Behavioral Health Agency Rulemaking workshop - Notes
July 20, 2021

Slide 1

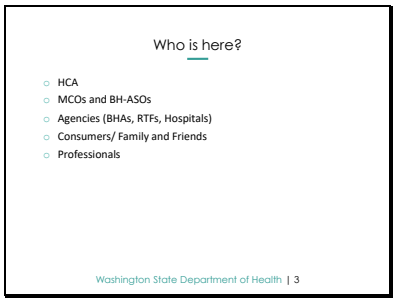
Welcome!

Slide 2

DOH team: Facilities Program Managers, providing technical assistance and conducting policy work for our assigned facilities types.

- Julie Tomaro, Oversee/supervise all facility type work and lead for acute care hospitals.
- Michelle Weatherly, Outpatient behavioral health.
- Dan Overton, Inpatient/residential behavioral health facilities.
- Stephanie Vaughn (not pictured), policy analyst support.

Slide 3



A list of attendees may be provided if requested. Meetings are open to anyone who wishes to attend. We invited HCA and MCOs and BH-ASOs because the nature of potential changes may require their input. Input from agencies, consumers, family and friends, and behavioral health professionals allow for balanced conversations and collaboration.

Workshops are not recorded, however, meeting notes, slides, handouts, etc. will be sent via GovDelivery.

Today's meeting is for brainstorming the direction that we may want to head in.

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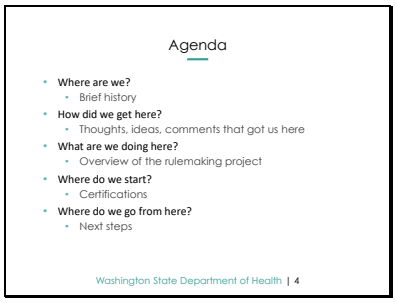
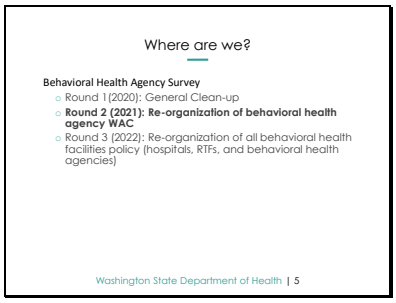


Slide 5

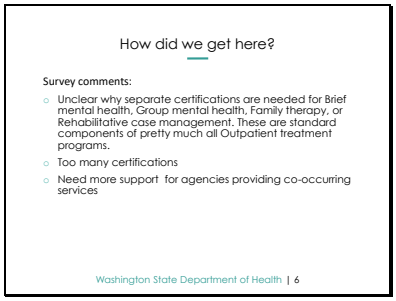


This is phase 2 of our BHA rules makeover. In the fall of 2019 we asked agencies, and anyone else who wanted to participate, to take a survey that went WAC section by WAC section. This provided an opportunity to tell the Department of Health (department) which WACs needed changes and why. We reviewed the data, and with the help of stakeholders, broke the comments down into three buckets.

Phase 1 was more micro-level clean up. Phase 2 is going to be an opportunity to zoom out and see if we can make improvements to the structure of the WAC. This phase will not focus so much on the detailed language, but the broader licensing and certification structure.

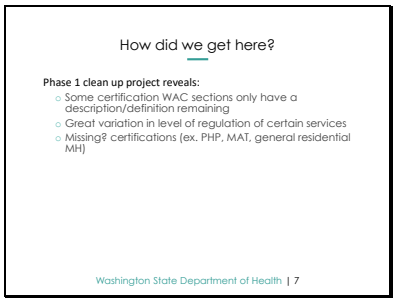
Phase 3 will be focused on moving beyond the Behavioral Health Agency (BHA) WAC to potentially streamline and integrate the behavioral health (BH) facility WAC chapter requirements.

Slide 6



Phase 2 work stemmed from comments – examples located on slide 6 – and focused on our certification structure, suggesting we consider bundling certain certifications, streamline or simplify certifications, and possibly create BH versions of certifications rather than Mental Health (MH) and Substance Use Disorder (SUD).

Slide 7

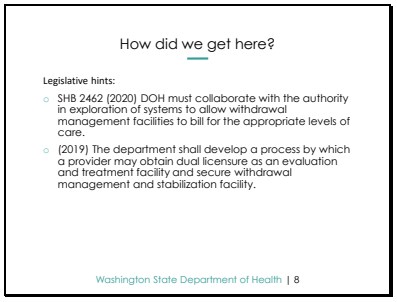


In addition to the survey comments our phase 1 project revealed other items, such as:

- Some sections left with only a description of a service but with no specific requirements. This left the question of, "what is the point of having that as a certification?"
- Highlighting inconsistencies in the level of regulation for different services, for example, some only had a description and other more in-depth requirements.

Additionally, we continue to hear about the desire for some to add certain certifications such as PHP, MAT, general MH residential services.

Slide 8



There were also a couple of "legislative hints" that could potentially play into phase 2 work. For example, in the 2020 session there was a bill, primarily aimed at billing/reimbursement, that mentioned a barrier to withdrawal management facilities being able to bill for lower levels of care. This is a concern that had been brought up to the department before and it was suggested that withdrawal management facilities weren't able to provide lower levels of care because they need additional certifications in order to do so, and that was a barrier.

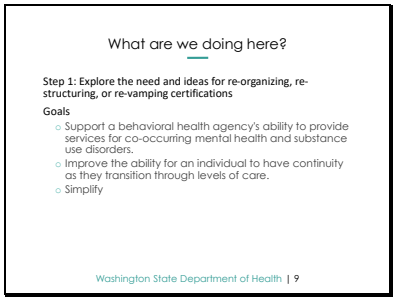
In 2019 there was also a bill requiring the department to develop a process for an agency to obtain dual licensure as an E&T and SWMS facility. This is already allowed, however, a recent question made us wonder if perhaps the bill sponsor was wanting us to go a few steps further. The agency asking the questions referenced this bill and wanted to know if the department had created a single certification that would allow them to do both services versus having to get separate certifications.

The survey comments, things that phase 1 revealed, and these bills were a flag that we may need to see if the WAC might be "remodeled" to address potential concerns, barriers, concepts.

Discussion:
In regard to other potential legislation that affect the WAC, will these be addressed in this round?

The department will consider that but depends on scope.

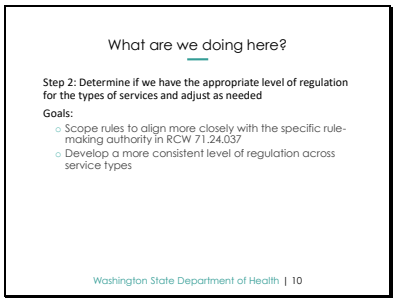
Slide 9



What are we doing here?

First - Explore the need and ideas for re-organizing, or re-structuring the WAC, mainly the certification structure: Support ability to provide services for co-occurring disorders, improve ability to have continuity of care, and simplify rules.

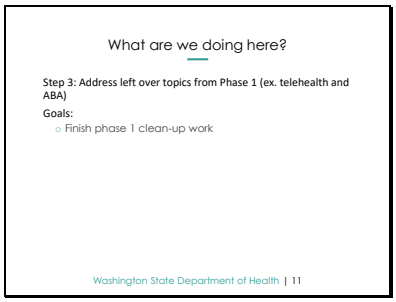
Slide 10



Second - Explore and discuss the inconsistency in the level of regulation for different types of services. Some services are just a description, others have minimal requirements, and others have pages of requirements.

We would like to determine if we have the appropriate level of regulation for the different service types and align with the specific rule-making authority in statute.

Slide 11



Third – follow up from phase 1 work including, the need to circle back to telehealth, the ABA section, etc.

Summary: re-think certifications, make sure there are consistent levels of regulation, and finish some phase 1 work.

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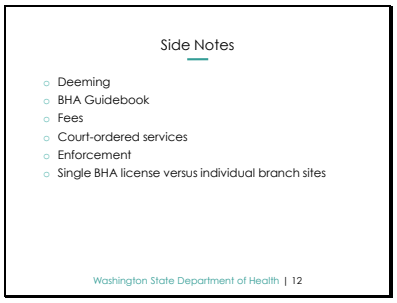


Deeming. Identify gaps between standards and work with you on how to address those gaps. The department developed a crosswalk of WAC standards to different Accreditation Organization standards and we would like our work double checked to make sure it makes sense and we didn't miss something.

An invitation was sent out for deemed agencies to participate in a short series of workshops to review the crosswalk starting this fall. Once the crosswalk is finalized, we will do broader stakeholder work and potentially rulemaking.

We are working on a BHA guidebook that will be filled with resources, tips, FAQs, and WAC implementation guidance. This will be a living document that we can update. Work is wrapping up on the general WAC requirements and then we'll start on the service specific requirements.

Fees. we will not be doing fee work as part of this rules project.

Phase 1 included minimal work on the WAC sections related to certain court-ordered services, such as DUI assessment, and counseling under RCW 46.61.5056 because we hoped that there might be a bill presented during session that might address some things; however, it wasn't introduced, and we need to circle back to see what our next steps might be on this topic.

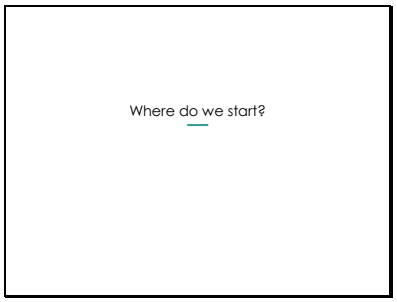
We didn't do any work on the enforcement sections of the WAC. This is because the department, per a bill, is exploring the need for a more uniform facilities enforcement act, like the UDA for professions.

We must continue to issue a statement of deficiency (SOD) for each licensed location; however, you are able to submit a single combined plan of correction (POC) if you desire.

Poll: For those of you with branch sites, is this something you would be interested in? **Yes 82%;** Maybe 14%; No 5%.

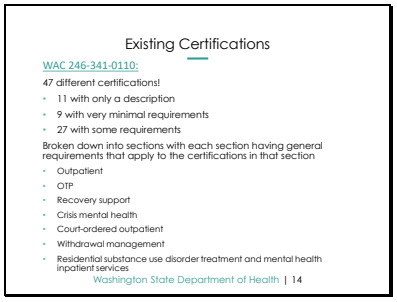
ACTION - We will work with the department enforcement group to see if we can implement single BHA licensure.

Slide 13



Where do we start?
Explore the idea of restructuring certifications. Decisions we make on this topic will inform the other two pieces of our rulemaking project.

Slide 14



WAC 246-341-0110 – Available certifications.
The list of certifications closely mirrored the services listed in the state Medicaid plan. This made sense when licensing and Medicaid work were all done by the same agency and was a great way to regulate agencies to make sure that they were following the requirements in the state Medicaid plan. A lot has changed since the original design of the licensing and certification rules and today we do not have to necessarily tie ourselves so closely to Medicaid; however, since reimbursement allows you to keep your doors open we don't want to stray too far. We want to make sure agencies can get paid for services.

We reached out to HCA to determine if changing certifications would be a problem and they were ok with being creative in how these are structured.

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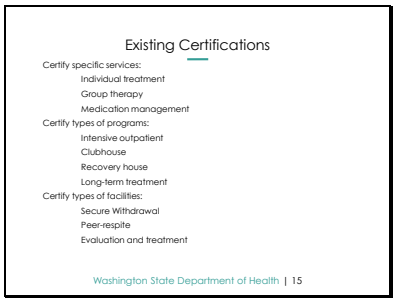
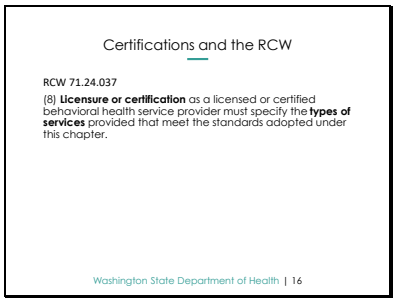


Slide 16

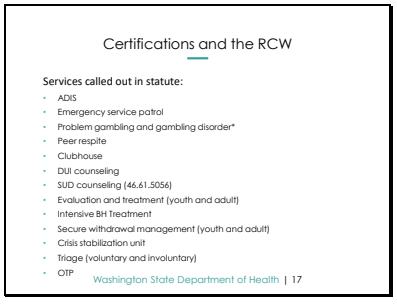


Slide 16 states how the statute uses the term "certified". It implies that "license" or "certification" are mutually exclusive and that the licensure or certification of an agency must specify the types of service the agency provides, implying that not all agencies are authorized to provide all of the services.

How many of the 47 services do you think are listed in statute? 16!

Extra Info:
(2) The secretary shall establish by rule minimum standards for licensed or certified behavioral health agencies that must, at a minimum, establish:
(a) Qualifications for staff providing services directly to persons with mental disorders, substance use disorders, or both;
(b) **the intended result of each service**; and
(c) the rights and responsibilities of persons receiving behavioral health services pursuant to this chapter and chapter **71.05** RCW…

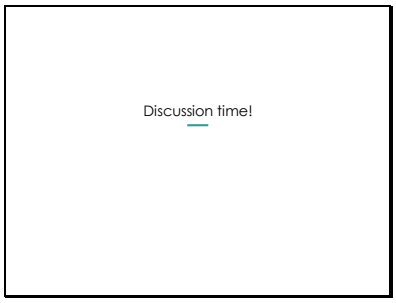
Slide 17



The services listed on slide 17 are the ones that the statute gives the department direct rulemaking authority for, or states that this service must be provided by an agency.

*Problem gambling and gambling disorder is a bit different as the statute says "may" instead of "must."

Slide 18



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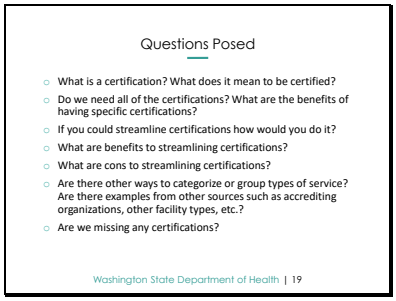
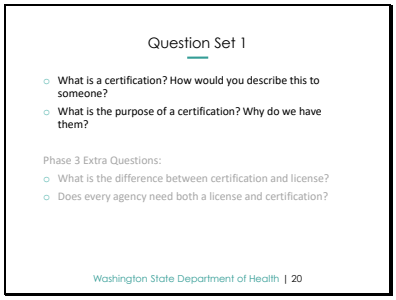


These were the questions that were sent out via GovDelivery to ponder for today's discussion.

Slide 20



How would you describe what a certification is to someone?

Discussion:
A specific set of certifications that can be demonstrated during a review.

Permission for the agency to provide services and the rules they need to comply with.

It means that your agency has the correct administrative policies and procedures that comply with minimum best practices.

Next, why is a certification important. What purpose does it serve?

This core purpose will help ground us and where we go next.

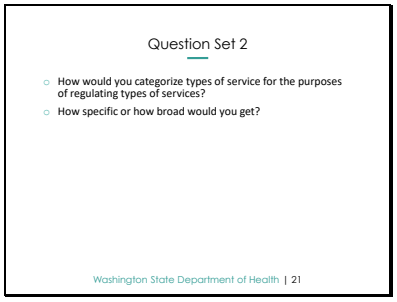
Discussion:

- Tells us which standards to apply.
- Consumer confidence.
- Consistent availability of care across the state; following the same standards.

- Describes the deliverables that will be evaluated during a review.
- Standardized practices overseen by the state.
- Provider types are limited to work within that type and professional scope of work.
- Basics for informed care and consent for treatment.

DOH: A certification tells us what services you are approved to provide. It tells us which standards to apply to your agency. We also use the data to populate the "Greenbook" so consumers and others can tell what services are provided at the different agencies.

Slide 21



Do you have ideas for how you might categorize types of services for the purpose of regulating the service? How specific or how broad would you get?

There may be three ways of looking at this: current way, overarching categories, or super broad like SUD, MH or co-occurring?

- Like the second option of overarching categories.
- RTF example – helpful to get specific.
- Umbrella with granular levels to help understand the details.
- Do the certifications allow us to provide the services to individuals when and where they want it?
- Specificity helps during review time so we know what we are subjected to.
- Combine by type of service.
- Two goals – integration of SUD and consolidation and simplification.
- Per types of level of care.
- Avoid being too broad but explore umbrella certifications.
- Prefer broad certifications: E&T; outpatient, hospitals, inpatient, withdrawal management.
- Evaluate v. efficiency.
- RTFs include 90/180 inpatient/competency restoration. Being clear about what sections they fall under.

- Include information to clarify that if you provide a specific service then you need to comply with specific WACs.
- Recommend certification at the broadest level.
- Integration will require flexibility.
- Expanded services don't always fit in the current structure.
- Broad certifications with some specialties.
- Creating documentation for improved clarity.
- Broad certification. Shift to less dictating way of defining certifications.
- Regulation v. innovation – Guard against what we don't know. The system changes over time including pilot projects. BH and physical health crossover. Co-occurring treatment program mental health and SUD staff – one treatment plan for both.

The department has made some improvements to co-occurring services to help with barriers but there may be more we can do.

ACTION - Clarify requirements and description of a certified problem gambling counselor. Michelle will touch base with Roxane to discuss further. We try not to have specific professions language in facilities WAC however, the certification of gambling counselor is not done by DOH.

Barriers do still exist around integrating care.

Let the department know if there are barriers because of this particular WAC.

If we leave these categories intact, what if we explored certification of the numeric items and then within the body of the WAC place the cluster of possibilities.

That was one of the options and thank you for articulating that! We can consider as a middle ground. We are broadening it enough to simplify

while maintaining the particular regulatory pieces that may be necessary under each umbrella.

Certified with service designations.
Co-occurring – barriers are mostly regarding funding silos.

Licensing and certification could include core services and then customized for each agency. Flexibility and oversight might be challenging.

Oversight – if we broaden – we will have to ask:

- Ex. Gen Outpatient services – you can automatically choose to provide the services under that category.
- Could be flexible – today we provide these services and then six months later we want to add another service and it falls under the certification so lets just add it. Normally to add a service, you have to do an amended application and updated policies and procedures. Do we want to maintain that or do we want to have it broad and agencies can let us know on annual renewal and then survey would audit P&Ps at that time?

Great example!
Would agency certification fees increase with broad certs?

ACTION - Currently, our fee structure is not based on the number of certs you have. Inpatient – bed fees; outpatient – service hours. It might not impact fees greatly except that when you add a service, you pay a fee. We might lose revenue. We will need to think through that.

ACTION - Broad certification may pose an issue with survey teams. We will ask Survey Program if there would be an impact on staffing.

ACTION - Would the administrative burden for department be reduced with broad certifications? We will need to talk with leadership to see if there is

a concern over a delay in knowing about a service and also a potential issue with complaints.

Hospitals do an annual update. Choose to provide any of the services (surgical, OB, Emergency, etc..) They don't have to add a service right away – they update it annually when they submit their licensing information when they renew. Policies and procedures are only reviewed when reviewers go on-site. Difference between BHA and Hospitals.

Hospitals are accredited and most BHAs are not.

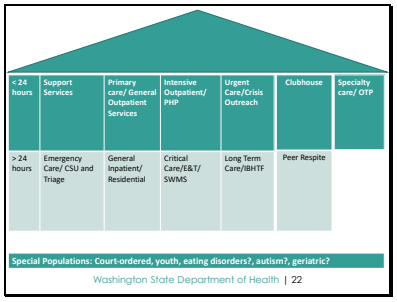
Hospitals are CMS certified so they have additional oversight.

Flexibility to pilot this would be great.

Hospital certification process makes sense. BHA certification process does not.

Are there examples you can think of that we might use? Other states, other facility types, AOs, etc?

Slide 22



Julie's brainstorm: FYI only
I've explored some existing models such as CARF, ASAM, some other states, and then I thought about organizing BH categories in a similar way that the physical health care system is laid out.

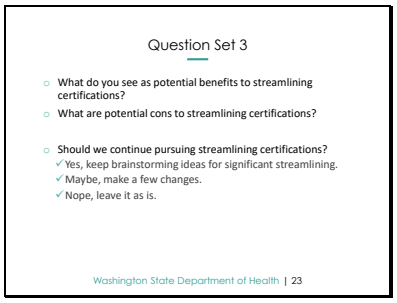
Special populations can be served in any of the units on the graphic.

Discussion:

- Peer respite – urgent care and can be less than 24 hours.
- BHA urgent care – crisis triage and stabilization.
- Where would ASAM 3.7 detox fit on this?

If we create a model like this, we can talk about this then.

Slide 23



Poll: For the purposes of DOH regulating/certifying types of service would you:

- Keep the same? 17%
- **Broaden some? 50%**
- Broaden a lot? 33%

Benefits to broadening certifications?

- Less admin burden, ability to innovate.
- Facilitates rapid adjustment and innovation.
- Reduce admin burden to adding services.
- Increase flexibility – clear designations would still be helpful.
- Can be inclusive of new services to be developed as it is formed.
- Promotes flex and aligns with other health care sectors
- Encourage innovation and less burdensome. Breaking out intensive to be separate because there are significant differences.
- Access to more services; reduced admin burden; real time services to meet community needs.

Cons?

- Change brings conflict. The legwork for the department to create rules.
- Cause confusion on regulatory standards. Be clear about which WACs apply.
- Set us up for bad actors – a broad process creates vulnerabilities with agencies that are not committed to providing high quality of care. Ex. Large corporations from out of state; telehealth; may be certifying folks that do not have the needs of our citizens in mind.
- Careful not to create conflicts with Medicaid state plan.

Rules were based on the State Medicaid Plan. Example – assessments must be done by an appropriately credentialed professional. For SUD, under professions law there are other professionals that can do assessments besides an SUDP. Our rules do allow working to full scope of practice so technically this could be done by a non-SUDP but the SMP requires SUDP to do the assessment for reimbursement. We aligned with statute but doesn't

align with the state Medicaid plan. Also, not all BHAs bill Medicaid. We want to be flexible for providers who are not recipients of Medicaid so we can regulate.

Caution on separate outpatient and intensive – there may be some unintended consequences.

The goal of phase 2 is not to add more regulations. If we don't regulate intensive outpatient differently than general outpatient then it doesn't need to be its own category. Also true for level one and level two outpatient services. They are regulated the same. It's the intensity of the service that is being provided. These we would need to look at.

Possible to change the state Medicaid plan but would require HCA coordination.

Poll: Should we continue exploring modifications to certifications?

- **Yes – keep brainstorming 78%**
- Maybe - just a few 20%
- Nope - leave alone 2%

Slide 24

Three weeks of workshops to focus on the following:

- Broaden certifications
- Develop consistent level of regulations for certifications.
- Address leftover topics.

Notes, agenda, supporting documents will be sent via GovDelivery prior to each meeting.

Slide 25

If you'd like to talk, reach out and Julie Tomaro first via email at Julie.tomaro@doh.wa.gov. If needed, she can set up a conference call.

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