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WASHINGTON COUNCIL
FOR BEHAVIORAL HEALTH

BEHAVIORAL HEALTH TEACHING CLINIC DESIGNATION AND ENHANCEMENT RATE

DEMONSTRATION PROJECT — STAKEHOLDER REPORT

PREPARED BY:

WASHINGTON COUNCIL FOR BEHAVIORAL HEALTH

NATIONAL COUNCIL FOR MENTAL WELLBEING

COHNREZNICK

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Executive Summary

Community behavioral health agencies (BHAs) are the essential safety net providers for adults, children, youth, and families experiencing mental health and/or substance use disorders in Washington State. Decades of underinvestment, including chronically low Medicaid reimbursement rates, have left BHAs unable to offer competitive compensation packages to their employees. In addition to providing clinical services and care coordination, BHAs are the training ground for students and new graduates pursuing behavioral health careers across sectors and settings, bearing the cost for the essential training and supervision infrastructure that sustains this crucial workforce development pipeline. This role, however, is an unofficial and uncompensated one. The Behavioral Health Teaching Clinic Designation and Enhancement Rate is one way to recognize and compensate our BHAs for training the broader behavioral health workforce in cutting-edge, critical behavioral health treatment modalities.

A Teaching Clinic Is an Innovative Solution to Help Increase the Behavioral Health Workforce Pipeline Across All Healthcare Settings

To sustain our community behavioral health agencies and incentivize providers to remain in the field, both of which are critical to the mental health of Washingtonians, the legislature should invest in developing and funding the Behavioral Health Teaching Clinic Designation and Enhancement Rate, with the ultimate goal of receiving a federal Medicaid match to sustain the model in perpetuity. This solution will be achieved through a partnership between the Washington State Legislature (to codify and fund the model), the Department of Health (as the certifying body), the Health Care Authority (as the contracting body), and a wide array of community behavioral health providers and advocates who are dedicated to improving the lives of people living with serious mental illness and/or addictions disorder.

The data show that with an investment by the legislature of $100 million, 1,850 to 2,643 new master's level clinicians, including counselors, therapists, and substance use treatment providers could enter the community behavioral health field annually, all with the guarantee of high-quality supervision and competitive compensation.

The Washington Council for Behavioral Health (WA Council) developed this concept with the intent to formally identify and compensate BHAs for the true cost of this teaching role. A two-part process was developed to recognize, describe, and test the concept, which utilized a public-private resource development path, including legislative appropriations and philanthropic grant funding.

- In 2021, the legislature funded a workgroup led by the Health Care Authority (HCA) to develop preliminary standards and rate estimates for the concept, which resulted in a preliminary report that was a starting point for this demonstration project.
- In 2023, after the WA Council received a $1.1 million grant from the Ballmer Group to launch a demonstration project, the legislature funded a 0.5 FTE at HCA to ensure the agency could participate in these efforts to ensure BHAs are compensated for their role as teaching clinics for students seeking professional education in behavioral health disciplines and for new graduates working toward clinical licensure.

Methods of Analysis

This Report is comprised of data collected from six participating BHAs, analyzed to accurately capture the true cost of the hours of investment put into supervising, training, and preparing clinicians to administer behavioral healthcare across the spectrum of patient needs. Teaching clinic standards and billing

eligibility requirements, as well as a calculated projected enhancement rate have been developed from this data, described in detail in the full Report.

To develop these standards and rates, five categories of individuals were identified as receiving investments by the BHAs in the form of uncompensated training and supervision:

- **Trainee A:** Individuals who are employees and working toward independent clinical licensure.
- **Intern–Master's+:** Individuals in an accredited (or in process of accreditation) **master's or higher** educational institution or program, seeking training as part of their degree program.
- **Trainee B:** Individuals who are employees and working toward certification.
- **Intern–Bachelor's:** Individuals in an accredited (or in process of accreditation) **bachelor's** educational institution or program, seeking training as part of their degree program.
- **Trainee C:** Individuals who do not meet the definition for Trainee A or Trainee B and meet one or more of the following: a) less than five years in the workforce; b) less than five years at the organization; c) new to their roles and responsibilities.

Demonstration Project Findings

Financial advisory firm CohnReznick analyzed significant data reported to determine the true total cost for BHAs to function as a teaching clinic, including personnel costs related to training, supervision, and administrative functions of teaching clinic work, as well as other non-personnel costs specific to the training of interns and trainees. The total cost was then reduced by third-party revenue (e.g., Medicaid reimbursement) generated during teaching activities to arrive at a net, unfunded cost to inform development of an enhancement rate and Medicaid funding strategy to sustain the teaching clinic program. These assumptions used by CohnReznick consider the cost of activities outside of services covered under Washington's Medicaid state plan and would be permissible under 42 CFR § 438.60.

Costing data show that the vast majority of individuals served through the teaching clinic program will be enrolled in Medicaid, with approximately 70–91% of services rendered by interns and trainees to Medicaid-enrolled individuals.

Payment of interns was a topic of particular interest, as unpaid internships and practicums may disproportionately affect low-income students and students of color by limiting access to education and family-wage careers in the behavioral health field. Payment of interns is vital to improving equity among behavioral health staff and decrease socioeconomic challenges experienced by the behavioral health workforce. Further, costing data demonstrate that an enhanced rate is necessary to support the payment of a stipend/honorarium at a minimum for each intern.

Potential aggregate impact of a teaching clinic model was calculated based on an estimate of 70–100 teaching clinics statewide. Two potential rates were developed for each intern type (Intern–Master's+ and Intern–Bachelor's), with one supporting the cost of providing a stipend to each individual intern and a second that would support the cost of providing hourly wages to interns. As highlighted above, the total projected annual cost of enhanced rate implementation is **$71.1 million to $101.7 million**, with an estimated impact of supporting 1,850 to 2,643 Trainee A FTEs and 295 to 421 Intern–Master's+ annually.

Conclusions and Recommendations

The Behavioral Health Teaching Clinic Designation and Enhancement Rate is an investment that will yield workforce stability in behavioral healthcare across the state of Washington. Further, once a proven

model and sustained greatly in part by a Medicaid match, it will act as an innovative tool sure to be emulated by states across the country in order to help alleviate the behavioral health workforce shortage crisis.

To successfully implement this model, the Washington State Legislature should enact legislation codifying the Behavioral Health Teaching Clinic Designation and Enhancement Rate into law in Washington State as well as appropriate the funds necessary to provide the enhancement rate to certified agencies. In addition, the legislature should direct HCA, during the FY2026–2027 biennium, to take the necessary steps to submit the Behavioral Health Teaching Clinic Designation and Enhancement Rate for approval by the Centers for Medicare and Medicaid Services (CMS) in order to secure federal investment necessary for long-term sustainability.

As additional important considerations, HCA should explore methods for incorporating the Behavioral Health Teaching Clinic Designation and Enhancement Rate into the Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS), and direct universities, community, and technical colleges that offer behavioral health education programs to reevaluate policies that disincentivize hiring and paying student interns to better align with industry workforce needs.

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Introduction

Community behavioral health agencies (BHAs) are the essential safety net providers for adults, children, youth, and families experiencing mental health and/or substance use disorders in Washington State. Decades of underinvestment, including chronically low Medicaid reimbursement rates, have left BHAs unable to offer competitive salaries and compensation to their employees. This historical baseline has been exacerbated by a growing national behavioral health shortage and simultaneous loss of workers during and following the COVID-19 pandemic. Competition for behavioral healthcare workers is heightened and accelerating, and the compensation gap between community behavioral healthcare providers and other practice settings continues to grow.

Typical BHA Workforce
In addition to providing clinical services and care coordination, BHAs often serve as the training ground for the entire behavioral health workforce, as they provide the clinical supervision needed for students to complete internship and practicum degree requirements and for new graduates to obtain supervised practice hours required for independent clinical licensure. This results in significant costs related to supervising interns and new graduates when clinicians and staff would otherwise be providing billable direct services to patients.

Because BHAs rely primarily on Medicaid reimbursement, they struggle to offer competitive salaries to better recruit and retain their workforce. Once licensed, clinicians often leave for higher-paying roles in private practice, hospitals, managed care organizations, or state agencies. While training a behavioral health workforce of clinicians that will pursue careers across sectors and settings is central to the identity of community behavioral health, it is imperative to recognize that this churn occurs and to create levers to bolster the integral infrastructure of the community behavioral health system. The Teaching Clinic Designation and Enhancement Rate is one way to recognize that, like teaching hospitals, our BHAs are training the broader behavioral health workforce in cutting-edge, critical behavioral health treatments, such as crisis interventions, wraparound care, and other evidence-based treatment modalities.

By formalizing the teaching role, a teaching clinic enhancement rate will improve quality of care for those patients being served in the public behavioral health system, while simultaneously incentivizing clinical providers and supervisors to continue their careers training our current and future behavioral health workforce. It will also reduce some of the stigma around behavioral healthcare by recognizing the innovation occurring every day in community BHAs across the state.

Typical Population Served
The community behavioral health system provides care to an underserved and highly vulnerable health disparities population: people with serious mental illness (SMI) who experience premature mortality. There is a 10- to 25-year life expectancy reduction in patients with SMI. This population typically experiences physical co-morbidities and frequently interacts with more than one public system (e.g., child welfare; criminal justice). By supporting the infrastructure of the system caring for this population, the teaching clinic model contributes to ensuring better and more equitable access to behavioral healthcare for those who have the least access and highest need.

Additionally, people of color are disproportionately represented in the public behavioral health system due to impacts of poverty, racism, and other social determinants of health. By providing upstream identification and intervention to children, youth, and families, we can reach those in need sooner. A

teaching clinic enhancement rate would promote system stability and capacity by compensating essential but currently non-reimbursable supervisory- and training-related tasks required to appropriately and adequately train clinicians to work with complex or historically marginalized populations.

Terminology & Key Definitions

Behavioral Health Agency: An entity licensed by the Washington State Department of Health to provide behavioral health services under chapter 71.24 RCW, chapter 71.05 RCW, or chapter 71.34 RCW.

Certification: For the purposes of this report, "certification" refers to the following credentials issued by the Washington State Department of Health: substance use disorder professionals (SUDP).

Clinical Supervision: Regular and periodic activities performed by a mental health professional, co-occurring disorder specialist, or substance use disorder professional who is either licensed, certified, or registered under Title 18 RCW. Clinical supervision may include review of assessment, diagnostic formulation, individual service plan development, progress toward completion of care, identification of barriers to care, continuation of services, authorization of care, and the direct observation of the delivery of clinical care.

Clinical Supervisor: An individual mental health professional permitted by the Washington State Department of Health to provide clinical supervision services.

Independent Clinical Licensure: For the purposes of this report, "independent clinical licensure" refers to the following credentials issued by the Washington State Department of Health: licensed mental health counselors (LMHC); licensed independent clinical social workers (LICSW); licensed marriage and family therapists (LMFT); and licensed advanced social workers (LASW).

Intern: An individual in an accredited (or in-process of accreditation) master's degree, bachelor's degree, or higher educational institution or program, who is seeking behavioral health training as part of their degree program.

Onboarding: The process of orienting to the expectations of the individual's position's roles and responsibilities and general organization requirements, policies, and procedures.

Practicum/Internship: A clinical field experience under clinical supervision that prepares a student enrolled in a behavioral health degree program for work in the behavioral health field. For the purposes of this report, the terms are used interchangeably.

Serious Mental Illness: A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.

Shadowing: A type of training using observation as the learning process, typically utilized during the early phases of practicum/internship and field training.

Teaching Clinic: A licensed and certified behavioral health agency that meets the teaching clinic standards and billing eligibility to provide high quality evidence-based training and clinical supervision to our students and recent graduates.

Trainee: An individual behavioral health professional who is an employee at a behavioral health agency, receiving clinical supervision, and working toward independent clinical licensure or certification. Please see Appendix A for detailed descriptions by trainee type.

Project Context & Background

Concept Origin

Community BHAs have long served as the primary training ground for students and new graduates pursuing behavioral health careers across sectors and settings, bearing the cost for the essential training and supervision infrastructure that sustains this critical workforce development pipeline. Despite this longstanding practice, BHAs have served this role in an uncompensated capacity, making significant investments in the development of our workforce without recouping return on these investments when staff leave for roles with higher salaries, smaller caseloads, and less administrative burden.

There are other healthcare settings that are compensated for their interdisciplinary training and workforce development programs, including teaching hospitals and federally qualified health centers (FQHCs). Recognizing that community BHAs have played this valuable role in behavioral healthcare for decades without formal recognition or compensation, the Washington Council for Behavioral Health (WA Council) developed the concept of a behavioral health teaching clinic model and accompanying enhancement rate with the intent to formally identify and compensate these agencies for the true cost of this role.

The teaching clinic model, both as a classification and an enhancement rate, would be developed specifically within the context of community practice, rather than applying similar models from physical health to the existing system. The WA Council's intention was to identify training and oversight practices already in place at BHAs, address the cost and resources associated, and develop standards that would ensure high-quality clinical training and supervision are provided and maintained while receiving the appropriate compensation for that coverage.

The following goals of developing and implementing a teaching clinic enhancement rate were identified:

1. BHAs are recognized and compensated for the critical workforce development role that they provide to students and new graduates.
2. Clinical supervisors in BHAs are acknowledged and supported by functioning within a teaching clinic model that has met the standards of this new classification, resulting in improved supervisor job satisfaction and retention rates.
3. Students and new graduates view community behavioral health as a desirable setting to complete their training and are incentivized to remain in the community behavioral health field as they begin their careers post-licensure.
4. BHAs are able to provide improved care to the most vulnerable Washingtonians.

Once the concept was identified, the WA Council developed a two-part process to recognize, describe, and test a formal teaching clinic classification, including establishing quality standards and financing mechanisms for a rate enhancement. This involved pursuing a public-private resource development path involving legislative advocacy and philanthropic grant funding.

Legislative Workgroup

In 2021, the WA Council successfully advocated for a state budget proviso that established and funded a legislative workgroup led by the Health Care Authority (HCA), with the WA Council named as a workgroup member, to develop a recommended teaching clinic enhancement rate. Appropriated funds for the workgroup efforts reflected the legislature's willingness and commitment to engage in the

teaching clinic initiative, and to work to find ways to incorporate this role and related rate into the ongoing community behavioral health system financing structure.

The workgroup efforts began in August 2021, with WA Council staff and member agencies participating extensively in all workgroup activities. A background, vision, and goals statement developed by WA Council staff was adopted by the full workgroup. In the fall of 2021, the workgroup identified a series of standards to be met and upheld by BHAs seeking to qualify as a teaching clinic.

Several stakeholders cited concerns, included in the final report from HCA, that the initial standards developed by the workgroup were overly prescriptive, had the potential to increase the already substantial administrative burden faced by BHAs, and did not adequately address the need for organizational flexibility. The WA Council sought to utilize the Demonstration Project timeline as an opportunity for more in-depth discussion, development, refinement, and testing of the standards, to ensure they would uphold a high quality of clinical care while allowing for the scalability necessary to allow BHAs of all sizes and geographic regions to participate in the teaching clinic model.

The final report of the aforementioned workgroup, including actuarial analysis conducted by Mercer, was initially expected at the end of 2021 and ultimately delivered in April 2023.

Mercer Actuarial Report

In order to fulfill the legislature's charge to develop a teaching clinic enhancement rate, HCA contracted with Mercer for actuarial analysis. Mercer developed a survey intended to identify costs associated with the clinical training and supervision provided by BHAs. The survey content included cost differentials for student interns and associate clinicians versus other staff; expenses related to supervision; and service billing codes utilized by student interns and associate clinicians.

WA Council member agencies and staff offered extensive input to conceptualize and refine this survey and participated in multiple provider orientation and technical assistance calls. Ultimately, the survey experienced a low response rate of only seven total responses. This was due in part to a series of factors cited in HCA's final report: the brief timeline for survey completion; the complexity of requested data reporting; and the technical expertise necessary to understand and complete the survey.

Additionally, in reviewing the draft report, WA Council staff and members cited concerns that the survey as presented did not fully capture the costs borne by BHAs, including that the relatively small sample size was not representative of the broader community behavioral health system statewide. Likewise, additional substantive costs were not fully captured by the survey, including time spent in team meetings and consultation, cost of evidence-based practice training, and the full cost per student for Medicaid and non-Medicaid services.

The WA Council submitted written feedback highlighting these and other concerns, which was included as an addendum in the final workgroup report. As with the standards developed by the legislative workgroup, the WA Council identified the need for a significantly more robust data reporting and cost modeling effort to be included as part of the Demonstration Project, providing participating agencies with both the necessary time and technical assistance to more accurately capture the costs associated with operating as a teaching clinic.

Description of Teaching Clinic Demonstration Project & Related Activities

Ballmer Group Grant Funding
In the same timeframe as the legislature's initial investment, the WA Council received a $1.1 million grant from the Ballmer Group to launch a demonstration project to collect data and demonstrate the value of a teaching clinic designation for BHAs in Washington. In addition to providing stipends of $100,000 to each of the participating BHAs, grant funding was used to secure clinical programmatic expertise from the National Council for Mental Wellbeing (National Council) and financial consultation from national experts at CohnReznick, a firm with extensive experience in financing and payment models for federally qualified health center training residency programs.

Selection of Clinics
The WA Council, in partnership with the funder, hoped to identify up to six volunteer BHAs that were interested in becoming demonstration sites for the two-year project duration, providing significant data and feedback necessary to validate and/or adjust the proposed standards and rate developed by HCA and Mercer.

In the summer of 2022, a formal request for interest was extended to all WA Council member agencies, which resulted in eleven member BHAs submitting Letters of Interest (LOI). Based on the enthusiastic response, the WA Council submitted a proposal to expand the cohort to incorporate ten total participant clinics. Ultimately, the decision was made to maintain the original cohort scope and size of six clinics. BHAs that submitted an LOI were asked to submit a brief application, detailing regions served, size of patient population, age groups served, and clinical service type(s) provided. Using this information, the Ballmer Group and WA Council identified six member BHAs to participate, ensuring the cohort would represent all regions of the state (both urban and rural), the full lifespan of patient populations, small and large agencies, and a diversity of clinical service array.

Subject Matter Experts
With the WA Council serving as project manager and advocacy lead, subject matter experts were brought in to provide technical assistance and guidance on both programmatic (e.g., teaching clinic standards) and fiscal (e.g., cost modeling and rate development) aspects of the work. Alongside staff from the WA Council, these subject matter experts compose the Project Team.

The National Council is a nationwide membership organization advocating for and representing thousands of mental health and substance use treatment providers, as well as the children, families, and adults they serve. For the Demonstration Project, the organization was contracted to lead efforts related to reviewing and refining the teaching clinic definition and standards as initially developed by the legislative workgroup; identifying standards and core competencies; proposing potential performance metrics; and conducting external research as needed.

CohnReznick is a nationally recognized advisory, assurance, and tax firm that has developed several innovative behavioral health fiscal rates, including the federal Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System rate and the New Journeys Coordinated Specialty Care case rate in Washington State. For the Demonstration Project, CohnReznick was contracted to provide services to include assistance around testing and validating a proposed teaching clinic enhancement rate by developing a costing model; mapping the program components; collecting and analyzing cost data; providing technical assistance to demonstration clinics; and testing the costing model.

Meeting Activities
Following a formal launch in September 2022, both the Project Team and the full Demonstration Project (including participating BHAs) met virtually on a monthly basis to accomplish the aforementioned goals of developing and implementing the teaching clinic designation and enhancement rate.

Project Team meetings focused on discussing development and refining of standards and evaluation metrics, costing model development, reviewing progress, and identifying areas where additional support for participating BHAs was needed. Monthly webinars, hosted by the Project Team, offered participating BHAs an opportunity to dive deeper into a particular topic related to either the quality standards and evaluation metrics or development of the cost model.

In addition to monthly webinars, Demonstration Project BHAs participated in several one-on-one technical assistance calls, particularly related to the data reporting and cost modeling work led by CohnReznick.

Building Off Legislative Workgroup
With the formal Demonstration Project launch, it was important to not disregard the previous work of the legislative workgroup, including the contributions of HCA, Mercer, participating BHAs, and WA Council staff. The final legislative report, including the proposed eligibility standards and Mercer's actuarial analysis and cost assumptions, was identified as a preliminary starting point for defining the behavioral health teaching clinic classification and exploring the teaching clinic enhancement rate.

With this in mind, the first monthly webinar focused on an overview of the HCA legislative workgroup process and draft report, led by HCA staff, to provide a shared starting point and context for this work, as not all Demonstration Project BHAs participated in the HCA efforts.

In addition, WA Council staff reviewed both the draft and final editions of the HCA's report, determining that the Demonstration Project would need to address and refine the following programmatic and fiscal elements:

Programmatic Elements

- Review, refine, and finalize the vision statement for a teaching clinic, using the vision statement finalized by the HCA workgroup as a starting point.
- Finalize the operational definition of a behavioral health teaching clinic, including a definition and regulation, using the description developed by the HCA workgroup as a starting point.
- Identify and define teaching clinic standards, including clear definitions of an intern and a trainee.
- Identify basic program metrics to describe and document the teaching clinic role.
- Review the proposed teaching clinic standards and program components to identify which should be used in developing the costing model.
- Discuss the appropriateness and effectiveness of preliminary standards in a variety of practice settings, including Mercer's recommended requirement for payment of interns to qualify as a teaching clinic.
- Assess demonstration BHAs' satisfaction with the draft standards, including supervisors and students/trainees.

Fiscal Elements

- Identify necessary inputs and data elements to be used in development of a cost tracking model.
- Provide technical assistance and guidance to demonstration participants to assist with updating accounting and other financial reporting systems to allow for tracking and monitoring of required financial data elements that are identified but sites do not collect.
- True cost of training, supervising, and supporting interns/trainees, and the extent which reimbursement rates for Medicaid encounters adequately recoup these costs.
- Provide guidance to ensure the costing model complies with 42 CFR § 438.60 – Prohibition of additional payments for services covered under MCO, PIHP, or PAHP contracts.

In 2023, as the Demonstration Project was well underway, the WA Council continued its advocacy for the long-term sustainability of this project. The legislature appropriated funding so that HCA could dedicate a 0.5 FTE “to participate in efforts to ensure behavioral health agencies are compensated for their role as teaching clinics for students seeking professional education in behavioral health disciplines and for new graduates working toward licensure.” HCA has been a partner in this effort since the beginning, and this funding ensured its ability to participate and stay connected to this legislative priority.

Teaching Clinic Standards & Billing Eligibility

The following standards are requirements to meet eligibility for behavioral health teaching clinic certification. Listed under each standard are key components and considerations factoring into their development, including how each standard will be evaluated and measured.

Overall, the principles reflected in the teaching clinic standards aim to achieve the following goals:

- Maintain a **high standard of clinical care while allowing flexibility** to meet the training needs specific to each agency, intern, or trainee;
- **Leverage existing processes** to streamline organizational integration of the standards and **limit additional administrative burden** on behavioral health agencies;
- **Prioritize equity** by removing barriers created by uncompensated internships and expanding organizational ability to provide training and supervision to a diverse array of interns and trainees; and
- **Foster high-quality training** while not overburdening supervisory staff who may be limited in number and capacity in behavioral health agencies due to existing workforce shortages.

Clinic Standards & Billing Eligibility Requirements	
Agency Eligibility Criteria	**1. The teaching clinic must be licensed and certified to provide behavioral health services under the Revised Code of Washington (RCW 71.24.037) and related Department of Health regulations.** Teaching clinics must meet minimum state standards for licensure and be in good standing. This standard utilizes an existing license to reduce the administrative burden by not requiring the introduction of a new clerical requirement. While some behavioral health agencies may have specialized licenses as listed in WAC 246-341-0110, only the main licensure level would be required for teaching clinic eligibility. *Evaluation and measurement: current license and good standing with DOH.*
	2. The teaching clinic must be certified by the Department of Health (DOH) as a teaching clinic and maintain compliance of standards to remain certified. *Evaluation and measurement: current teaching clinic certification and good standing with the state.*
	3. The teaching clinic trains interns, trainees, or both.

	While a teaching clinic certification will be issued to the agency as a whole, only those individuals who meet the definitions in Appendix A are considered active participants in the teaching clinic, thereby eligible to bill for or be included in the teaching clinic enhancement rate. A teaching clinic enhancement rate is intended to compensate agencies for training and supervision that is beyond the regular onboarding activities for new employees. *Evaluation and measurement: organizational attestation.*
	4. The teaching clinic describes organizational admissions policies and procedures that make the clinic equitable and inclusive to populations served, with particular attention to marginalized populations. A teaching clinic will attest that its admission policy is equitable and inclusive. The language of this standard aligns with the educational policy and accreditation standards for those working in substance use and addiction services; emotional health; physical health; and social services. *Evaluation and measurement: organizational attestation.*
Billing Eligibility	**5. Billable services rendered to clients by an intern or trainee will be billed and reimbursed for only in accordance with payor and organizational billing structures.** A teaching clinic will attest that it tracks, executes, and (when applicable) receives reimbursement for billable and non-billable services by interns and trainees. All clinics must follow state- and CMS-issued guidance for billing and reimbursement. Some clinics may also offer grant-covered services or services paid for through sliding-scale fees. Designation as a teaching clinic does not replace the clinic's payor and organizational billing structures. *Evaluation and measurement: organizational attestation.*
	6. Teaching clinics will pay interns a stipend or honorarium in accordance with the teaching clinic payment structure and when not prohibited by educational institutions. Unpaid placements may be a barrier to interns completing their training. However, some agencies face barriers to providing payment to interns, including rules stemming from educational institutions' policies regarding payment for services completed as part of required coursework. Any payment to teaching clinic interns must be included as part of the funding model and not create an additional financial burden for agencies. *Evaluation and measurement: organizational attestation.*

Environment of Care	**7. Interns and trainees will be provided with physical or virtual space and resources similar to that of non-teaching clinic eligible staff functioning in a similar role.** Workspaces and resources provided to teaching clinic interns and trainees should be similar to those provided to similar non-teaching clinic staff to maintain equitable services and quality experiences in the workplace. *Evaluation and measurement: organizational attestation.*
Supervision	**8. Each intern or trainee is assigned a supervisor as defined by teaching clinic supervisor definitions [see Appendix A].** A teaching clinic must attest that supervisors are appropriately matched based on their license and credentials to each of their interns and trainees. Definitions in Appendix A align with Washington Administrative Code requirements for supervisors. Some supervisors may meet the Appendix A definitions to supervise different and multiple categories of interns or trainees. Some supervisors may have credentials that exceed minimum standards for different supervisory groups. *Evaluation and measurement: organizational attestation.* **9. Interns and trainees will receive, at minimum, the equivalent of one hour per week of clinical supervision via the methods and deliveries determined by their professional licensure standards.** The method of supervision may vary between individual and group structures. The frequency and consistency of supervision should equate to one hour per week. The minimum supervision amount was identified following an analysis of credentialing organizations and national standards across various fields. Ideally, supervision occurs weekly; other structures or frequency that are the equivalent. Additional time beyond one hour per week is strongly recommended to further support competency, and a teaching clinic will provide more supervisory hours when made necessary by educational, licensing, or certification standards. *Evaluation and measurement: tracking the frequency and duration of supervision for each intern and trainee.* **10. Accessibility and oversight of an intern or trainee during their internship or training will be provided by their assigned supervisor who is employed or contracted by the teaching clinic, either in-person or virtually.** Teaching clinics shall be allowed flexibility in where and how their agencies provide oversight by assigned supervisors so the process can be adapted to

	their requirements and needs. Agencies may leverage external support when needed to meet supervisor requirements. *Evaluation and measurement: organizational attestation.* **11. A teaching clinic with interns must attest to having an active contract or agreement with each intern's accredited (or in-process of accreditation) educational institution or program.** Per definitions included in Appendix A, interns are enrolled in an educational institution or program. A teaching clinic must have a formal contract or agreement in place with each educational institution or program providing one or more interns to the teaching clinic. *Evaluation and measurement: organizational attestation.*
Training & Shadowing	**12. The teaching clinic must attest to having formal onboarding, training, and shadowing processes. The training program will describe how its program ensures that practice opportunities are provided to interns or trainees. The agency must meet regulatory standards, competencies, and scope of work requirements that align with higher education and professional standards.** A teaching clinic will attest that training prepares interns or trainees for full-time functionality in the workforce and that training builds competency. Onboarding, training, and shadowing should be similar to that for non-teaching clinic employees and may also include additional training specific to the intern or trainee role. Interns and trainees are expected to be working on tasks that build competency comparable to employees in similar roles. *Evaluation and measurement: organizational attestation.*
Quality Improvement	**13. The teaching clinic utilizes continuous quality improvement strategies in their operational and clinical practices, as well as to inform strategic planning.** A teaching clinic will attest that it maintains a quality improvement and strategic planning process. Clinics should have an ongoing practice of iteration and sustainability, which may involve using process and outcome measures, to elevate the quality of care and practices in clinical, operational, administrative and educational functioning of the clinic. *Evaluation and measurement: organizational attestation.*

Teaching Clinic Rate Methodology

Approach to Determine Teaching Clinic Total Cost and Unfunded Medicaid Cost Share
The WA Council contracted with CohnReznick to determine the true total cost for BHAs to function as a teaching clinic, including determining the personnel costs related to training, supervision, and administrative functions of teaching clinic work, as well as other non-personnel costs specific to the training of interns and trainees. The total cost of the teaching clinic was then reduced by third party revenue (e.g., Medicaid reimbursement) generated during teaching activities to arrive at a net, unfunded cost to inform development of an enhancement rate and Medicaid funding strategy to sustain the teaching clinic program.

CohnReznick developed data collection templates to intake detailed personnel time and effort and other costing information related to teaching clinic activities from the six agencies participating in the Demonstration Project. Data collection was specific to each of the five categories of interns and trainees as developed under the project and with support and guidance from the National Council for Mental Wellbeing, including:

- **Intern–Master's+:** Individuals in an accredited (or in process of accreditation) **master's or higher** educational institution or program, seeking training as part of their degree program.
- **Intern–Bachelor's:** Individuals in an accredited (or in process of accreditation) **bachelor's** educational institution or program, seeking training as part of their degree program.
- **Trainee A:** Individuals who are employees and working toward independent clinical licensure.
- **Trainee B:** Individuals who are employees and working toward certification.
- **Trainee C:** Individuals who do not meet the definition for Trainee A or Trainee B and meet one or more of the following: a) less than five years in the workforce; b) less than five years at the organization; c) new to their roles and responsibilities.

Each of the six participating agencies in the Demonstration Project provided data for a twelve-month time period. Five of six agencies provided data for that twelve-month period ending June 30, 2023, chosen to align with the fiscal year-end of most participating agencies. One agency provided data for an alternative twelve-month period ending December 31, 2023, as the agency had initiated a new intern training program in 2023 that would not otherwise be captured in a June 30, 2023 year-end period and in addition, because of a change in the agency's internal data systems, would be unable to provide data for the final six months in 2022 without significant manual effort.

Each of the agencies provided the following data metrics over a twelve-month collection period:

- **Intern** hours worked and intern hours paid, including all salary/hourly wages or stipends paid (as applicable) over the twelve-month period;
- **Trainee** hours paid and all salary/hourly wages paid over the twelve-month period;
- **Teaching clinic staff** hours paid and salary/hourly wages paid over the twelve-month period, as well as time and effort allocation that each of the teaching clinic staff members spent in individual/group supervision, clinical practice supervision, or on administrative tasks related to teaching clinic activities for each of the five intern/trainee categories, respectively;
- **Direct non-personnel costs** related to teaching clinic activities, including educational/didactic materials costs; licensing/certification fees; program fees and costs; or other direct teaching clinic costs.

- **Other agency costs** were provided for the twelve-month data collection period to inform assumptions for other expenses such as employee-related expenses (e.g., fringe benefits and payroll taxes), facility costs, and overhead.
- **Revenue generated** by teaching clinic activities was collected for each type of intern, trainee, and teaching clinic staff member, including the number of billable services provided by payer type during the twelve-month period and payments received by payer class (if fee for service, or FFS). For agencies paid under a case rate, capitation, or other Medicaid bundled payment methodologies, agencies provided counts of Medicaid services by CPT or HCPCS code that were provided under non-FFS reimbursement methodologies for each type of intern, trainee, and supervising clinic staff member.

Similar to other costing and payment models for health-related teaching programs, CohnReznick's approach was to calculate the net, unfunded cost of teaching activities on a per full-time equivalent (FTE) basis for interns and trainees. The net, unfunded cost per intern/trainee FTE includes the time spent by supervisors and teaching clinic staff allocated to each intern/trainee type. This approach included assessing costs of training each type of intern and trainee based on actual wages paid to intern/trainee types, time and effort spent by supervisors and teaching clinic staff in direct supervision, clinical supervision, and on teaching clinic-related administrative tasks related to each type of intern and trainee, and direct non-personnel costs and allocation of overhead. This total cost was then offset by the revenue interns, trainees, and teaching clinic staff can generate due to provision of billable client services, to arrive at a net unfunded cost of teaching clinic activities that are recommended to be supported through an enhanced reimbursement rate.

Cost components of the proposed teaching clinic enhancement rates were developed as follows:

Teaching Clinic Cost Component	Assumptions Developed for each Intern/Trainee Type
Teaching Cost Staff Cost per Intern/Trainee FTE	Average Weighted Staff Cost per Hour
	Average Weighted Fringe Benefit Rate
	Average Weighted Ratio of Intern/Trainee FTE to Staff FTE
Direct Non-Personnel Cost per Intern/Trainee FTE	Average Weighted Non-Personnel Costs per FTE (%)
Teaching Clinic Facility Cost per Intern/Trainee FTE	Average Weighted Facility Cost per FTE (%)
Teaching Clinic Admin Cost per Intern/Trainee FTE	Average Weighted Administrative Cost per FTE (%)
Intern / Trainee Cost per FTE	Average Weighted Cost per Intern FTE, including: - Average cost per Intern FTE - Stipend per Intern - Average hourly pay rate per Intern
	Average Weighted Cost per Trainee FTE
Sum of assumptions developed above inform Total Cost per Intern/Trainee Type	

<table>
<tr><td rowspan="3">Offsetting Revenue per Intern / Trainee FTE</td><td>Average number of billable services per Intern/Trainee FTE</td></tr>
<tr><td>Average proportion of services billable to Medicaid</td></tr>
<tr><td>Average Medicaid payment per service</td></tr>
<tr><td colspan="2">Total Cost per Intern/Trainee Type less Revenue per Intern/Trainee Type = Unreimbursed cost per Intern / Trainee FTE</td></tr>
</table>

The above assumptions are aligned with the type of inputs that Mercer considered in its original cost estimates provided to HCA and are specific to the work of a teaching clinic. **As such, these assumptions consider the cost of activities outside of services covered under the state plan and would be permissible under 42 CFR § 438.60.**

Technical Assistance Provided to Clinics

Demonstration agencies' completion of the costing and revenue data templates occurred between December 2023 and July 2024, during which time CohnReznick provided technical assistance to clinics in their completion of the data templates. Each costing template component was previewed during demonstration project-wide meetings to allow for group feedback and discussion on approach and assess ability of agencies to report data aligned with the categories requested.

Following distribution of the costing template components, demonstration clinics were each provided with individual technical assistance support to complete the costing templates. Individual technical assistance calls were provided on a minimum monthly basis per clinic and included individual explanation and review of the template components, assistance in interpreting and understanding data fields, and discussion and review of agency data to identify and correct errors or omissions (as needed) and validate inputs.

CohnReznick also provided support through responding to questions through email. Results of the cost and revenue results were presented to agencies during demonstration project-wide meetings to gather additional feedback from the agencies.

<u>Interns</u>

Intern Payment Structure

All demonstration agencies reported training master's level interns, and three of six currently train bachelor's level interns. Agencies had varying size of master's level internship programs, with ranges from five interns per year to over thirty interns per year. Across all agencies, an average of twenty master's level interns received training per year, equating to a 4.21 full-time equivalent (FTE). Among those three agencies that trained bachelor's level interns during the fiscal year for which data was collected, two had robust bachelor's internship programs with an average of twenty interns supported annually per agency and the third supported one bachelor's level intern during the twelve-month data period, equating to an average of 1.68 FTEs per annum. Two agencies did not provide interns with any payment, whether hourly wages based on time worked or a nominal stipend. Within the other four agencies, payment structure was often mixed with some interns receiving hourly rates and some receiving stipends/honorariums, as well as some that remained unpaid. Agencies cited prohibitions from schools as a primary reason for difficulty in maintaining a uniform payment policy across an agency internship program.

- Most master's level interns in the Demonstration Project (47%) received payment structured as a nominal stipend based on either the length of time worked (e.g., $150/month) or a flat fee that applied regardless of hours or duration of internship (e.g., $500/internship).
- Where permitted by schools, some agencies paid master's level interns based on hours worked (9%). Average hourly rates for master's level interns when paid based on time and effort were approximately $16.47/hour less than trainees with master's degrees (Trainee As).
- The remaining master's level interns (44%) were unpaid, receiving neither hourly wages nor stipend for the hours spent at the agencies for their internship.
- Bachelor's level interns were also primarily unpaid (69%), although some received stipends (26%) and a small percentage (5%) received hourly wages based on time worked. Those that received hourly wages were primarily existing employees of an agency who returned to school and were able to receive permission to count their work hours toward school requirements.

Rate modeling sensitivities for interns were prepared based on current state of costs as well as applying intern payment structure to incentivize payment of interns in accordance with the proposed standards.

Teaching Clinic Staff Costs – Interns
Agencies reported time and effort that teaching clinic staff members spend on activities related to the teaching clinic, including individual/group direct supervision of interns and provision of educational and practical training without a client present (e.g., didactic time); clinical supervision, including direct supervision of services provided by the intern/trainee as well as being shadowed by an intern/trainee to provide a learning experience; and administrative tasks related to the oversight of the intern and/or coordination with the schools. Interns required significantly more staff time and effort than trainees, and within the intern category, bachelor's level interns required comparatively more staff time and effort from staff than training master's level interns. The table below summarizes the average weighted staffing requirements per intern type.

Teaching Clinic Staff Requirements		
Intern Type	**Average Weighted Annual Staff Hours Required per Intern FTE**	**Average Weighted Supervision Ratio of Intern to Staff FTEs**
Master's Level Intern	538 Annual Staff Hours per Intern FTE	4.83 Intern FTEs per Staff FTE
Bachelor's Level Intern	1,858 Annual Staff Hours per Intern FTE	1.82 Intern FTEs per Staff FTE

Offsetting Intern Revenue
Interns receive training, education, and oversight on ability to provide a wide range of services, including over 30 unique CPT/HCPCS service codes. The most frequent service codes that represent the services that demonstration agencies trained interns to provide included:

CPT/HCPCS Code	Description
90834, 90837	Psychotherapy with patient and/or family member
90846	Family psychotherapy (w/ patient)
90853	Group psychotherapy
H0004	Behavioral health counseling and therapy
H0030	Behavioral health hotline service
H0032	Mental health service plan development by non-physician

H2011	Crisis intervention service
H2015	Comprehensive community support services
H2027	Psychoeducational service
T1017	Targeted Case management

CohnReznick determined the average number of billable services generated per intern FTE, inclusive of both services generated by the intern as well as those allocable to the clinical supervision and/or shadowing time associated per intern FTE to allocate revenue to the teaching clinic program. The table below summarizes the average number of billable services generated per intern FTE and the average Medicaid share of such services.

Teaching Clinic Revenue Metrics		
Intern Type	**Average Annual Billable Services Generated per Intern FTE**	**Average Proportion of Services Rendered to Medicaid-Enrolled Individuals**
Master's Level Intern	680 billable services per Intern FTE	89% Medicaid services
Bachelor's Level Intern	584 billable services per Intern FTE	91% Medicaid services

Trainees

Trainee Type and Payment Structure

All demonstration agencies reported training individuals seeking independent clinical licensure (Trainee A), and five of six agencies reported training individuals seeking certification (Trainee B). In addition to these trainees, agencies reported spending additional significant time and effort training individuals that are new to the workforce, agency, or their position, above and beyond that of general onboarding (Trainee C).

- Agencies reported providing training and supervision for several distinct types of behavioral health staff seeking independent clinical licensure (Trainee A), including those candidates pursuing Licensed Mental Health Counselor (LMHC), Licensed Independent Social Worker (LISCW), Licensed Marriage and Family Therapist (LMFT), and Licensed Advanced Social Worker (LASW) status.
    - All agencies reported providing supervision for individuals seeking LMHC and LISCW licensure, with some agencies supporting training and supervision for up to four different independent licensure types.

Average costs per trainee type were calculated using a weighted average across the demonstration agencies that trained each respective category of trainee. The table below represents average wages per trainee type, before fringe benefits.

Trainee Payment Structure		
Trainee Type	**Average Weighted Trainee Wages/Hour**	**Cost Differential**
Trainee A	$39.03/hour on average	N/A
Trainee B	$32.98/hour on average	$6.05/hour less than Trainee A
Trainee C	$26.31/hour on average	$6.67/hour less than Trainee B

Teaching Clinic Staff Costs – Trainees
Agencies similarly reported three primary activities related to teaching clinic supervision and staffing, including individual/group direct supervision of trainees (without a client present), clinical supervision, and administrative tasks related to the oversight of the trainee. The table below summarizes the average weighted staffing requirements per trainee type.

Teaching Clinic Staff Requirements		
Trainee Type	**Average Weighted Annual Staff Hours Required per Trainee FTE**	**Average Weighted Supervision Ratio of Trainee to Staff FTE**
Trainee A	124 Annual Staff Hours per Trainee FTE	26.7 Trainee FTEs per Staff FTE
Trainee B	428 Annual Staff Hours per Trainee FTE	18.3 Trainee FTEs per Staff FTE
Trainee C	438 Annual Staff Hours per Trainee FTE	27.7 Trainee FTEs per Staff FTE

Agency interviews confirmed that supervision of staff pursuing certification, particularly substance use disorder professionals (SUDP), is more time intensive and proscriptive than supervision of trainees pursuing independent clinical licensure. Average hourly rates per teaching clinic staff, fringe benefit rates, and direct non-personnel costs reported across the agencies were used to develop the teaching clinic cost per trainee FTE.

Offsetting Trainee Revenue
Trainees likewise provide a wide range of services in the demonstration agencies. Over forty unique CPT/HCPCS services were rendered by trainees across the demonstration agencies, with the below representing a selection of services that represent the top ten most common services delivered by these trainee types across the agencies.

CPT/HCPCS Code	Description	Trainee A	Trainee B	Trainee C
H0004	Behavioral health counseling and therapy	Included	Included	Included
90832-37	Psychotherapy with patient and/or family member	Included		
H2011	Crisis intervention service, per 15 minutes	Included	Included	Included
90846-47	Family psychotherapy (w/ patient)	Included	Included	Included
H2015	Comprehensive community support services	Included	Included	Included
H0032	Mental health service plan development by non-physician	Included	Included	Included
H0046	Mental health services not otherwise specified	Included	Included	
T1017	Targeted Case management		Included	
H0036	Community psychiatric supportive treatment, face-to-face		Included	
H2021	Care coordination services		Included	Included
H0038	Self-help/peer services			Included
H0030	Behavioral health hotline service			Included

CohnReznick similarly determined the average number of billable services per trainee FTE, inclusive of both services generated by the trainee as well as allocable to the clinical supervision and/or shadowing time associated per trainee FTE to allocate revenue to the teaching clinic program. The table below summarizes the average number of billable services generated per trainee FTE and the average Medicaid share of such services.

Teaching Clinic Revenue Metrics		
Trainee Type	**Average Annual Billable Services Generated per Trainee FTE**	**Average Proportion of Services Rendered to Medicaid-Enrolled Individuals**
Trainee A	764 billable services per Trainee FTE	88% Medicaid services
Trainee B	592 billable services per Trainee FTE	70% Medicaid services
Trainee C	806 billable services per Trainee FTE	90% Medicaid services

See **Appendix C** for a detailed list of the assumptions developed for each type of intern and trainee category.

Differences in Demonstration Project Approach from HCA/Mercer Approach

The costing approach utilized within the Demonstration Project captured similar cost categories included in the approach used by Mercer Government Human Services (Mercer) and the Washington State Health Care Authority (HCA), which also included establishing assumptions for staffing costs and wages related to interns, trainees, and their supervisors, fringe benefits (or employee-related expenses), provider overhead expenses, and productivity assumptions.

However, the approach developed by CohnReznick and described above differs from the prior approach utilized by HCA in conjunction with Mercer in several ways. Conceptually, the approaches were different in that HCA and Mercer used a rate differential approach between the hourly rate of a baseline professional behavioral health service (i.e., hourly rate for a Licensed Mental Health Practitioner [LMHP]) to an hourly rate for a professional behavioral health service at a teaching clinic. The hourly rate differentials were calculated for clinical supervisors, interns, and trainees. CohnReznick's approach, on the other hand, calculated a fully-loaded cost (including the cost of teaching clinic staff) of teaching activities for interns and trainees, on a per FTE basis. For comparison purposes, the teaching clinic cost per FTE was converted to hourly rates by dividing the cost per FTE by the number of billable hours per FTE.

In its formulation of cost estimates, HCA and Mercer developed a survey to collect information from a workgroup of community behavioral health agencies on the service codes that student interns and pre-licensed trainees are billing; to develop cost differentials for interns and trainees compared to other practitioners; to understand cost of supervision and other expenses; and to understand impacts to productivity. The survey was distributed to thirty-three behavioral health agencies. Of those, seven providers (21%) completed the survey. Responding providers noted several challenges in completion of the survey, including a variety of Medicaid reimbursement payment arrangements as well as a high degree of technical expertise and time commitment required to extract cost and revenue data by staff type. Only three and a half weeks were allotted to survey data collection. In contrast, agencies in the Demonstration Project were allotted more than six months to complete data collection, with individual technical assistance provided to not only assist in agency understanding of data collection, but also to review and validate data with agencies to ensure a more robust development of assumptions to inform the enhancement rate. Other variations in approach include:

Staffing Assumptions Related to Wages

Mercer utilized compensation data compiled from the U.S. Bureau of Labor Statistics data published in March 2022 and trended to a projected time period. Feedback from stakeholders identified that this data may not accurately reflect salary costs, particularly in light of the post-COVID environment that has driven up wages in the healthcare market and required behavioral health agencies to increase salary

costs in order to continue to recruit and retain qualified professionals. To address this, CohnReznick's methodology included collection of actual salary data for each of the intern, trainee, and supervisory staff utilized during the data collection time period, although agencies also noted that salaries have continued to rise following the data collection period (through FY2023).

In addition, Mercer's approach considered only teaching clinic staff time related to clinical supervision and provision of a shadowing experience; however, agencies employ other additional staff members that provide administrative functions related to teaching clinic activities (e.g., to develop contracts with schools, coordinate placement of interns, and monitor and submit documentation) that should be included in the cost of a teaching clinic.

Employee Related Expenses
Mercer assumed employee-related expenses to be 25% of wages for full-time workers and 15% for part-time workers, including health insurance, unemployment taxes, workers' compensation, FICA, and other contributions. Employee-related expenses calculated in the demonstration project included both full-time and part-time employees to arrive at a blended rate of approximately 23% on average across all intern and trainee categories. CohnReznick's methodology included collection of actual fringe expenses for agencies at the organizational level to apply a blended rate applicable to all benefits-eligible staff.

Provider Overhead Expenses
Mercer included an assumption of 15% for overhead costs such as program management, equipment, and supplies. CohnReznick's data collection included a broader set of overhead costs including direct non-personnel, facility, and administrative costs. The below table summarizes the percentage of direct non-personnel costs, facility costs, and administrative costs identified for each intern and trainee category. Assumptions for overhead allocations percentages were adjusted to allow non-personnel costs to remain consistent when modeling hourly pay for interns.

Teaching Clinic Non-Personnel Costs by Percentage of Staffing Costs				
	Modeling Assumption of Stipend Pay		**Modeling Assumption of Hourly Pay**	
Cost Type	**Master's Interns**	**Bachelor's Interns**	**Master's Interns**	**Bachelor's Interns**
Direct non-personnel Costs	14%	21%	8%	12%
Facility Costs	11%	8%	7%	5%
Administrative Costs	16%	19%	10%	13%

Teaching Clinic Non-Personnel Costs by Percentage of Staffing Costs			
Cost Type	**Trainee A**	**Trainee B**	**Trainee C**
Direct non-personnel Costs	6%	5%	6%
Facility Costs	4%	5%	4%
Administrative Costs	2%	4%	5%

Productivity Assumptions
Mercer utilized survey responses to form assumptions for productivity rates, including supervision time per week for interns and trainees and absentee factors to form assumptions for full-time hours available for billable services. However, data and interviews with the demonstration agencies identified that teaching clinic staff spend time and effort outside of supervision, including direct/group supervision (without a client present), clinical supervision (shadowing/being shadowed during a clinical service), and administrative tasks. CohnReznick's data collection methodology included collection of working hours (or full-time equivalency) status for interns, trainees, and clinical supervisors as well as detailed provision of the number of hours supervising clinicians spent in direct supervision, clinical supervision, and administrative tasks related to the teaching clinic and number of billable services that each intern, trainee, and teaching clinic staff member was able to produce, allowing for a more targeted calculation of productivity. CohnReznick's approach also included staff that contribute to the teaching clinic outside of approved clinical supervisors, such as task instructors, and included an allocated portion of billable services and revenue attributed to those activities in addition to costs associated with those activities.

Costs Associated with Clinical Supervision
Mercer's approach developed a singular enhancement rate applicable to a clinical supervisor, which assumes that clinical supervision provided in a teaching clinic is similar across intern and trainee types. Data collection from the demonstration project highlights that average supervision time required per intern/trainee varies significantly depending on the type of intern and trainee category under supervision. For this reason, CohnReznick identified supervision costs specific to each type of intern and trainee for inclusion within intern and trainee-specific enhancement rates rather than developing a universal supervisor enhancement rate.

Summary of the Teaching Clinic Enhancement Rate
In determining the potential aggregate impact, CohnReznick used the expectations provided by HCA to Mercer in the original report for the number of clinics expected to pursue the teaching clinic designation, estimated to be between 70–100 behavioral health agencies statewide. For the number of eligible individuals per provider, CohnReznick used the average FTEs of each intern/trainee type across the demonstration agencies to inform the statewide impact assumptions. In estimating the billable hours per intern/trainee FTE, CohnReznick combined the billable hours that result from the intern/trainee type and clinical supervision of the supervisor combined, as the total cost of each intern/trainee category aggregated these costs.

Two potential rates were developed for each intern type, with one supporting the cost of providing a stipend to each individual intern ($3,000 per master's level intern and $570 per bachelor's level intern), and a second enhancement rate that would support the cost of providing hourly wages to interns. Hourly wages were modeled based on the average rate paid per intern type among those demonstration agencies that paid interns hourly rates based on hours worked.

<u>Intern Cost Comparison</u>

The table below compares the cost estimate provided by Mercer related to extension of the teaching clinic model to 70–100 behavioral health agencies across the state to the new costs calculated with an enhancement rate that supports provision of a stipend in alignment with the teaching clinic standards, as well as a second version that supports payment of interns based on hours worked.

	Mercer Estimate	MA Intern – Paid Stipend ($3,000/Intern)	BA Intern – Paid Stipend ($570/Intern)	MA Intern – Paid Hourly ($22.55/Hour)	BA Intern – Paid Hourly ($19.27/Hour)
Number of Individuals per Provider	18 FTE	4.21 FTE	1.68 FTE	4.21 FTE	1.68 FTE
Estimated Billable Hours per FTE Annually	360 to 500	1643 (intern and clinical supervision)	1532 (intern and clinical supervision)	1643 (intern and clinical supervision)	1532 (intern and clinical supervision)
Number of Participating Clinics	70 to 100	70 to 100	70 to 100	70 to 100	70 to 100
Total Hours	630,000 to 648,000	432,729 to 618,184	164,214 to 234,591	432,729 to 618,184	164,214 to 234,591
Medicaid Cost Share	N/A	89%	91%	89%	91%
Enhancement Add-on	$14.65 to $25.75	$1.77	$69.98	$21.72	$110.13
Total Annual Cost Impact	$9.2 to $16.7 million	$765,900 to $1.0 million	$11.4 to $16.4 million	$9.3 to $13.4 million	$18.0 to $25.8 million
Total Annual Cost Comparison	$9.2 to $16.7 million	$12.2 to $17.5 million		$27.4 to $39.2 million	

Costs to support both master’s and bachelor’s level interns are summed in the cost comparison line to provide a comparison to the total cost calculation that Mercer arrived at to support an enhanced payment rate for interns.

Trainee Cost Comparison

The table below compares the cost estimate provided by Mercer related to extension of the teaching clinic designation to 70–100 behavioral health agencies across the state related to the new costs calculated with an enhancement rate that supports trainees. Note that Mercer's trainee cost analysis only considered the costs associated with training master's level staff pursuing independent licensure (Trainee A) and did not contemplate those pursuing certification (Trainee B) or the additional training and upskilling performed by teaching clinics outside of onboarding activities related to individuals new to their role or the profession (Trainee C). Note also that the estimated billable hours per FTE annually includes time for both the trainee and associated clinical supervision hours in the calculations provided by CohnReznick.

	Mercer Estimate	**Trainee A**	**Trainee B**	**Trainee C**
Number of Individuals per Provider	45 FTE	26.4 FTE	4.2 FTE	43.0 FTE
Estimated Billable Hours per FTE Annually	690 to 920	1527 (trainee and clinical supervision)	1550 (trainee and clinical supervision)	1528 (trainee and clinical supervision)
Number of Participating Clinics	70 to 100	70 to 100	70 to 100	70 to 100
Total Hours	2,898,000 to 3,105,000	2,481,618 to 3,545,168	321,835 to 459,764	4,127,747 to 5,896,781
Medicaid Cost Share	N/A	88%	70%	90%
Enhancement Add-on	$9.80 to $13.35	$28.38	$37.41	$33.63
Total Annual Cost Impact	$28.4 to $41.4 million	$70.4 to $100.6 million	$12.0 to $17.1 million	$138.8 to $198.3 million

Costs to support all three categories of trainees are shown within each individual category in comparison to the total cost calculation that Mercer arrived at to support an enhanced payment rate for trainees.

Aggregate Cost Comparisons

The below table demonstrates variations of adoption of various categories of Interns and Trainees to demonstrate the **total cost of the enhancement rate implementation**, as well as the reduced amount that would need to be appropriated by the legislature following approval of rate through the Centers for Medicare and Medicaid Services (CMS) that would allow for a Federal Medical Assistance Percentage (FMAP) for Medicaid services. The current FY2025 FMAP rate was used in the projections below.

Variations of Total Annual Cost Impact	Total Annual Cost of Enhanced Rate Implementation	State Dollars Appropriated by Legislature once Federal Match Approved	Number of Interns and Trainees Supported by Investment
All Trainees and Interns (with Stipends)	$233.5 to $333.6 million	$116.7 to $166.8 million	5,572 to 7,960 FTEs annually
Master's Level Trainees (Trainee A) and Master's Interns Only (Stipend)	$71.1 to $101.7 million	$35.5 to $50.8 million	1,850 to 2,643 Trainee A FTEs; and 295 to 421 Master's Interns FTEs annually
Master's Level Trainees (Trainee A) and Master's Interns Only (Hourly Wage)	$79.8 to $114.0 million	$39.9 to $57.0 million	1,850 to 2,643 Trainee A FTEs; and 295 to 421 Master's Intern FTEs annually
Trainee As and Trainee Bs and Master's and Bachelor's Interns (Stipend)	$94.7 to $135.3 million	$47.3 to $67.6 million	2,149 to 3,070 Trainees; and 413 to 590 Interns annually
Trainee As and Trainee Bs and Master's and Bachelor's Interns (Hourly Wage)	$109.9 to $157.0 million	$54.9 to $78.5 million	2,149 to 3,070 Trainees; and 413 to 590 Interns annually

Recommendations for the Washington State Legislature

1. The legislature should enact legislation codifying the Behavioral Health Teaching Clinic Designation and Enhancement Rate into law in Washington State.
    a. implementation should, at a minimum, begin with the inclusion of Trainee A and Intern–Master's+.
    b. Future expansion of the Behavioral Health Teaching Clinic Designation and Enhancement Rate should incorporate the categories of Trainee B, Intern–Bachelor's, and Trainee C, as appropriate.

2. The legislature should appropriate funds necessary to enact the rate component of the Behavioral Health Teaching Clinic Designation and Enhancement Rate.
    a. This includes amounts adequate to fund the payment of a Behavioral Health Teaching Clinic Enhancement Rate to qualifying behavioral health agencies throughout the state.
    b. This includes amounts necessary to fund the administration and oversight conducted by the following state agencies:
        i. Department of Health – as the credentialing body
        ii. Health Care Authority – as the contracting body
    c. Cost data show that the vast majority of individuals that will be served through the teaching clinic program will be enrolled in Medicaid, with approximately 70–91% of services rendered by interns and trainees delivered to Medicaid-enrolled individuals. As such, the enhanced rate will support much of the costs related to the intern and trainee teaching program.

3. The legislature should direct the Health Care Authority, during the FY2026–2027 biennium, to take the necessary steps submit the Behavioral Health Teaching Clinic Designation and Enhancement Rate for approval by the Centers for Medicare and Medicaid Services (CMS) in order to secure federal investment and matching necessary for long-term sustainability.
    a. HCA should seek CMS approval for directed payments and amend MCO contracts to include language that requires MCOs to pass the enhanced rate funding through to approved teaching clinics.

4. The Department of Health should certify as teaching clinics those behavioral health agencies who meet the qualifying standards and billing eligibility described in this report.

5. The Health Care Authority should ensure certified teaching clinics are compensated in accordance with the payment model(s) described in this report.
    a. Teaching clinics should pay interns a stipend or honorarium in accordance with the teaching clinic payment structure and when not prohibited by educational institutions.

6. Universities, community, and technical colleges offering behavioral health education programs should reevaluate policies that disincentivize hiring and paying student interns to better align with industry workforce needs.
    a. These disincentives may disproportionately affect low-income students and students of color by limiting access to education and family-wage careers in the behavioral health field.

    b. Payment of interns is necessary to improve equity amongst behavioral health staff and decrease socioeconomic challenges experienced by the behavioral health workforce and costing data show that an enhanced rate is necessary to support the payment of a stipend/honorarium at a minimum for each intern.

7. The Health Care Authority should explore methods for incorporating the Behavioral Health Teaching Clinic Designation and Enhancement Rate into the Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS), for future teaching clinics who become certified as a CCBHC.
    a. This should involve reviewing eligibility for the Behavioral Health Teaching Clinic Designation and Enhancement Rate should the state develop a list of CPT/HCPCS eligible CCBHC services in the future that would be eligible for CCBHC PPS reimbursement to ensure that reimbursement for services is not duplicated.
    b. Behavioral health agencies who meet the teaching clinic standards but do not become certified as a CCBHC should still be eligible for the Behavioral Health Teaching Clinic Designation and Enhancement Rate described in this report.

Conclusion

The state of Washington continues to grapple with a severe behavioral health workforce shortage. Myriad factors contribute to the ongoing need to recruit, train, and retain healthcare workers in BHAs, most notably a limited access to competitive compensation in relation to the large caseloads of complex patients found in the community behavioral health system. While losing workforce to other healthcare environments such as private practice, federally qualified health centers, state agencies, or other fields, BHAs are simultaneously training the next generation of staff, many of whom will follow their predecessors out of the community setting. This training is resource-demanding, requiring many hours of supervision and oversight, leading BHAs to invest much of their already strained revenues in a fleeting workforce.

To address this complicated issue head on, the Washington Council for Behavioral Health set out to design and test a model that would compensate BHAs for their crucial investment in training the behavioral health workforce, thus bolstering an agency's ability to incentivize healthcare workers to remain in community practice, through competitive compensation and other positive impacts, such as decreased caseloads and greater institutional support. This multi-year project has culminated in the Behavioral Teaching Clinic Designation and Enhancement Rate and a robust set of recommendations to the legislature, including instructions to codify the teaching clinic model in statute and pursue Federal Medical Assistance Percentage (FMAP) for Medicaid services via CMS approval.

The findings of the data collection were conclusive: BHAs expend resources to train and supervise behavioral health workers that are not sufficiently recouped through current reimbursement rates. This one-way investment continues to put a strain on our community behavioral healthcare system and will continue to increase as our population's needs grow. **This demonstration offers a solution. With the implementation and funding of the teaching clinic model, thousands of new therapists, counselors, and substance use disorder professionals could join the behavioral health workforce in the coming years, with strong incentives to remain and serve our most vulnerable populations.**

This report serves as the blueprint for the Washington State Legislature, as supported by the Department of Health and the Health Care Authority, to formally establish the teaching clinic designation and enhancement rate statewide. The implementation of this work will act as a vital and necessary investment in the community behavioral healthcare system in Washington, helping to address decades of underinvestment and to sustainably support the behavioral healthcare needs of all Washingtonians.

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Appendix A

Category	Category Description	Supervisor
Trainee A	Individual who is an employee and working toward independent licensure. *An individual designated as "Trainee A" is eligible for trainee status until their required hours have been obtained for independent licensure, or up to 8 years, whichever occurs first.*	Group 1 Supervisor <u>only</u>
Intern – Master's+	Individual in an accredited (or in-process of accreditation) master's or higher educational institution or program, who is seeking training as part of their degree program.	Group 1 Supervisor Group 2 Supervisor
Trainee B	Individual who is an employee and working toward certification. *An individual designated as "Trainee B" is eligible for trainee status until their required hours have been obtained for certification, or up to 8 years, whichever occurs first.*	Group 3 Supervisor <u>only</u>
Intern – Bachelor's	Individual in an accredited (or in-process of accreditation) bachelor's educational institution or program, who is seeking training as part of their degree program.	Group 1 Supervisor Group 2 Supervisor Group 4 Supervisor
Trainee C	An optional designation for an individual who is an employee and requires further training, or does not fit the definition for Trainee A, Trainee B, Intern—Master's+, or Intern—Bachelor, and meets one or more of the following: a) Less than five years in the workforce; b) Less than five years at the organization; c) New to their roles and responsibilities. *An individual designated as "Trainee C" is eligible for trainee status until determined by the supervisor in collaboration with the Trainee, or up to 1 year, whichever occurs first.*	Group 5 Supervisor

Supervisor	Supervisor Description	Applicable Supervisee(s)
Group 1	Meets criteria for an approved supervisor under WAC 246-809, including WAC 246-809-134, WAC 246-809-234, and WAC 246-809-334.	Trainee A Intern—Master's+ Intern—Bachelor's
Group 2	Licensed or credentialed professional who meets educational institution or program requirements.	Intern—Master's+ Intern—Bachelor's
Group 3	Licensed or credentialed professional who meets board/licensure requirements for supervision pursuant to WAC 246-811-049.	Trainee B
Group 4	Professional who meets the bachelor's-level educational institution or program requirements.	Intern—Bachelor's
Group 5	Employed or contracted individual designated by employing agency.	Trainee C

Appendix B

Recommended Practices and Training Opportunities for Interns and Trainees

The following list includes recommended practices and training opportunities for interns and trainees. The topics listed may be covered by an educational institution or program or by the teaching clinic, or both. While not exhaustive, this list was developed by the National Council team and informed by facilitated discussions with participating agencies in the demonstration project. Although recommended, these practices are not required for teaching clinic certification. This is intended to allow for flexibility in addressing teaching clinic-specific training needs and an evolving understanding of best practices. *They should be regarded as internal guidance only.*

- ASAM (American Society for Addiction Medicine) criteria, addiction treatment and recovery-oriented systems of care
- Care management and coordination (problem solving, critical decision making, triaging)
- Continuous quality improvement (CQI), data-informed care and approaches, use of metrics
- Confidentiality and mandatory reporting (HIPAA and 42 CFR)
- Conflict resolution
- Cultural and linguistic responsiveness
- De-escalation, crisis intervention, and safety
- Documentation and compliance
- Effective communication
- Formulating and applying DSM criteria
- Managing caseload
- Motivational interviewing
- Overdose prevention
- Organizational and workforce wellness
- Peer recovery and voice of lived experience
- Suicide prevention, intervention and postvention
- Team-based care
- Trauma-informed care
- Use of electronic health record (EHR)

Cultivating a Teaching Environment: Best Practices in Supervision

Supervision plays a key role in the development and training of interns and trainees in teaching clinics and contributes to workforce retention by fostering growth in a healthy workplace. The National Council team identified the following strategies for supervisors and organizations to cultivate within a teaching environment. Utilizing the strategies will support supervisees to be successful in their roles and will promote resilience on individual and organizational levels.

Self-care for Supervisors: It can be a common pitfall for supervisors to overlook actions to care for themselves. Therefore, intentionally structuring self-care activities such as proper rest, nutrition, exercise, and stress reduction are necessary for the individual and professional well-being of supervisors.

Strengths-based Approach for Supervision: A primary purpose of supervision is to provide support to interns and trainees so they may be successful in their role and functioning. The recommended approach is strengths-based supervision, which focuses on three elements: 1) supportive supervision, 2) educative supervision, and 3) administrative supervision.

> **Supportive supervision** includes goal setting, problem solving, boundary setting, and a space to discuss resiliency building, and self-care strategies. Supportive supervision facilitates opportunities for reflections and feedback that can help to decrease job stress.
>
> **Educative supervision** includes training, coaching, teaching, modeling skills, and professional development to increase knowledge, skills, and competencies. The focus of educative supervision is the core competencies interns and trainees need for their role.
>
> **Administrative supervision** includes working with supervisees to improve their practices with accurate implementation of organizational policies and procedures, communicating and managing changes to policies, and advocating for changes at the organizational level to better support its workforce. Administrative supervision also includes performance evaluation.

Structuring Supervision Time: In a supervision session, time is spent in a combination of educative, administrative, and supportive supervision. The recommended structure is sixty percent of the time is focused on what is going well and what has been challenging in working with program participants, twenty percent of the time is spent on task management and skill building (such as data collection and reporting or learning an evidence-based practice), and twenty percent of the time is spent on developing knowledge and skills.

Supervisor Tasks to Support Resilience: In addition to taking a strengths-based approach to supervision and structuring supervision time to cover necessary components, supervisors support intern and trainee resilience through the following tasks:

- Build an environment of trust and safety
- Structure supervision to include time to talk about self-care
- Help achieve and maintain quality work
- Help manage boundaries
- Model self-care behaviors
- Help model change and being a change agent

Organizational wellness: Wellness, self-care, and supervision all happen in the context of the broader system of a workplace. Organizational culture, climate, and processes contribute to a healthy and successful learning and work environment. From a systems perspective, there is an organizational responsibility to foster an environment that uses and models adaptive leadership and a growth mindset, creates strong communication, and embodies the following trauma-informed principles: safety and stability; trustworthiness and transparency; peer support and the voice of lived experience; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender considerations. Creating and nurturing organizational wellness allows for the teaching environment and all the connected people to thrive.

Appendix C

Assumptions and Proposed Enhancement Rates

Appendix C, Table 1 – Intern—Master's+

	Modeling Pay Scenarios per Intern	
	Stipend/Honorarium	Hourly Wages
MASTERS LEVEL INTERNS	**$3,000/Intern**	**$22.55/Hour**
Avg. Intern Count per Agency	20	20
Avg. Intern FTE per Agency	4.21	4.21

Teaching Cost per Intern FTE	**Total**	**Total**
Avg. Staff Costs per Intern FTE based on Above	**$ 27,747**	**$ 27,747**
Avg. Cost per Intern FTE	**$ 14,129**	**$ 46,910**
Avg. Non-Personnel Costs per Intern FTE	**$ 5,844**	**$ 5,844**
Avg. Facility Costs per Intern FTE	**$ 5,315**	**$ 5,315**
Avg. Administrative Costs per Intern FTE	**$ 8,414**	**$ 8,414**
Total Cost per Intern FTE	**$ 61,450**	**$ 94,230**
Revenue per Intern FTE		
Avg. Services generated per Intern FTE	680.65	680.65
Avg. Reimbursement per Service	$ 86.00	$ 86.00
Less Avg. Revenue generated per Intern FTE	**$ 58,537**	**$ 58,537**
Total Net Unreimbursed Cost per Intern FTE	**$ 2,913**	**$ 35,694**

Total Cost per Billable Hour	**$1.77 Per Hour**	**$21.72 Per Hour**
Total Cost per Service	**$4.28 Per Service**	**$52.44 Per Service**
Total Medicaid Cost per Month	**$216.90 per Month**	**$2657.43 per Month**

Mercer Enhancement Add-on per Hourly Rate	**$14.65 to $25.75 per Hour**	
Mercer Estimated Cost Impact	**$9.2 to $16.7 million**	
New Estimated Cost Impact	**$765k to $1.09 million**	**$9.3 to $13.4 million**

Appendix C, Table 2 – Intern—Bachelor's

	Modeling Pay Scenarios per Intern	
	Stipend/Honorarium	Hourly Wages
BACHELORS LEVEL INTERNS	**$570/Intern**	**$19.27/Hour**
Avg. Intern Count per Agency	14	14
Total FTE per Intern/Trainee Type	1.68	1.68

Teaching Cost per Intern FTE	Total	
Avg. Staff Costs per Intern FTE based on Above	**$ 84,285**	**$ 84,285**
Avg. Cost per Intern FTE	**$ 5,943**	**$ 67,483**
Avg. Non-Personnel Costs per Intern FTE	**$ 18,660**	**$ 18,660**
Avg. Facility Costs per Intern FTE	**$ 8,209**	**$ 8,209**
Avg. Administrative Costs per Intern FTE	**$ 22,654**	**$ 22,654**
Total Cost per Intern FTE	**$ 139,751**	**$ 201,291**
Revenue per Intern FTE		
Avg. Services generated per Intern FTE	583.74	583.74
Avg. Reimbursement per Service	$ 55.70	$ 55.70
Less Avg. Revenue generated per Intern FTE	**$ 32,512**	**$ 32,512**
Total Net Unreimbursed Cost per Intern FTE	**$ 107,239**	**$ 168,779**

Total Cost per Billable Hour	**$69.98 Per Hour**	**$110.13 Per Hour**
Total Cost per Service	**$183.71 Per Service**	**$289.13 Per Service**
Total Medicaid Cost per Month	**$8123.14 per Month**	**$12784.66 per Month**

Mercer Enhancement Add-on per Hourly Rate	**$14.65 to $25.75 per Hour**	
Mercer Estimated Cost Impact	**$9.2 to $16.7 million**	
New Estimated Cost Impact	**$11.4 to $16.4 million**	**$18.0 to $25.8 million**

Appendix C, Table 3 – Trainee A

TRAINEES		Trainee A
Avg. FTE per Trainee Type		26.43

Teaching Cost per Trainee FTE		Total
Avg. Staff Costs per Trainee FTE based on Above		$ 5,027
Avg. Cost per Trainee FTE		$ 97,856
Avg. Non-Personnel Costs per Trainee FTE	6%	$ 5,926
Avg. Facility Costs per Trainee FTE	4%	$ 4,365
Avg. Administrative Costs per Trainee FTE	2%	$ 2,782
Total Cost per Trainee FTE		$ 115,956

Revenue per Trainee FTE	Total
Avg. Services generated per Trainee FTE	763.99
Avg. Reimbursement per Service	$ 95.07
Less Avg. Revenue generated per Trainee FTE	$ 72,636

Total Net Unreimbursed Cost per Trainee FTE	$ 43,320

Total Cost per Billable Hour	$28.38 Per Hour
Total Cost per Service	$56.7 Per Service
Total Medicaid Cost per Month	$3171.62 per Month

Mercer Enhancement Add-on per Hourly Rate	$9.80 to $13.35 per Hour
Mercer Estimated Cost Impact	$28.4 to $41.4 million
New Estimated Cost Impact	$70.4 to $100.6 million

Appendix C, Table 4 – Trainee B

TRAINEES	Trainee B
Avg. FTE per Trainee Type	**4.27**

Teaching Cost per Trainee FTE		Total
Avg. Staff Costs per Trainee FTE based on Above		$ 14,260
Avg. Cost per Trainee FTE		$ 80,717
Avg. Non-Personnel Costs per Trainee FTE	5%	$ 4,280
Avg. Facility Costs per Trainee FTE	5%	$ 4,648
Avg. Administrative Costs per Trainee FTE	4%	$ 4,442
Total Cost per Trainee FTE		$ 108,347

Revenue per Trainee FTE	Total
Avg. Services generated per Trainee FTE	591.57
Avg. Reimbursement per Service	$ 85.16
Less Avg. Revenue generated per Trainee FTE	$ 50,376

Total Net Unreimbursed Cost per Trainee FTE	$ 57,972

Total Cost per Billable Hour	$37.41 Per Hour
Total Cost per Service	$98 Per Service
Total Medicaid Cost per Month	$3359.92 per Month

Mercer Enhancement Add-on per Hourly Rate	N/A
Mercer Estimated Cost Impact	N/A
New Estimated Cost Impact	$12.0 to $17.1 million

Appendix C, Table 5 – Trainee C

TRAINEES	**Trainee C**
Avg. FTE per Trainee Type	**43.01**

Teaching Cost per Trainee FTE		**Total**
Avg. Staff Costs per Trainee FTE based on Above		**$ 15,934**
Avg. Cost per Trainee FTE		**$ 66,535**
Avg. Non-Personnel Costs per Trainee FTE	*6%*	**$ 5,255**
Avg. Facility Costs per Trainee FTE	*4%*	**$ 3,940**
Avg. Administrative Costs per Trainee FTE	*5%*	**$ 5,018**
Total Cost per Trainee FTE		**$ 96,682**

Revenue per Trainee FTE	**Total**
Avg. Services generated per Trainee FTE	806.73
Avg. Reimbursement per Service	$ 56.17
Less Avg. Revenue generated per Trainee FTE	**$ 45,316**

Total Net Unreimbursed Cost per Trainee FTE	**$ 51,366**

Total Cost per Billable Hour	**$33.63 Per Hour**
Total Cost per Service	**$63.67 Per Service**
Total Medicaid Cost per Month	**$3842.31 per Month**

Mercer Enhancement Add-on per Hourly Rate	**N/A**
Mercer Estimated Cost Impact	**N/A**
New Estimated Cost Impact	**$138.8 to $198.3 million**

Appendix D

Regions, Populations, and Service Provision of Participating Agencies

Catholic Community Services of Western Washington (CCS-WW)
Columbia River Mental Health Services (CRMHS)
Comprehensive Life Resources (CLR)
Frontier Behavioral Health (FBH)
Peninsula Behavioral Health (PHB)
Sunrise Services, Inc. (SSI)

	CCS-WW	CRMHS	CLR	FBH	PBH	SSI
Counties of Operation	King Pierce North Sound Thurston-Mason Southwest Washington	Southwest Washington	Pierce	Spokane	Salish	North Sound
Number of Clients Served per Month	1,300	2,644	1,400	6,500	1,100	1,300
Ages Served	0–21	All ages	All ages	All ages	All ages	Adults (18+)

	CCS-WW	CRMHS	CLR	FBH	PBH	SSI
Mental Health (MH) Inpatient/E&T				√		
MH Residential			√		√	
MH Outpatient	√	√	√	√	√	√
SUD Outpatient	√	√	√		√	√
Crisis Services	√	√		√	√	
WISe Services	√		√	√	√	
PACT Services		√	√	√		
New Journeys				√		
Supported Employment		√	√		√	
Supportive Housing	√	√	√	√	√	