

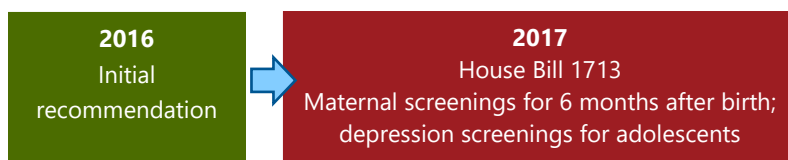
Progress on mental health assessments for infants and young children



Children’s behavioral health screenings and maternal depression screenings

With passage of House Bill 1713 (2017), maternal depression screenings are now required, though only until the child is six months old. Depression screenings are required for youth ages 12-17, short of the extended age range recommended by the work group. In 2020, the work group included in its recommendations a statement of support for the Washington Chapter of the American Academy of Pediatricians’ (WCAAP) learning collaborative on postpartum mood and anxiety screening. The collaborative aims to identify why more screenings are not done (or appropriately coded), and how to remove any clinical barriers.

Progress on children’s and mothers of young children’s depression screenings



Additional 2016 recommendations

Provider outreach and education

The Legislature should require HCA and DBHR to provide outreach and education to primary care practitioners and mental health providers regarding:

- Expectations of services to be performed during an EPSDT exam;
- Maternal depression or other contributing mental health conditions that directly impact the child that are noted in the child's treatment plan; and
- Billing requirements for mental health screening and referrals to mental health services, including new billing and coverage options developed pursuant to EPSDT visits...

HCA reached out to primary care providers when maternal depression screening was added as a required part of EPSDT visits for mothers of children ages 0-6 months. Also, HCA's [EPSDT program billing guide](#) provides detailed information about the required elements of an EPSDT visit, frequency of visits, and billing information. HCA's contracts with MCOs include performance measures for postpartum care and well-child (EPSDT) visits (actual number of visits compared to recommended number of visits).

Well-child visits for all ages continue to be an area where improvements could be made. In 2019, HCA's statewide numbers for Medicaid MCOs were at the 50th percentile nationally for well-child visits in the first 15 months, and below the 50th percentile nationally for older children. The lowest numbers were for adolescents, with 46.6 percent of adolescents receiving well-child visits, compared to 67.7 percent of children ages 3-6.⁶ (Additional Information can be found in Appendix A of HCA's [Medicaid Managed Care preventive services and vaccinations](#) report.)

The Legislature should identify a full complement of medically necessary behavioral health services to be covered by all commercial carriers.

There has been no legislation to require a specified list of medically necessary behavioral health services that commercial carriers must include. However, state and federal mental health parity laws provide some protections:

- [Substitute House Bill 1154](#) (House Bill 1154, 2005) required group health insurance plans covering over 50 employees to cover "medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders" equal to their coverage of other medical and surgical services. Treatment for life transition problems and substance use disorders, skilled nursing facility services, home health care, residential treatment, custodial care, and court-ordered treatment were exempted. The bill also required a comparable medical necessity standard to that used for medical and surgical services.

⁶ See hca.wa.gov/assets/program/comagine-health-comparative-regional-report-20190129.pdf.

- [Engrossed House Bill 1460](#) (House Bill 1460, 2007) extended these mental health parity requirements to individual and small group insurers.
- Most recently, in 2020, the Legislature passed [Substitute House Bill 2338](#) (House Bill 2338) which removes the exemptions for coverage of selected treatment services described above.
- At the federal level, the [Mental Health Parity and Addiction Equity Act of 2008 \(MHPAEA\)](#) and the Affordable Care Act (2010) also provide mental health parity protections.

The Legislature should enlist local health districts and other appropriate venues and providers to provide behavioral health screening for all children ages 0-20.

There has been no legislation to address this recommendation.

Workforce development

Prioritized recommendations

Tuition loan repayment program

- ✓ The Legislature should provide a tuition loan repayment program targeted for child psychiatrists, therapists, and clinicians working for BHO- or MCO-funded agencies that serve a high percentage of children, youth, and families on Medicaid. The tuition loan repayment program should be directed at professionals in the above fields who make a commitment to work for five years in the public sector setting, working more than 20 hours per week on average. Loan repayment amounts should be commensurate with the average training costs for the respected specialties.

In 2019, the Legislature passed House Bill 1668, creating a tuition loan repayment program for behavioral health professionals working at community health clinics in underserved areas, and administered by the Washington Student Achievement Council. It currently offers 100 scholarships.

In a prioritized recommendation for 2021, the CYBHWG is recommending that:

- The program be expanded to cover an additional 100 providers;
- Existing barriers be reduced, such as the length of time providers are required to stay in a position; and
- Priority be given to applicants with diverse ethnic and cultural backgrounds.

Progress on tuition loan repayment for behavioral health professionals



Additional 2016 recommendations

Supervision incentives

The Legislature should incentivize clinical supervision of therapists working in MCO or BHO agencies through individual agency contracts, by restricting counselor-to-supervisor ratios in contracts with MCOs and BHOs, and/or capping the caseload size for supervisors to be consistent with recommendations from evidence-based and research-based practices.

2018's children's mental health bill, House Bill 2779, allows reimbursement for supervision of staff working toward satisfying clinical supervision requirements. Additional measures, such as restricting counselor-to-supervisor ratios and capping caseload size for supervisors, have not been legislated.

The CYBHWG has recommended, for the 2021 session, that the Legislature establish a work group to develop a behavioral health teaching clinic enhancement rate that would apply to behavioral health agencies that are training and supervising students and those seeking their certification or license.

Progress on supervision incentives



Options for payments and variety of professionals providing interventions

The Legislature should increase options for payments and increase the variety of professionals who can help provide mental health interventions, such as parent-family partners and peer support in communities and non-traditional locations, including settings such as primary care, education, child welfare, and juvenile justice, in order to increase the diversity of the settings in which mental health settings can be provided.

There has been no legislation that addresses this recommendation. HCA continues to explore ways to expand peer services, and the Department of Health (DOH) and legislators are evaluating an advanced peer certification. One of the work group's 2020 recommendations is to expand the availability of youth and family peer services across the continuum of care.

Evaluation of the children's mental health system

The Legislature should require the Washington State Institute for Public Policy (WSIPP), or a similar organization, to conduct a study in collaboration with interested stakeholders and communities to evaluate the children's mental health system and available workforce. At a minimum the study should evaluate:

- The number of mental health providers serving children, including children birth to age 5 and those on Medicaid;

- The demographics of providers and their clients including, but not limited to, race and ethnicity, languages services are provided in, ages of children served, the use of screening tools and assessments that are culturally and linguistically appropriate, and the level of cultural competency training received by providers; and
- The availability of culturally and linguistically diverse services and providers.

The study should also review the public mental health services available to children and the corresponding child outcomes in order to determine where racial and ethnic disparities exist and the severity of those disparities. Racial and ethnic disparities should be monitored on an ongoing basis.

To date, the Legislature has not directed WSIPP or any other organization to do this work. While HCA collects information about the demographics of Medicaid clients and MCOs collect some information about Medicaid providers, there is no mechanism or organization that collects this data for all behavioral health providers statewide. The CYBHWG and others continue to identify the need for more data to address access issues and health equity disparities. HCA recently hired a Chief Data Officer in its Clinical Quality and Care Transformation division and is in the process of hiring a Health Equity, Social Justice, and Strategy Manager. These positions may expand HCA’s capacity to track some of this data.

Related recommendations

Child and adolescent psychiatric residencies

While not part of the overall work group’s recommendations, the Workforce subgroup submitted a recommendation, as an appendix to the 2016 report, to establish a child and adolescent psychiatric residency at Washington State University (WSU). Establishment of a 24-month residency at WSU was included in the 2017 children’s mental health bill, House Bill 1713.

In 2017, the work group recommended that an additional residency be established at the University of Washington (UW). This recommendation was enacted in 2018 as part of House Bill 2779. In 2018, the work group recommended that the number of residency positions be increased. In 2019, Senate Bill 5903 increased the number to two residencies each at WSU and UW.

New recommendations since 2016

Since 2016, the CYBHWG proposed these recommendations for improvements aimed at workforce development:

Year Recommended	Recommendation	Legislation
2018	Expand capacity for preceptorships, dual licensing and credentialing, and other mechanisms.	Engrossed Substitute House Bill 1768 (2019) directed DOH to develop certification standards for a co-occurring disorder specialist enhancement for psychologists, therapists, and counselors.
2019	Develop and fund clear, transparent, and flexible payment models for adequate training (including training for those working with children ages 0-5), supervision (including Reflective Supervision), and coaching within children’s behavioral health programs.	Senate Bill 6168 (2020) included a budget proviso for a grant program to provide flexible funding for training and mentoring of clinicians serving children and youth (birth through adolescence). It was vetoed as part of the Governor’s pandemic response.

Behavioral health service delivery and care coordination

Behavioral health services in schools

The Legislature should:

- ✓ Fund an FTE mental health lead at each of the nine ESDs and a coordinator at OSPI. The mental health leads will help coordinate Medicaid billing, mental health services, and other system level supports;
- ✓ Create 2-3 regional pilot projects to fund a provision of mental health services in school districts struggling to address mental and behavioral health needs in K-12; and
- Fund one “lighthouse” ESD, which has experience providing mental health services and billing through Medicaid, to serve in an advisory role for the other districts.

The 2017 children’s mental health bill, House Bill 1713, directed OSPI to select two ESDs in which to pilot a lead staff person, or navigator, for behavioral health services.

The 2018 children’s mental health bill, House Bill 2779, expanded the duties of the lead behavioral health staff person in each ESD pilot to include delivering a mental health literacy curriculum to students in one high school in each pilot site.

The CYBHWG supported the recommendations developed by the Washington Mass Shootings Work Group in 2018, in particular, recommendations around increased investments in school and broader systems’ mental health services for children and youth, as well as suicide prevention outreach and education. The CYBHWG also recommended building upon previous suicide prevention work as part of the broader work on school-based recognition and response to emotional and behavioral distress by addressing the urgency of need across the K-12 system and including student voice.

In 2019, the Legislature enacted some of the recommendations of the Washington Mass Shootings Work Group. [Second Substitute House Bill 1216](#) (House Bill 1216), established regional school safety centers that include behavioral health coordination. The behavioral health part was not funded in the budget.

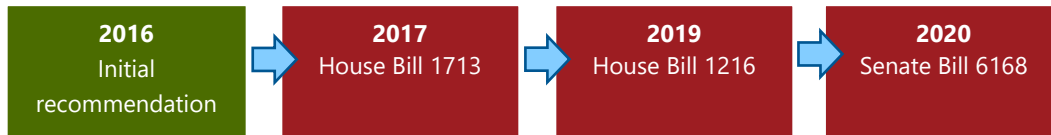
Later in 2019, the CYBHWG recommended for the 2020 legislative session that the Legislature fully fund navigators at each of the nine ESDs and further specify their role. Funding was included in the 2020 operating budget, Senate Bill 6168. This bill also appropriated additional funds for the behavioral health work of school safety centers, including offering grants to schools or school districts for planning and integrating tiered evidence-based suicide prevention and behavioral health supports.

Additionally, in its 2019 operating budget, [Engrossed Substitute House Bill 1109](#) (House Bill 1109), Section 606 (dd), the Legislature appropriated funds for two years for UW and Seattle Children’s Hospital, in consultation with OSPI, to implement a pilot program of middle school and high school mental health education in two school districts, including trainings for school staff, and teleconsultations for psychologists and psychiatrists, as well as students.

While the Legislature did not fund a lighthouse ESD, the overall goals of the work group's recommendations were met through the funding of mental health leads in all nine ESDs.

As part of its 2021 plans, the CYBHWG's School-based Behavioral Health and Suicide Prevention subgroup plans to work with OSPI, HCA, and others to examine funding streams that contribute or could contribute to supporting K-12 students' emotional well-being and behavioral health.

Progress on mental health services in schools



Care coordination

The Legislature should require HCA to incorporate care coordination into larger primary care provider practices. The care coordination model must:

- Use a psychiatric registered nurse or master's level mental health clinician with specified knowledge and training in mental health care, including, but not limited to, mental health screening, motivational interviewing, and suicide prevention.
- ✓ Provide advocacy and engagement services which foster warm hand-offs to mental health professionals, tracks compliance with recommendations and referrals, facilitates communication between health care providers, and provides education to children and families.

Psychiatric RN or master's level mental health clinician in primary care

This recommendation has not been legislated. HCA continues to explore opportunities to improve access to care coordination services.

Care coordination advocacy and engagement

In 2017, the children's mental health bill, House Bill 1713, addressed some care coordination issues by directing HCA to require each MCO and BHO to:

- Follow up with individuals to ensure an appointment has been secured;
- Coordinate with and report back to primary care providers on individual treatment plans and medication management; and
- Provide information to plan members and primary care providers about the behavioral health resource line⁷.

While the directives in House Bill 1713 expired on June 30, 2020, the requirements continue to be a part of MCO contracts.

⁷ The behavioral health resource line, now called the Washington Recovery Help Line, provides 24-hour help for substance abuse, problem gambling, and mental health.

Substitute Senate Bill 6452 (Senate Bill 6452, 2018), which focused primarily on new Partnership Access Line pilots, also directed HCA to enforce requirements in MCO contracts to ensure care coordination and network adequacy issues are addressed. Contract requirements regarding care coordination include:

- Plans for managing individuals with both physical and behavioral health needs;
- Ensuring that individuals receive follow-up services and referrals;
- Ensuring access to medically necessary behavioral health and community-based services; and
- Identification of gaps in an individual’s care.

Contracts also specify care coordinator responsibilities, including cultural competency, ensuring referrals are made and services are delivered, and developing processes to ensure that an individual has follow-up with a Behavioral Health Administrative Services Organization (BH-ASO) within seven calendar days of receiving crisis services.

HCA’s contracts with MCOs include specific requirements for care coordination for children participating in WISe and require transition plans for transition-age youth.

Progress on care coordination



Since the transition to integrated managed care began, care coordination has been a focus for HCA and the CYBHWG. HCA continues to explore ways to improve care coordination and, beginning in 2021, the CYBHWG will have a Behavioral Health Integration subgroup.

New recommendations since 2016

Year Recommended	Recommendation	Legislation
2017	Amend the mental health parity laws to prohibit the use of preauthorization as a management tool for mental health services for enrollees under the age of 18.	
2018	Fund day treatment programs for children.	See below.
2019	Appropriate funding for partial hospitalization (PH) and intensive outpatient (IOP), which allow children and youth to receive intensive therapies three to eight hours a day as an alternative to inpatient hospitalization; require reimbursement for these services.	Senate Bill 6168, Sec. 215 (76) (2020): HCA to implement two pilot programs for IOP and PH services for certain children and adolescents, contracting with one hospital in western Washington and one hospital in eastern Washington, effective January 1, 2021.
2017	Expand the Partnership Access Line (PAL) or contract with another entity to include a referral line for parents, youth, etc., to find mental health services and providers.	Senate Bill 6452 (2018): Initiated new PAL lines for families, and for primary care providers seeing infants and new mothers.
2018	Ensure Washington State Mental Health Referral Service for Children and Teens (i.e., PAL) can serve both Medicaid and non-Medicaid families by securing a funding source.	Senate Bill 5903 (2019) directed the CYBHWG to convene a subgroup to develop a funding model for PAL for Moms and Kids, PAL for ESDs, and PAL for professionals serving adults.

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Year Recommended	Recommendation	Legislation
2019	Develop a funding model that builds upon HCA’s previous funding model efforts, and: <ul style="list-style-type: none"> • Determines the annual cost of operating the PAL and its various components; • Collects a proportional share of program costs from each health insurance carrier; and • Differentiates between activities that are eligible for Medicaid funding and those that are not. 	Substitute House Bill 2728 (House Bill 2728, 2020) established a funding model for all PAL programs in which commercial carriers pay a proportional share of costs.
2020	Continue funding the Washington State Mental Health Referral Service for Children and Teens.	
2017	Require DBHR to work with stakeholders and provide recommendations to the Children’s Mental Health work group on age of consent for parental involvement in youth treatment decisions, clarifying Parent Initiated Treatment process forms, and strengthening notice requirements for providers.	House Bill 2779 (2018) directed a subgroup of the CYBHWG to review and make recommendations regarding the family initiated treatment (FIT) process.
2018	Adopt full FIT advisory work group recommendations.	Engrossed Second Substitute House Bill 1874 (House Bill 1874, 2019) adopted the Parent Initiated Treatment stakeholder advisory group recommendations .
2019	Task HCA to develop a data collection and tracking system for youth served under FIT to identify opportunities to fill gaps in care, expand services, and better understand the needs of our adolescent population (details, including recommended data to collect, in recommendation proposal).	Substitute House Bill 2883 (House Bill 2883, 2020) adds specific requirements for HCA data collection for FIT.
2019	Include adolescent residential treatment as a service that a parent can consent to under the FIT section of Revised Code of Washington (RCW) 71.34.600-670 . Residential treatment facilities must be licensed under 246-337 Washington Administrative Code (WAC) . Use the same monitoring and reporting guidelines and provider/facility safeguards for residential treatment that were established for IOP and PH under House Bill 1874.	House Bill 2883 (2020) adds residential treatment facilities (RTFs) to FIT; requires additional medical necessity review every 30 days; and states that MCOs can also conduct medical necessity reviews. If an adolescent is not released as a result of a petition, they may remain in RTF as long as it continues to be a medical necessity.
2019	Explore whether to create a licensing category for wilderness therapy and therapeutic boarding schools that would be considered residential treatment under FIT.	Senate Bill 6637 (2020) <i>Not passed</i>

Year Recommended	Recommendation	Legislation
2019	Extend Medicaid coverage to 365 days postpartum.	Engrossed Second Substitute House Bill 6128 (House Bill 6128, 2020) directed HCA to submit a waiver request to CMS and to implement 365 days of postpartum Medicaid coverage once it becomes eligible to receive federal financial participation for persons with income $\geq 193\%$ of FPL. This bill was vetoed as part of the Governor’s pandemic response.
2020	Expand youth mobile crisis services statewide and ensure existing teams can meet increased demand.	
2020	Direct HCA to explore Medicaid waiver options for respite care for youth with behavioral health challenges, without adversely impacting the DDA and DCYF respite waivers.	
2020	Expand availability of youth and family peer services across the continuum of care, reduce barriers to entry and retention, enhance diversity, and ensure peers are supported in their recovery.	

Network adequacy

The following recommendations regarding network adequacy were submitted in 2016.

Behavioral health network adequacy

In addition to the network adequacy reporting requirement established in House Bill 2439 and other federal requirements, state agencies should ensure network adequacy and promote continuity of care in multiple care settings for both commercial and Medicaid coverages by:

- ✓ Performing quarterly evaluations of network adequacy;
- Encouraging MCOs to contract with private behavioral health providers who are part of the BHO;
- Increasing primary care provider and care coordinator awareness of PAL consultative services; and
- ✓ Facilitating or requiring provision of telephonic or telemedicine consultations with psychiatric care.

Quarterly evaluations of network adequacy

Federal law requires that states monitor MCO network adequacy. Each Medicaid MCO is contractually required to report quarterly on its provider network, including critical provider types and all contracted specialty providers, and demonstrate that the MCO has adequate provider capacity to deliver services in a timely way. As Washington has transitioned to behavioral health integration, HCA has expanded its monitoring of mental health care providers, including specific reporting on providers serving children and youth.

Encouraging MCOs to partner with private behavioral health providers

At each phase of the transition to behavioral health integration, HCA encouraged MCOs to contract with the providers who had previously contracted with the BHOs. As a result, provider availability within each region was maintained during and after the transition.

Increasing awareness of the Partnership Access Line (PAL)

PAL provides a variety of consultative services to primary care providers and consumers. Two of these consultative services, currently pilot programs, directly serve children, youth, and families:

- The Mental Health Referral Service for Children and Teens connects children and youth, and their families, with evidence-supported mental health services in their community.
- PAL for Moms provides consultation services for health care providers caring for patients with mental health problems who are pregnant, postpartum, or planning a pregnancy.

When these pilots began, HCA required MCOs to provide information about them to primary care providers. HCA includes information about these services in the provider guides and on its website. In addition, each call line has its own marketing program. A new payment system for these services, with commercial insurers paying a share of the costs, is currently being implemented. As part of this process, HCA is establishing new performance measures. Additional outreach may also be included.

Telehealth

Two bills in 2017 increased access to telehealth services:

- The 2017 children's mental health bill, House Bill 1713, required BHOs to reimburse providers for behavioral health services provided through telehealth.
- [Senate Bill 5436](#) (2017) allows patients to receive telehealth services in their home.

In 2020, as part of its response to the COVID-19 pandemic, the federal government and HCA allowed flexibility in its Medicaid provider policies, including the ability to provide services through platforms that are not HIPAA-compliant, such as telephone calls, FaceTime, Skype, texting, and e-mail. Providers and others are learning from the expanded use of telehealth during this pandemic. As a result, future legislation related to telehealth is anticipated.

For the 2021 session, the CYBHWG issued a statement of support for efforts to assess and improve telehealth access and services to reduce racial and income disparities in access and ensure that virtual services are clinically effective for children and youth. The statement of support included policy recommendations to review data and research focused on telehealth for prenatal to age 25 with

stakeholders, and develop standards of practice. It also recommended publicizing the Washington Lifeline program, which offers free wireless services and cell phones to low income families and individuals.

More on network adequacy

As part of House Bill 2439 (2016), the initial authorizing legislation for the Children’s Mental Health Work Group, the Legislature directed HCA and DBHR to report annually on the status of access to behavioral health services for children and youth, including:

1. The percentage of discharges for patients ages 6-17 who had a visit to the emergency room with a primary diagnosis of behavioral health and who had a follow-up visit with a provider with a corresponding behavioral health diagnosis within 30 days of discharge, with data broken down by age, gender, race, and ethnicity; and
2. The percentage of plan members with an identified mental health need who received mental health services.

In 2017, House Bill 1713 built on these report requirements, directing HCA to report annually on the number of children’s mental health providers available in the previous year, the languages spoken by those providers, and the percentage of providers who were actively accepting new patients.

In 2018, Senate Bill 6452 added a directive to HCA to enforce contract requirements regarding network adequacy. House Bill 2779 added an annual reporting requirement regarding network adequacy for eating disorder treatment.

In addition to these bills that address network adequacy for Medicaid clients, [Engrossed Substitute House Bill 1099](#) (House Bill 1099, 2019) directs the Office of the Insurance Commissioner (OIC) to require commercial carriers to:

- Post in electronic directories when a behavioral health provider is closed to new patients; and
- Prominently post information on finding available providers and filing complaints.

While the requirements of House Bill 1099 are now in place, work group members have communicated the impossibility of having up-to-date information on insurers’ websites on a day-to-day basis. Reports from the Mental Health Referral Service for Children and Teens indicate that families with private insurance are having more difficulties finding appropriate providers than are families on Medicaid.

In 2020, the Workforce and Rates subgroup identified network adequacy as an ongoing concern that required more study before informed recommendations could be made and acknowledging the linkage between network adequacy issues and workforce shortages, particularly in specialty areas. In 2021, it will convene a dedicated advisory group to focus on network adequacy, working closely with HCA and OIC representatives, with a goal of making recommendations for the 2022 legislative session.

MCO performance measures

HCA should establish performance measures for MCOS related to the delivery of:

- ✓ Developmental screenings;
- Behavioral health screenings for children ages 5-12;
- Adolescent depression screenings; and

- Maternal depression screenings.

Developmental screening, behavioral health screening, and maternal depression screening for new mothers are a required part of well-child care. Well-child visits for infants and children through age six, and adolescents (ages 12-17) are required reporting measures. Performance on these measures is incentivized through value-based purchasing efforts for integrated managed care and integrated foster care contracts. Adolescent depression screening is also a separate billable service. Well-child visits and behavioral health screenings for children ages 7 to 11 are not currently included in performance measures.

Paperwork reduction

In accordance with the federal Paperwork Reduction Act of 1995, state agencies should reduce the amount of paperwork required by clinicians providing mental health services to children on Medicaid by replacing current rules with regulations that focus on the use of best practices for age-appropriate, strength-based psychosocial assessments, including current needs and relevant history in areas such as behavioral/emotional health, mental health safety/risk, and functional impairment.

State agencies should eliminate duplicate documentation requirements in state rules for provider agencies, except when this documentation is required for medical necessity or meeting access-to-care standards.

State agencies should review the House Bill 1713, Sec. 533(4) report and the Workforce Training and Education Coordinating Board 2017 report regarding paperwork reduction, and suspend the development of any new rule changes related to behavioral health until rule integration is finished in 2017.

In 2017, the Legislature passed [Engrossed Second Substitute House Bill 1819](#) (House Bill 1819), directing the Department of Social and Health Services (DSHS) to streamline documentation requirements, provide a single set of regulations by April 1, 2018, and simplify and align audit practices.

DSHS implemented these directives, consolidating behavioral health rules into one “single set,” with the goal of eliminating as much administrative burden as possible for behavioral health agencies. When the State implemented behavioral health integration legislation ([Second Engrossed Substitute House Bill 1388](#) [House Bill 1388]) in 2018, which moved authority for some behavioral health rules from DSHS to DOH, DOH adopted the DSHS rules ([Chapter 246-341 WAC](#)).

In 2019, the Legislature passed [Engrossed Second Substitute House Bill 5432](#) (House Bill 5432), which states that HCA may not provide initial documentation requirements for patients receiving behavioral health care that are substantially more administratively burdensome to complete than those for primary care.

The CYBHWG continues to identify this as an issue – particularly for intake – with paperwork requirements varying between providers, services, MCOs and commercial carriers, and other entities. These requirements continue to cause barriers for providers and force patients to tell their stories multiple times.

Child care services

Working Connections Child Care for families who are homeless or in the child welfare system

State agencies should provide at least 12 months of stable child care through the Working Connections Child Care (WCCC) program for children involved in the child welfare system or who are homeless, regardless of the employment status of their parents or guardians.

In 2017, the Legislature passed House Bill 1624, directing the Department of Early Learning (now the Department of Children, Youth and Families) to allow eligibility for families with children who have, in the past six months:

- Received child protective services, child welfare services, or a family assessment response;
- Have been referred for child care as part of the family's case management; or
- Are living with a biological parent or guardian.

A Senate amendment exempted these families from the employment requirement. It was not included in the final version of the bill.

In 2020, the Legislature passed House Bill 2456, extending the grace period for homeless families to meet WCCC program requirements, including employment, from 4 months to 12 months.

Progress on child care for families who are homeless or in the child welfare system



Mental health consultation and coaching for child care providers

- ✓ The Legislature should require the Department of Early Learning (DEL) to reinstate and expand mental health consultation and coaching for child care providers who care for children with behavioral health needs.
- The DEL Early Achievers program should provide funding to assist participating child care providers in meeting the necessary training and supervision requirements for an Infant Mental Health Endorsement (IMH-E®) at the infant family associate or specialist levels to serve children birth to age three.

As a result of this recommendation, the Legislature included in House Bill 1713 (2017) a requirement that DEL establish a child care consultation program for providers to link providers with evidence-based, trauma-informed, best practice resources for caring for infants and young children who present behavioral concerns or symptoms of trauma. DEL, or an organization it contracts with, were directed to help providers recognize signs and symptoms of trauma in children; provide support and guidance to staff; consult and coordinate with parents, other caregivers, and early childhood experts; and provide

referrals. Child Care Aware of Washington originally contracted with DEL and now contracts with DCYF to provide these services.

In 2017, after passage of House Bill 1713, the CYBHWG recommended that the child care consultation program be expanded to include provider training and onsite consultation. In 2019, the Legislature passed Senate Bill 5903, which included a provision that DCYF contract with an organization providing coaching services to the Early Achievers program participants (Child Care Aware) to provide one qualified mental health consultant in each of the six regions designated by DCYF. The mental health consultant will support the child care providers' work with children with behavioral health challenges and their families.

In 2017, after passage of House Bill 1713, the CYBHWG recommended that the child care consultation program be expanded to include provider training and onsite consultation.

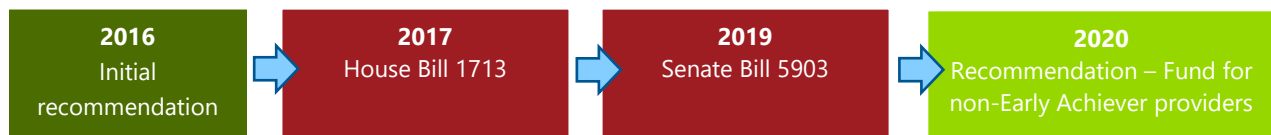
In 2019, the Legislature passed Senate Bill 5903, which included a provision that DCYF contract with an organization (Child Care Aware Washington) to work with Early Achievers coaches and participants to provide information and guidance regarding behavioral health needs. Annual funding in the amount of \$773,000 General Fund-State (GF-State) began in 2019 to support this work. It funds one qualified mental health consultant in each of the six regions designated by DCYF.

Over 3,800 child care providers in Washington participate in Early Achievers. 68 percent of these providers serve more than 38,000 children whose families access care through the WCCC subsidy program. It is an ongoing challenge for the six regional consultants to serve this number of providers and children.

Looking forward, additional funding to support further development of this program, expand the number of consultants, and build its infrastructure will be needed to adequately serve the most vulnerable children with the least opportunities – those served by the Early Achievers program.

Preserving existing funding for this program is one of the CYBWHG's recommendations for the 2021 legislative session. Additionally, due to the demand for behavioral health supports, the CYBHWG also recommended in 2020 that a complex needs fund be established to (a) help early providers who do not have access to mental health consultation pay for it; and (b) help the mental health consultants working in the field pay for behavioral health, anti-bias, and anti-racist training that will make an immediate impact on their practice.

Progress on mental health consultation and coaching for child care providers



Mental health training and education

- The Legislature should fund development of expanded behavioral health training and coaching opportunities for early learning through K-12 providers, educators, administrators, and parents, which are culturally competent and utilize multiple approaches including employment of paraprofessionals and peers.

- ✓ The Legislature, state agencies, and school districts should implement developmentally and culturally appropriate K-12 Social Emotional Learning (SEL) standards and competencies to complement existing early learning SEL standards, using the proposed SEL framework outlined in the October 1, 2016, Legislative report, "Addressing Social Emotional Learning in Washington's K-12 Public Schools."

Expanded behavioral health training for educators

Some progress has been made in this area, as noted in earlier sections, through behavioral health navigators in schools and the Early Achievers child care consultation program.

In 2020, the Legislature included a budget proviso (Sec. 215 [56]) in Senate Bill 6168 for HCA to develop and implement grants to provide flexible funding for training and mentoring of clinicians serving children, including the 0-5 population. This proviso was vetoed as part of the Governor's pandemic response.

K-12 social-emotional learning standards

Over time, since 2016, progress has been made in this area, with additional recommendations and legislation expanding upon the original recommendation.

In 2018, the CYBHWG recommended that:

- A work group be established to improve school-based services and SEL curriculum;
- Funds be established for and connected to the ESD behavioral health pilots to build capacity; and
- OSPI provide resources to schools for staff and student training in behavioral health, suicide prevention, and anti-bullying.

Several bills moved this work forward:

- House Bill 2779 (2018) required ESDs piloting a lead behavioral health staff person to deliver a mental health literacy curriculum to students in one high school in each pilot site.
- Senate Bill 5903 (2019) directed school districts to use one professional learning day each year for SEL, trauma-informed practices, mental health, anti-bullying, or cultural sensitivity.
- House Bill 1109 (2019) established a two year pilot program, with UW's Department of Psychiatry and Seattle Children's Hospital working with OSPI, to provide behavioral health education to middle and high school students in two school districts, and provide teleconsultations for students and staff in these districts.

Conclusion

The value of the CYBHWG's process – bringing together many voices, perspectives, and systems – is demonstrated in the progress that has been made on the original 2016 Children's Mental Health Work Group recommendations. The successes and challenges vis-à-vis CYBHWG recommendations also offer an illustrative example of the legislative process. While some objectives have moved from recommendation to passed legislation within a single year, many have taken a number of years to be realized, and some have not yet been achieved and continue to be recommended by the CYBHWG.

With over 200 individuals contributing to the 2020 recommendations, the current work group continues to focus on coordinating efforts and integrating across systems and settings to improve access to behavioral health services for children, youth, and families regardless of race, ethnicity, income, geographic location, or type of insurance. The need for improved access and services remains great, and has only been exacerbated by the COVID-19 pandemic and its impacts.

Among the priorities of the work group are:

- Addressing racial inequities;
- Strengthening preventive measures and early intervention from infancy to young adulthood to prevent more acute problems downstream; and
- Ensuring that there are "step-up" and "step-down" services between levels of care so children and youth can avoid or safely transition from more intensive services, such as inpatient treatment.

With its work extended through 2026, the work group will continue to identify needs, develop and evaluate potential solutions, and make recommendations to the Governor, the Legislature, state agencies and others to improve access to and quality of behavioral health services for children, youth, and young adults, ages 0 to 25.

Appendix A: CYBHWG recommendation status (2016-2020)

Note: In the Legislation column, an asterisk (*) identifies operating budget bills. Programs authorized through budget provisos operate only through the period the budget is in effect (1-2 years), and must be reauthorized, in a policy bill or in the budget bill for the next biennium.

Area	Recommendations	Year Recommended	Progress	Legislation
Rates	1a. Increase Medicaid rates to achieve equity with Medicare rates, to increase the number of providers who will serve children and families on Medicaid. After the rate increases have been implemented for two years, the Legislature should require an outcome-based study on providers, analyzing the impact on the workforce and the number of providers who serve children and families on Medicaid.	2016 2017	↗ Progress made	Senate Bill 5779 (2017): Increases in bi-directional behavioral health rates. *House Bill 1109 (2019): Increases in behavioral rehabilitation services rates.
	1b. Increase children’s Medicaid behavioral health counseling and psychotherapy rates by 8% or to the Medicare reimbursement rate, whichever is higher.	2019	Vetoed	*Senate Bill 6168, Sec. 215 (78) (2020): Increases state fee-for-service (FFS) provider rates by 15%, or to Medicare rate or an equivalent relative value, whichever is lower.
	1c. Increase state FFS provider rates by 15% or to Medicare rate (or an equivalent relative value, if there is no Medicare rate), whichever is lower.	2020		
	2. Remove limitations on treatment options focused on treating the family dyad or a particular familial relationship.	2016	✓	House Bill 2779 (2018): Adds “family support” as an allowable outpatient service.
	3a. Provide increased funding for infant mental health services and training.	2016		
	3b. Provide scholarships and training for perinatal and infant mental health for maternity support services and infant case management providers.	2019	Vetoed	*Senate Bill 6168, Sec. 215 (56): Grants to provide flexible funding for training and mentoring clinicians serving children and youth (0-18).
	4a. Provide increased funding for early intervention for treating psychosis.	2016	✓	See below.
	4b. Provide increased funding for early intervention for treating psychosis: <ul style="list-style-type: none"> Determine cost for statewide implementation of Coordinated Specialty Care (CSC); Fund CSC teams in each regional service area (RSA); and Fund additional CSC teams to ensure capacity based on incidence and population. 	2018	✓	Senate Bill 5903 (2019): HCA to develop a statewide plan to implement evidence-based CSC programs that provide early identification and intervention for psychosis.

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Area	Recommendations	Year Recommended	Progress	Legislation
Rates	5. Provide increased funding for Wraparound with Intensive Services (WISe)	2016	✓	While there has been no legislation to increase funding for WISe, the case rate has been increased several times as part of HCA's rate-setting process.
	6. Provide increased funding for treatment for eating disorders.	2016		House Bill 2779 (2018): Requires the HCA to report annually on mental health and medical services for eating disorder treatment in children and youth.
	7. Provide increased funding for interventions that are culturally and linguistically appropriate.			
	8. Direct HCA to contract with an outside facilitator to build on the 2017 home visiting and Medicaid financing strategies recommendations and develop an implementation plan for Medicaid coverage of home visits.	2017	↗ Progress made	House Bill 2779 (2018): DCYF and HCA to develop a strategy for Medicaid funding for home visiting.
	9. Create Medicaid codes for supervision of mental health practitioners and partial hospitalization treatment and services (expand these services as well).	2017	↗ Progress made	House Bill 2779 (2018): Allows BHOs to reimburse providers for partial hospitalization or intensive outpatient treatment.
	10. Require that proposals related to increasing Medicaid rates must be grounded within the rate-setting process for the provider type or practice setting, incentivize preventive care, and recognize the shift toward value-based purchasing. Any increase in Medicaid rates for behavioral health services must include a proportional increase to services with a case rate, with a priority on WISe.	2019	✓	House Bill 2584 (2020): Requires HCA to: <ul style="list-style-type: none"> • Work with actuaries and MCOs in implementing funded behavioral health rate increases to ensure appropriate adjustments are made to the WISe case rate; and • Establish a process for verifying that funding appropriated for targeted behavioral health provider rate increases, including rate increases through MCOs, is used for the objectives stated in the appropriation.
11. Require HCA, with respect to funds appropriated by the Legislature with the intent of increasing Medicaid rates paid to providers, to establish mechanisms that ensure these funds are passed on by MCOs directly to behavioral health providers.	2019	✓	House Bill 2584: Requires HCA to establish a process for verifying that funding appropriated for behavioral health provider increases, including rate increases provided through MCOs, is used for the objectives stated in the appropriation.	

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Area	Recommendations	Year Recommended	Progress	Legislation
Rates	12. Enhance transparency and accountability mechanisms utilized by HCA and MCOs to ensure that appropriated community behavioral health funds are used by HCA and MCOs for their intended purpose.	2019	↗ Progress made	House Bill 2584: Requires HCA to provide annual reports to the Legislature regarding the implementation processes and results of targeted behavioral health provider rate increases.
Screening and assessment	1a. Require HCA to assemble a work group to: <ul style="list-style-type: none"> Identify a standardized list of culturally and developmentally appropriate screening tools for children ages 0-20, for Medicaid and non-Medicaid use. Identify standardized mental health assessment, outcome, and diagnostic tools (culturally/developmentally appropriate for children ages 0-5) that support access to services. Identify billing options and propose coverage for a new or redefined code with an adequate reimbursement rate for the following services performed during an Early and Periodic Screening Diagnostic, and Treatment (EPSDT) visit, or other primary care office visit for a child: <ul style="list-style-type: none"> Maternal depression screening when children are ages 0-5; and Behavioral health, including depression, screening for children. 	2016	✓ ↗ Progress made. ↗ Progress made.	The screening tools approved by the workgroup begin on page 37 of Medicaid EPSDT billing manual . Cultural assessment not yet done. See recommendations 1b and 1c. House Bill 1713 (2017): Requires provider reimbursement for depression screens for: <ul style="list-style-type: none"> Youth ages 12-18 (annual); and Mothers of infants ages birth - 6 months.
	1b. Require HCA to analyze the fiscal impact of changing Medicaid policy to match best practices for mental health assessment and diagnosis of children ages 0-5, including: <ul style="list-style-type: none"> Allowing three to five sessions for intake and assessment. Allowing assessments to occur in home or community settings, and reimbursing clinicians for travel. Requiring use of the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). 	2019	✓	*House Bill 6168, Sec. 215 (62) (2020): Directs HCA to conduct an analysis on the impact of changing Medicaid policy to match best practices for ages 0-5 mental health assessment and diagnosis.
	1c. Change Medicaid policy to allow three to five sessions (including in natural settings) utilizing the DC: 0-5 manual so that misdiagnosis and subsequent ineffective/harmful treatment are avoided, thereby reducing diagnosis and treatment disparities currently experienced (particularly by boys of color) and cost of ineffective treatment.	2020		

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Area	Recommendations	Year Recommended	Progress	Legislation
Screening and assessment	2. Require HCA/DBHR to provide outreach and education to primary care and mental health providers regarding: <ul style="list-style-type: none"> • Services performed during an EPSDT exam; • Maternal depression or other conditions that impact a child; and • Billing requirements for BH screening and referrals. 	2016	↗ Progress made.	HCA did outreach to primary care providers when maternal depression screening was added as a requirement for EPSDT visits.
	3. HCA and DBHR should identify a full complement of medically necessary behavioral health services to be covered by all commercial carriers.	2016		
	4. The Legislature should enlist local health districts and other appropriate venues/providers to provide behavioral health screening to children ages 0-20.	2016		
Workforce development	1a. Tuition loan repayment program for behavioral health professionals who commit to five years in public sector setting >20 hours/week.	2016 2018		See below.
	1b. Increase availability of loan repayment options and conditional health scholarships for behavioral health providers. (2018)		✓ 100 scholarships	House Bill 1668 (2019): Tuition loan repayment/conditional scholarship program for behavioral health professionals working in underserved areas.
	1c. Expand the tuition loan repayment and conditional scholarship program for behavioral health professionals (by providing 100 additional scholarships) and reduce existing barriers to access in order to reach and retain more providers.	2020		
	2a. Incentivize clinical supervision of therapists by restricting supervisory ratios in MCO/BHO contracts and/or capping supervisors' caseloads.	2016	↗ Progress made	House Bill 2779 (2018): Requires BHOs (now MCOs) to allow reimbursement for supervising providers working toward credentials.
	2b. Establish a work group to develop a behavioral health teaching clinic enhancement rate for behavioral health agencies that are training and supervising students and those seeking their certification or license.	2020		
	3. Increase options for payments and variety of professionals who can help provide mental health interventions to increase diversity of settings where services can be provided.	2016		
	4. The Legislature should require the Washington State Institute for Public Policy, or a similar organization, to conduct a study to evaluate the children's mental health system and workforce, including number of providers serving children, demographics of providers and children served, and availability of culturally diverse services and providers.	2016		

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Area	Recommendations	Year Recommended	Progress	Legislation
Workforce development	5a. Establish a child and adolescent psychiatry residency.	2016	✓	House Bill 1713 (2017): Established a 24-month child psychiatry residency at WSU.
	5b. Establish an additional child and adolescent psychiatry residency.	2017	✓	House Bill 2779 (2018): Established a 24-month child psychiatry residency at UW.
	5c. Increase residency positions for child and adolescent psychiatry.	2018	✓	Senate Bill 5903 (2019): Number of residencies increased to two each at UW and WSU.
	6. Expand capacity for preceptorships, dual licensing/credentialing, and other mechanisms.	2018	↗ Progress made	House Bill 1768 (2019): Certification standards for co-occurring disorder specialist enhancement for psychologists, therapists, and counselors.
	7. Develop and fund clear, transparent, and flexible payment models for training (including those working with ages 0-5), supervision (including Reflective Supervision), and coaching within children’s behavioral health programs.	2019	Vetoed	*Senate Bill 6168 budget proviso (2020): Provide grants for flexible funding of training for clinicians serving children and youth (0-18).
Service delivery and care coordination	1a. The Legislature should: <ul style="list-style-type: none"> • Fund an FTE mental health lead at each of the nine ESDs and a coordinator in OSPI to help coordinate Medicaid billing, mental health services, and other system level supports. • Create two to three regional pilot projects to fund mental health services in school districts. • Fund one “lighthouse” ESD with experience providing mental health services and billing through Medicaid to advise other school districts. 	2016	↗ Progress made	House Bill 1713 (2017): OSPI to pilot behavioral health leads at two ESDs. House Bill 1216 (2019): Each regional school safety center must provide behavioral health coordination to school districts in its region. Not funded *House Bill 1109, Sec. 606 (dd) (2019): \$500,000 in FY 2020 and FY 2021 to UW and Seattle Children’s, in consultation with OSPI, to implement a two year pilot program of middle school and high school mental health education in two school districts (east and west of the Cascades), including trainings for school staff, and teleconsultations for psychologists and psychiatrists, as well as students.
	1b. Establish funds, connected to ESD pilots, to build capacity.	2018		

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Area	Recommendations	Year Recommended	Progress	Legislation
Service delivery and care coordination	1c. Fund ESD navigators from HB 1216 and further specify their role.	2019		*Senate Bill 6168, Sec. 508 (6) (2020): Funding is provided to OSPI for the student mental health and safety network established in Chapter 333, Laws of 2019 (2SHB 1216). Activities funded include statewide coordination and oversight of the regional network at the EDSs, implementation of grants to school districts, and a contract with the UW-Forefront Suicide Prevention program.
	2. Require HCA to incorporate care coordination into larger primary care provider practices. Model must: <ul style="list-style-type: none"> Use a psychiatric Registered Nurse or master’s level clinician with mental health knowledge and training. Provide advocacy and engagement services which foster warm handoffs, track compliance with recommendations and referrals, facilitate communication between providers, and provide education to children and families. 	2016	➤ Progress made	House Bill 1713 (2017): HCA must oversee care coordination. BHOs/MCOs must maintain adequate capacity, follow up to ensure appointments are secured, report back to primary care on treatment, provide info on behavioral health resource line, and maintain accurate list of providers and availability. Senate Bill 6452 (2018): HCA to enforce contract requirements to ensure care coordination and address network adequacy concerns.
	3. Amend the mental health parity laws to prohibit the use of preauthorization as a management tool for mental health services for enrollees under the age of 18.	2017		
	4a. Fund day treatment programs for children.	2018	➤ Progress made	See recommendation 4b below.
	4b. Appropriate funding for partial hospitalization (PH) and intensive outpatient (IOP), which allow children and youth to receive intensive therapies three to eight hours a day as an alternative to inpatient hospitalization; require reimbursement for these services.	2019	✓	*Senate Bill 6168, Sec. 215 (76) (2020): HCA to implement two pilot programs for PH and IOP for certain children and adolescents, contracting with one hospital in western Washington and one hospital in eastern Washington, effective 1/1/2021.
	5a. Expand the Partnership Access Line (PAL) (or another entity) to include a referral line for parents, youth, etc., to find mental health services and consultation to health care providers in assessment and treatment of maternal depression.	2017	✓	Senate Bill 6452 (2018): Implemented referral services for families seeking mental health services and same-day consultation and support to health care providers in assessment and treatment of maternal depression.

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Area	Recommendations	Year Recommended	Progress	Legislation
Service delivery and care coordination	5b. Ensure PAL can serve both Medicaid and non-Medicaid families by securing a funding source.	2018	✓	Senate Bill 5903 (2019): CYBHWG to convene a sub-group to develop a funding model for PAL.
	5c. Develop a funding model for PAL that builds upon HCA's previous funding model efforts and: <ul style="list-style-type: none"> • Determines the annual cost of operating PAL and its various components; • Collects a proportional share of program cost from each health insurance carrier; and • Differentiates between activities that are eligible for Medicaid funding and those that are not. 	2019	✓	House Bill 2728 (2020): <ul style="list-style-type: none"> • Establishes a funding model for PAL program. • Establishes same funding model for Telehealth Access Line (PAL for Kids) and PAL for Moms, if they are continued beyond pilots. • Modifies data and reporting requirements for PAL programs. • Directs Joint Legislative Audit and Review Committee to conduct a review of PAL programs by 12/1/2022.
	5d. Pursue appropriation for Mental Health Referral Assistance Line for Children and Teens through June 30, 2021 to bring the program's funding on to the state's fiscal year cycle and avoid interrupting the service.	2019	✓	*Senate Bill 6168, Sec. 215 (2020): One-time funding to extend service until 6/30/2021.
	5e. Continue funding for Mental Health Referral Assistance Line for Children and Teens.			
	6a. Require DBHR to work with stakeholders and provide recommendations to the Children's Mental Health Work Group on age of consent for parental involvement in youth treatment decisions, and clarifying Parent Initiated Treatment (PIT) process forms and strengthening notice requirements for providers.	2017	✓	House Bill 2779 (2018): Subgroup to review PIT process.
	6b. Adopt full Family Initiated Treatment (FIT) advisory work group recommendations.	2018	✓	House Bill 1874 (2019): Adopted FIT advisory group recommendations.
	6c. Task HCA to develop a data collection and tracking system for youth served under FIT to identify opportunities to fill gaps in care, expand services, and better understand the needs of our adolescent population (details, including recommended data to collect, in recommendation proposal).	2019	✓	House Bill 2883 (2020): Adds specific requirements for HCA data collection.

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Area	Recommendations	Year Recommended	Progress	Legislation
Service delivery and care coordination	6d. Include adolescent residential treatment as a service that a parent can consent to under FIT. Use the same monitoring and reporting guidelines and provider/facility safeguards for residential treatment that were established for IOP and PH under HB 1874.	2019	✓	House Bill 2883 (2020): Adds residential treatment facilities (RTFs) to FIT; requires medical necessity review every 30 days; if adolescent is not released through petition, the adolescent may remain in RTF as long as it continues to be a medical necessity.
	7a. Support recommendations from the Washington Mass Shootings Work Group: <ul style="list-style-type: none"> • Increased investments in school and broader systems' mental health services; and • Suicide and bullying prevention outreach and education. 	2018	➤ Progress made	House Bill 1216 (2019): Each ESD to establish a regional school safety center. Unfunded Each center to provide behavioral health coordination to school districts, including suicide prevention training; facilitating partnerships, care coordination, and system integration; providing Medicaid billing training and technical assistance; and guidance in implementing best practices regarding suicide prevention.
	7b. Build upon previous Suicide Prevention work in the broader work on school-based recognition and response to emotional and behavioral distress by addressing the urgency of need across the K-12 system and including student voice.	2019	➤ Progress made	*Senate Bill 6168 (2020): Provide statewide support and coordination for the regional network of behavioral health, school safety, and threat assessment established in Chapter 333, Laws of 2019 (school safety and well-being). Within the amounts appropriated in this subsection (4)(f)(iv), \$200,000 of the general fund—state appropriation for fiscal year 2021 is provided solely for grants to schools or school districts for planning and integrating tiered suicide prevention and behavioral health supports.
	8. Explore whether to create a licensing category for Wilderness Therapy and Therapeutic Boarding Schools that would be considered residential treatment under FIT.	2019	Not passed	Senate Bill 6637 (2020): Wilderness therapy license

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Area	Recommendations	Year Recommended	Progress	Legislation
Service delivery and care coordination	9. Extend Medicaid coverage to 365 days postpartum.	2019	Vetoed	Senate Bill 6128 (2020): Takes effect when HCA becomes eligible to receive federal financial participation for persons with income \geq 193% of federal poverty level (FPL).
	10. Expand youth mobile crisis services statewide and ensure existing teams can meet increased demand.	2020		
	11. Direct HCA to explore Medicaid waiver options for respite care for youth with behavioral health challenges, without adversely impacting the DDA and DCYF respite waivers.	2020		
	12. Expand availability of youth and family peer services across the continuum of care, reduce barriers to entry and retention, enhance diversity, and ensure peers are supported in their recovery.	2020		
Network adequacy	<p>1. State agencies should ensure network adequacy and promote continuity of care in multiple settings (commercial and Medicaid) by:</p> <ul style="list-style-type: none"> Performing quarterly evaluations; Encouraging MCOs to contract with private behavioral health providers; Increasing primary care provider and care coordinator awareness of PAL consultative services; and Facilitating or requiring provision of telephonic or telemedicine consultations with psychiatric care. 	2016	↗ Progress made	<p>House Bill 1713 (2017):</p> <ul style="list-style-type: none"> HCA to report annually on # of providers accepting new patients, and languages spoken. BHOs/MCOs to provide info about PAL. Reimbursement required for telemedicine. <p>House Bill 2779 (2018): HCA to report annually on network adequacy for eating disorder treatment.</p> <p>Senate Bill 6452 (2018):</p> <ul style="list-style-type: none"> HCA and OIC to develop alternative funding model for PAL and PAL for Moms and Kids. PAL becomes permanent. Two year PAL for Moms and Kids pilot, beginning 1/1/2019. HCA to enforce contract requirements for care coordination and network adequacy. <p>House Bill 1099 (2019): OIC to require carriers' electronic directories note when behavioral health providers are closed to new patients, and post information on finding providers and filing complaints.</p>

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Area	Recommendations	Year Recommended	Progress	Legislation
	2. HCA should establish performance measures for MCOs regarding delivery of developmental screenings; behavioral health screenings (ages 5-12); and adolescent and maternal depression screenings.	2016		
Paperwork reduction	1. State agencies should eliminate duplicate documentation requirements in state rules for provider agencies, except when this documentation is required for medical necessity or meeting access-to-care standards.	2016	↗ Progress made	<p>House Bill 1819 (2017): Directed DSHS to streamline documentation requirements, provide a single set of regulations, and simplify and align audit practices. <i>Work has transitioned to DOH.</i></p> <p>House Bill 5432 (2019): HCA may not provide initial documentation requirements for patients receiving behavioral health care which are substantially more burdensome to complete than those for primary care.</p>
Child care services	1. Provide at least 12 mos. of child care through Working Connections Child Care (WCCC) program for children in welfare system or homeless, regardless of parents' employment status.	2016	↗ Progress made	<p>House Bill 1624 (2017): DEL, now DCYF, to establish and implement policies to allow eligibility for families with children who have, in the last six months received child protective services, child welfare services, or a family assessment response; have been referred for child care as part of the family's case management; and are residing with a biological parent or guardian.</p> <p>House Bill 2456 (2020): Extends the grace period for homeless families to meet WCCC program requirements to 12 months.</p>
	2a. Require DEL to reinstate and expand mental health consultation and coaching for child care providers who care for children with behavioral health needs.	2016	↗ Progress made	House Bill 1713 (2017): DEL must establish a child care consultation program for providers.
	2b. Expand the Child Care Consultation Program to include provider training and onsite consultation.	2017	✓	Senate Bill 5903 (2019): DCYF must contract to provide coaching services to Early Achievers program participants through one consultant in each region.
	2c. Establish a complex needs fund to address the behavioral health challenges of children ages 0-5.	2020		

Children and Youth Behavioral Health Work Group Recommendations (2016-2020)

Area	Recommendations	Year Recommended	Progress	Legislation
Training and education	1. The Legislature should fund development of expanded behavioral health training and coaching opportunities for early learning through K-12 providers, educators, administrators, and parents, which are culturally competent and utilize multiple approaches, including employment of paraprofessionals and peers.	2016	↗ Progress made	See recommendation #2 in Child care services and recommendation #1 in Mental health service delivery.
	2a. Legislature, state agencies, and school districts should implement developmentally and culturally appropriate K-12 SEL standards and competencies, using proposed SEL framework in Oct. 2016 report.	2016	↗ Progress made	See below.
	2b. Establish an OSPI and mental health providers work group to improve school-based services and Social Emotional Learning (SEL) curriculum.	2018	✓	2SSB 5082 (2019): Creates SEL Committee to develop state-wide SEL framework, update standards and benchmarks for SEL, identify best practices, and engage stakeholders and seek feedback. OSPI and Washington Professional Educator Standards board to adopt committee recommendations.
	2c. Provide resources to schools for staff and student training (behavioral health, suicide prevention, anti-bullying).	2018	✓	Senate Bill 5903 (2019): Beginning in 2020-21 school year, school districts to use one professional learning day for SEL, trauma-informed practices, mental health, anti-bullying, or cultural sensitivity. House Bill 2779 (2018): Requires ESDs piloting a lead behavioral health staff person to deliver a mental health literacy curriculum to students in one high school in each pilot site. *House Bill 1109 (2019): UW Dept. of Psych and Seattle Children’s Hospital, with OSPI, to implement a two year pilot program of middle school and high school behavioral health education for students, as well as teleconsultations for students and staffs, in two school districts.

Appendix B: CYBHWG Recommendations for 2021

Prioritized recommendations

Priority 1:

- Inclusion of the 2020 budget proviso [SB 6168, Sec. 211(78), 2020] to increase Medicaid rates for behavioral health services to retain workforce and ensure access. (Passed in 2020 legislative session for 2021 fiscal year; then vetoed as part of pandemic response.) *All of the recommendations for improving access and quality of services rely on the ability to recruit and retain a skilled workforce. An increase in existing Medicaid rates for behavioral health services is critical to achieving this goal.*
- Continue funding the “Washington State Mental Health Referral Service for Children and Teens” which helps families find providers that accept their insurance. *Current funding ends July 1, 2021.*

Priority 2: Expand youth mobile crisis services statewide and ensure existing teams can meet increased demand.

Priority 3: Change Medicaid policy to match best practices for mental health assessment and diagnosis of children 0-5, including allowing 3-5 sessions for intake/assessment in children’s homes and other natural settings.

Priority 4: Establish a workgroup to develop a behavioral health teaching clinic enhancement rate. *The rate would apply to Behavioral Health Agencies that are training and supervising students and those seeking their certification or license.*

Priority 5:

- Expand the Student Loan Repayment Program to serve 100 additional individuals and reduce existing barriers within the program.
- Preserve existing investments in infant and early childhood mental health consultation; and
- Establish a complex needs fund to expand access to consultant support for behavioral health challenges of children ages 0-5.

Priority 6: Direct the Health Care Authority (HCA) to explore Medicaid waiver options for respite care for youth with behavioral health challenges without adversely impacting the respite waivers for children and youth in the foster care system and for children and families enrolled with the Developmental Disabilities Administration (DDA).

Priority 7: Expand availability of youth and family peer services across the continuum of care, reduce barriers to entry and retention, enhance diversity, and ensure peers are supported in their recovery.

Statements of support, policy only recommendations, and CYBHWG work (not prioritized)

The CYBHWG and its subgroups have strived to avoid duplicative or competing proposals with others doing this work and have, wherever possible, coordinated their efforts with these groups.

The work group operates with the understanding that the challenges children, youth, and families face require cross-system solutions and span many arenas.

The following statements of support acknowledge the importance of work others are doing. In many cases, members of the CYBHWG and its subgroups are participating in these efforts, Representatives from these groups also participated in CYBHWG subgroups.

The items noted as “policy-only” and “work group” activities have no anticipated budget impact.

- Work with the Behavioral Health Apprenticeship Coalition to develop and implement a registered behavioral health apprenticeship model.
- Engage with and support the Workforce Training and Education Coordinating Board’s efforts to address barriers to employment created by background checks.
- Remove clinical barriers to postpartum mood and anxiety screening by supporting the Washington Chapter of the American Academy of Pediatrics’ “learning collaborative.”
- Support the Multi-tiered Systems of Support (MTSS) decision package submitted by the Office of Superintendent of Public Instruction (OSPI).
- Increase staffing levels in schools to support students’ social-emotional health by supporting the “Building Staffing Capacity to Support Student Well-Being” decision package submitted by OSPI.
- Improve transitional care for youth discharging from inpatient behavioral health and juvenile justice settings by supporting the work of the Senate Bill 6560 work group.
- Support efforts to ensure that quality, affordable childcare is available and accessible (workforce issue).
- Support development of a state implementation plan for the national 988 behavioral health crisis line, scheduled to go live in Washington in July 2022.

Statements of support, with policy-only recommendations

- Support current efforts to assess and improve telehealth, including audio-only, to reduce racial and income disparities in behavioral health service access, and ensure that virtual services are clinically effective and provide relief to children and families. Recommend review of data and research focused on prenatal to age 25 and development of standards of practice, with stakeholders, as well as a requirement that providers publicize the Washington Lifeline. (The Washington Lifeline program offers free wireless services and cell phones to low income families and individuals.)
- Support legislation requiring continuing education for behavioral health professionals in the provision of culturally responsive treatment.
- Support Representative Lauren Davis’ bill to create a Peer Support Specialist credential, allowing peers to serve individuals with commercial insurance and work directly for hospitals and correctional institutions.

CYBHWG activities

- School-based Behavioral Health & Suicide Prevention subgroup:
Examine funding streams that contribute or could contribute to supporting K-12 students' emotional well-being and behavioral health (OSPI, HCA, and others).
- The CYBHWG continues to support learning from the current partial hospitalization (PH) and intensive outpatient (IOP) pilot about how they may become part of the service continuum. (Added 12/23/2020.)

Appendix C: 2020 CYBHWG members

Asterisk (*) denotes members of original 2016 work group.

Representative Lisa Callan, 5th district, Co-chair

***MaryAnne Lindeblad**,

Medicaid Director, Co-Chair

Dr. Avanti Bergquist, Child psychiatrist

Tony Bowie, Department of Social and Health Services (DSHS), Child Study Treatment Center

Representative Michelle Caldier, 26th district

Diana Cockrell, Health Care Authority-Division of Behavioral Health and Recovery

***Senator Jeannie Darneille**, 27th district

Jamie Elzea, Washington Association for Infant Mental Health

Representative Carolyn Eslick, 39th district

Dr. Thatcher Felt,

Yakima Valley Farm Worker's Clinic

Tory Gildred, Coordinated Care

Camille Goldy, Office of the Superintendent of Public Instruction

Dorothy Gorder, Parent representative

Summer Hammons, Tulalip Tribes

***Dr. Robert Hilt**, Seattle Children's Hospital

***Kristin Houser**, Parent representative

Avreayl Jacobson, King County Behavioral Health & Recovery

Andrew Joseph, Jr., Confederated Tribes of the Colville Reservation

Kim Justice, Office of Homeless Youth, Department of Commerce

Michelle Karnath, Clark County Juvenile Court, Statewide Family, Youth and System Partner Roundtable Tri-lead

Judy King, Department of Children, Youth and Families

Sarah Kwiatkowski, Premera Blue Cross

Amber Leaders, Office of the Governor

***Laurie Lippold**, Partners for Our Children

Lauren Magee, Youth representative

Cindy Myers, Yakima Valley Farm Workers Clinic

Michele Roberts, Department of Health

***Joel Ryan**, Washington State Association of Head Start and ECEAP

Noah Seidel, Office of the Developmental Disabilities Ombuds

***Mary Stone-Smith**, Catholic Community Services of Western Washington

Representative My-Linh Thai, 41st district

Jim Theofelis, A Way Home Washington

***Dr. Eric Trupin**, University of Washington

***Senator Judy Warnick**, 13th district

Mandy Weeks-Green, Office of the Insurance Commissioner

Lillian Williamson, Youth representative

Dr. Larry Wissow, University of Washington

Jackie Yee, Educational Services District 113

2020 Subgroup Leads

Workforce and Rates

Representative Mari Leavitt, 28th district

Hugh Ewart, Seattle Children's Hospital

Laurie Lippold

Prenatal to Five Relational Health

Representative Debra Entenman, 47th district

Jamie Elzea

School-based Behavioral Health and Suicide Prevention

Representative My-Linh Thai

Camille Goldy

Youth and Young Adult Continuum of Care

Representative Lauren Davis, 32nd district

Appendix D: 2016 work group members

Representative Tana Senn,
41st district, Co-chair

MaryAnne Lindeblad,
Medicaid Director, Co-Chair

Tina Burrell, Department of Social and Health
Services

Ruth Bush, Apple Health Foster Care

Kathleen Crane, King County Behavioral Health &
Recovery

Senator Jeannie Darneille, 27th district

Representative Tom Dent, 13th district

Lacy Fehrenbach, Department of Health

Anna Marie Henninger, Foster parent
representative

Dr. Bob Hilt, Seattle Children's Hospital

Tatsuko Go Holo, Children's Alliance

Kristin Houser, Parent representative

Dr. Mona Johnson, Office of the Superintendent
of Public Instruction

Lonnie Johns-Brown, Office of the Insurance
Commissioner (consultant to work group)

Steve Kutz, Cowlitz Indian Tribe

Nickolaus D. Lewis, Lummi Nation

Laurie Lippold, Partners for Our Children

Joel Ryan, Washington State Association of Head
Start and ECEAP

Christi Sahlin, Molina Healthcare

Andy Smith, Office of the Governor

Mary Stone-Smith, Catholic Community Services
of Western Washington

Dr Sabine Thomas, Washington Association for
Infant Mental Health

Dr. Eric Trupin, University of Washington

Senator Judy Warnick, 13th district

Greg Williamson, Department of Early Learning