Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Enhancement for community based behavioral health services

Engrossed Substitute House Bill 1109; Section 215(23); Chapter 415; Laws of 2019

December 1, 2020

Enhancement for community based behavioral health services

Washington State Health Care Authority

Division of Behavioral Health and Recovery
P.O. Box 42730; Olympia, WA 98504
Phone: (360) 725-2091
Fax: (360) 763-4702
www.hca.wa.gov

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Executive summary

This report provides the status of the Community Based Behavioral Health Enhancement funding, as required in Engrossed Substitute House Bill (ESHB) 1109 (2019), Section 215(23):

> *The authority must submit a report to the legislature by December 1, 2020, summarizing how this funding was used and provide information for future options of increasing behavioral health provider rates through directed payments. The report must identify different mechanisms for implementing directed payment for behavioral health providers including but not limited to minimum fee schedules, across the board percentage increases, and value-based payments. The report must provide a description of each of the mechanisms considered, the timeline that would be required for implementing the mechanism, and whether and how the mechanism is expected to have a differential impact on different providers. The report must also summarize the information provided by managed care organizations in implementing the funding provided under this section.*

The intent of the legislation is to ensure adequate staffing levels for local community-based behavioral health providers. This was one of the previous five goals funded under Engrossed Substitute Senate Bill (ESSB) 6032 (2018), Section 213(5)(pp), which appropriated just under $70 million for the enhancement of community behavioral health services. This funding was allocated to behavioral health organizations proportionate to their regional population and/or enrollment. .

The legislature passed proviso language in ESHB 1109 (2019), stating that the funding is intended to directly increase rates for behavioral health services provided by licensed and certified community behavioral health agencies. Twenty percent of the general fund — state appropriation amounts for each regional service area must be used to increase their non-Medicaid funding and the remainder must be used to increase Medicaid rates above Fiscal Year (FY) 2018 levels.

- **$23,090,000 of the general fund** — state appropriation for FY 2020
- **$23,090,000 of the general fund** — state appropriation for FY 2021
- **$92,444,000 of the general fund** — federal appropriation are provided solely to maintain the enhancement of community-based behavioral health services that was funded in FY 2019. Twenty percent of the general fund—state appropriation amounts for each regional service area must be used to increase their non-Medicaid funding and the remainder must be used to increase Medicaid rates above FY 2018 levels.

The Health Care Authority (HCA) required each Managed Care Organization (MCO) and Behavioral Health-Administrative Service Organization (BH-ASO) to submit a plan for the use of the funding, to be approved by the Community Behavioral Health Enhancement Funds Workgroup at HCA. Approval of the plans was documented. The MCOs and BH-ASOs were then required to submit templates to HCA detailing quarterly expenditures to each provider, to include detailed descriptions of the funding mechanisms used to deliver the funds. The data was reviewed by HCA and is summarized below in this report.

Key findings and data results

BH-ASOs reported $2,634,198 in expenditures over the period from January 2020 through June 2020 (Thurston Mason included August expenditures in its template). The largest share of the funding that was specifically categorized was expended through sub-capitated rates. The majority (52.07%) was reported as other expenditures for "the expansion of provider facilities and services."

The MCOs reported $27,510,442 in expenditures for January 2020 through June 2020. As with the BH-ASOs, the largest share that was specifically categorized was sub-capitated rates, at 21.32% of the funding. General expansion of provider services was reported at 25%.

Data analysis can be found below in the summary of reported data, and additional narrative describing the funding mechanisms is included in Appendix A.

Background

In response to the requirements of the Legislature, this report addresses the following:

- How funding was used,
- Future options of increasing behavioral health provider rates through direct payment,
- Different mechanisms for implementing directed payment for behavioral health providers including, but not limited to:
    - Minimum fee schedules,
    - Across the board percentage increase, and
    - Value-based payments
- A description of each of the mechanisms considered,
    - The timeline that would be required for implementing the mechanism, and
    - Whether and how the mechanism is expected to have differential impact on different providers.
- Information provided by managed care organizations in implementing the funding provided.

Enhanced funding background

Three different time periods created the following distinct funding methodologies:

1. ESSB 6032 (2018) funds FY 2019 (July 1, 2018 through June 2019). The budget proviso mandates funds to be used for five focus areas related to behavioral health services, in which the BHO or community established a plan of funding in most regions.

2. ESHB 1109 (2019) funds the first six months of FY 2020 (July 1, 2019 through December 2019). The budget proviso mandates that MCOs, remaining BHOs and BH-ASOs distribute funds the same as in FY 2019.

3. ESHB 1109 (2019) funds the second six months of FY 2020 through the end of FY 2021 (January 1, 2020 through June 2021). The budget proviso mandates that distribution must be part of the MCO rates (as opposed to the previous FY 2019 plan) and it includes funding for the BH-ASOs.

For the period starting January 2020 and beyond, the MCOs have reported using the funds to increase the provider rates. However the methodology to increase rates continues to be complex for the following reason: (i) Rates are set regionally and thus there is regional variation; and (ii) Payment arrangements between MCOs/BH-ASOs and providers vary significantly, to include fee for service, capitated, value based payment, etc.

Time period three is the focus of this report

Fully integrated Behavioral Health and Primary Care allows state providers to treat the whole person. Staffing challenges have continued to be an issue for community behavioral health providers. This legislation was intended to assist in the effort to attract and retain qualified behavioral health professionals.

With the multi-year effort of behavioral health integration now coming to fruition statewide, any change can be disruptive, even if it is ultimately positive, due to the fragility of our system. Although we have come a long way, we have a long way to go as our state improves our community behavioral health system. HCA will continue to work with the state's contracted MCOs, our BH-ASOs and our providers, to do all we can to help ensure a successful system.

In summary, the Enhancement Funding Workgroup will provide clear instructions that follows the intent of the legislation. The MCOs have made strong efforts to produce clear provider communication plans for the disbursements of the estimated amount of enhancement funds. There are issues to resolve, but gainsharing provisions ensure that MCO profits are limited regardless of the type of funding received and this helps to ensure that the funds are used for the intended purpose.

Funding

The 80% of the appropriation designated for the managed care rates was allocated to the managed care organizations proportionate to their Medicaid enrollees. An analysis by Milliman showed the difference in the rates given the Enhancement funding to be as follows:

Table 1: Impact on Rates from Behavioral Health Enhancement Funding, January 2020 Rates

BHO	Historic Contract Rates (Blended using CY2020 MM Projections)			January 1, 2020		Impact	
	July 1, 2018 (excl FC)	January 1, 2019	July 1, 2019	Scenario 1: No BH Enh	Scenario 2: w/ BH Enh*		***Percentage difference***
Great Rivers	$55.13	$59.13	$59.56	$59.39	$62.56	$3,371,704	5.33%
Greater Columbia	$32.38	$32.69	$32.76	$34.48	$37.55	$8,360,106	8.89%
King	$51.10	$50.74	$51.42	$54.94	$58.48	$16,409,875	6.43%
North Central	$29.48	$29.09	$29.26	$31.38	$32.99	$1,310,903	5.14%
North Sound	$44.93	$45.32	$45.56	$49.68	$53.32	$10,879,296	7.33%
Pierce	$44.69	$44.74	$45.77	$48.58	$53.01	$11,019,107	9.10%
Salish	$58.14	$58.24	$59.10	$61.44	$64.21	$2,532,409	4.52%
Southwest	$-	$-	$-	$-	$-	$-	N/A
Spokane	$52.80	$54.81	$55.21	$56.07	$61.94	$13,014,305	10.46%
Thurston Mason	$45.81	$46.48	$47.30	$51.50	$56.15	$4,517,777	9.02%
Total	$46.13	$46.64	$47.15	$49.81	$53.60	$71,415,483	

The 20% of the appropriation designated for the BH-ASOs was allocated based on regional population consistent with the allocations of the FY 2019 funding.

Directed payments

The report must identify different mechanisms for implementing directed payment for behavioral health providers including but not limited to; minimum fee schedules, across the board percentage increases, and value-based payments. The report must provide a description of each of the mechanisms considered, the timeline that would be required for implementing the mechanism, and whether and how the mechanism is expected to have a differential impact on different providers. The report must also summarize the information provided by managed care.

We consulted guidance from CMS regarding directed payments as follows:

> **Directed payments guidance** CMS provided guidance on permissible state directed payment arrangements as defined in 42 CFR §438.6(c) in its November 2017 Informational Bulletin
>
> CMS defined three types of arrangements through which states may direct managed care plans to:

1. Implement value-based purchasing (VBP) models: includes bundled payments, episode-based payments, accountable care organizations (ACOs), and other models that reward providers for delivering greater value and achieving better outcomes

2. Implement multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives: includes pay-for-performance arrangements, quality-based payments, and population-based payment models

3. Adopt specific types of parameters for provider payments: includes minimum fee schedules, uniform dollar or percentage increases, and maximum fee schedules

In addition, CMS provided the following comment:

> *Finally, we note the following situations would not constitute a payment arrangement requiring approval under §438.6(c):*
>
> > States contractually implementing a general requirement for managed care plans to increase provider reimbursement for services provided to Medicaid beneficiaries covered under the contract, as long as the state is not mandating a specific payment methodology or amounts and managed care plans retain the discretion for the amount, timing, and mechanism for making such provider payments.

Due to the nature of the guidance received and requirements that the MCOs retain discretion regarding timing, mechanism, and methodology of payment of enhancement funds, directed payment would not be appropriate.

Additional guidance on directed payments was provided by HCA's contracted actuary, Milliman. (1)

The reference to the White Paper provided by Milliman regarding directed payments can be found at the link below. (2)

A link to the CMS website for directed payments can be found below. (3)

References:

(1) https://us.milliman.com/-/media/Milliman/importedfiles/uploadedFiles/insight/2018/approved-medicaid-state-directed-payments-full.ashx (as provided in 2018 from Milliman actuaries there have likely been changes since that time, but newer information is not publicly available at this time.)

(2) https://www.milliman.com/-/media/Milliman/importedfiles/uploadedFiles/insight/2018/approved-medicaid-state-directed-payments-full.ashx

(3) https://www.medicaid.gov/sites/default/files/2020-02/438-preprint.pdf

Graphic 1: Preprint Form

Preprint Form

In its Informational Bulletin, CMS also released the **"Section 438.6(c) Preprint" form** for states to use when applying for approval of state directed payments

- The Preprint contains a series of standard questions, including questions related to CMS' approval criteria, required assurances, quality criteria and framework

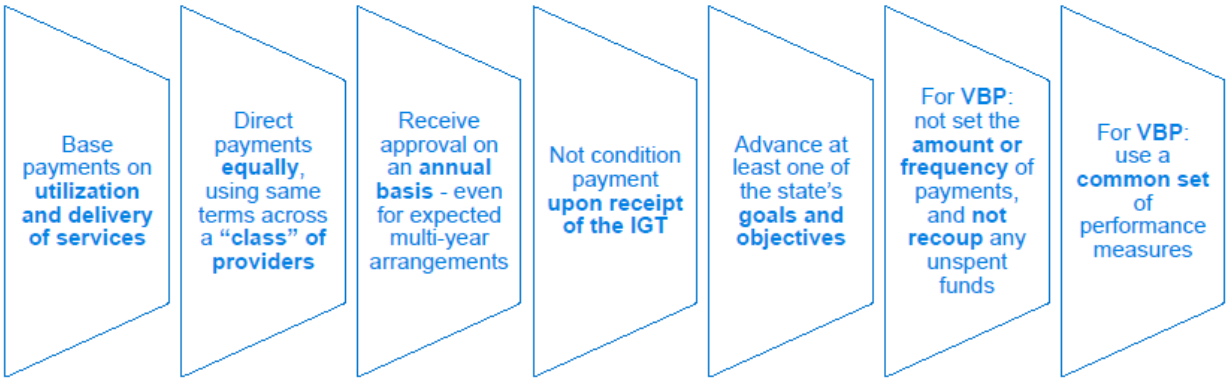
The Preprint groups each state directed payment arrangement into one of two primary categories:

State Directed Value-Based Purchasing	State Directed Fee Schedules
Includes: 1. VBP models 2. Multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives	Includes: 3. Parameters for provider payments

Graphic 2: Preprint Approval Criteria

Preprint Approval Criteria

CMS guidance regarding **Preprint form approval** requires that states must do the following in their proposed arrangements:



Graphic 3: Approved State Directed Fee Schedule Types

Approved State Directed Fee Schedule Types

Fee Schedule Type (Not Mutual Exclusive)	Examples	Total Preprints
Minimum Fee Schedule	*Directing managed care plans to pay no less than FFS rates*	25
Uniform Dollar or Percentage Increase	*Directing managed care plans to pay a per claim add-on or percentage increase above currently negotiated rates*	21
Maximum Fee Schedule	*Directing managed care plans to pay no more than the maximum FFS rate*	2
Total Unique Directed Fee Schedules		**47**

Graphic 4: State Directed Fee Schedule Common Arrangements

State Directed Fee Schedule Common Arrangements

The most common combinations of State Directed Fee Schedule type and provider type are:

1. *Mental health and HCBS providers with minimum fee schedules (**16 Preprints**)*: Many of these arrangements involve a minimum fee schedule based on FFS rates under the state plan

2. *Hospitals with a uniform dollar or percentage increase (**13 Preprints**)*: Many of these arrangements involve the distribution of a fixed payment pool or a prospective increase to claim payments based on recent (monthly or quarterly) utilization

3. *Professional service providers and minimum fee schedules (**8 Preprints**)*: Many of these arrangements involve a minimum fee schedule based on average commercial rates

Graphic 5: State Directed Fee Schedule Components

State Directed Fee Schedule Components

Payment Mechanisms

- Directed fee schedule increases can be made either **prospectively** (for each claim) or **retrospectively** (via lump sum payments based on prior period volume)
- Ultimately payments must be based on **utilization and delivery of services** in the contract period

Funding Sources

- **10 Preprints** funding the state share of payments through **IGTs**
- **10 Preprints** funding the state share of payments through **provider taxes**
- **Nine states** reported the use of **hospital taxes**, five of which replaced an existing supplemental payment program

Goals and Objectives

- The most frequently cited goal/objective was **maintaining access to care**
- States are not required to provide specific performance measures for State Directed Fee Schedules

Graphic 6: Approved State Directed VBP Arrangement Types

Approved State Directed VBP Arrangement Types

VBP Type (Not Mutual Exclusive)	Examples	Total Preprints
Medicaid-Specific Delivery System Reform	*Statewide Medicaid initiative, typically with another Alternative Payment Model (APM)-based VBP type*	11
Population-Based Payments / ACO (Category 4 APM)	*Population-based payments such as global budgets, and integrated payment and delivery systems such as ACOs*	7
Quality Payments / Pay for Performance (Category 2 APM)	*Incentive payment programs for development of infrastructure and operations, and improved quality and outcomes*	6
Performance Improvement Initiative	*Incentive programs to report and demonstrate improvements in access and quality, typically with another APM-based VBP type*	3
Multi-Payer Delivery System Reform	*Statewide all-payer initiatives, typically with another APM-based VBP type*	2
Bundled Payments / Episode-Based Payments (Category 3 APM)	*Shared savings arrangements, bundled payments, and episode-based payments*	1
Other Value-Based Purchasing Model	*Other initiatives such as a dental incentive program*	1
Total Unique Valued-Based Purchasing Arrangements		**18**

Graphic 7: State Directed VBP Arrangement Components

State Directed VBP Arrangement Components

Participating Providers

- Most VBP arrangements **involved professional service providers, hospitals, or clinics** as part of broader state delivery system reform initiatives
- Examples include **ACOs** or **pay-for-performance programs**

Funding Sources

- **4 Preprints** funding the state share of payments through **IGTs**
- **2 Preprints** funding the state share of payments through **provider taxes**

Goals and Objectives

- The most frequently cited goals/objectives were:
  - Improving **care quality and outcomes**
  - Reducing **delivery system fragmentation** and
  - Enhancing **care integration**

Graphic 8: State Directed Fee Schedules - Considerations

State Directed Fee Schedules - Considerations

While simplistic on the surface, the implementation of a State Directed Fee Schedule has the potential to introduce risk to the state and health plans

Considerations for states pursing directed fee schedules include:

	▪ Managed Care Plan Compliance
	▪ Fee Schedule Updates
	▪ Managed Care Plan Utilization Risk
	▪ Provider Utilization Risk
	▪ Revenue Source Risk

Summary of reported data

HCA created quarterly fiscal templates for entities to report on the implementation of the funding, including how much went to each provider and the financial mechanisms used to distribute the funding.

Quarterly reports were submitted by each of the five Managed Care Organizations (MCOs) as well as the Behavioral Health Administrative Service Organizations (BH-ASOs) in each region. In addition to showing which providers received funding, the templates divided out payments by the funding delivery mechanism used. A summary of payments by entity and by funding mechanism is shown below for the BH-ASOs and MCOs.

BH-ASO funds

BH-ASOs reported $2,634,198 in expenditures over the period from January 2020 through June 2020 (Thurston Mason included August expenditures in its template). The largest share of the funding that was specifically categorized was expended through sub-capitated rates. The majority (52.07%) was reported as other expenditures for "the expansion of provider facilities and services."

Table 2 - Amounts by identified funding delivery mechanism

	Adult Mobile Crisis	Commun. Support Teams - PACT	Fee Schedules	HCA Non-Medicaid	HCA-6032	Regional Jail Services	Sub-capitated Rates	TCAT	Lump Sum	Other	Grand Total
North Central						**$61,000**					**$61,000**
Jan-Mar 2020						$30,500					$30,500
Apr-Jun 2020						$30,500					$30,500
Pierce			**$237,000**					**$40,000**		**$1,686**	**$278,686**
Jan-Mar 2020			$237,000								$237,000
Apr-Jun 2020								$40,000		$1,686	$41,686
Southwest	**$206,425**	**$42,972**									**$249,397**
Jan-Mar 2020	$127,510	$12,112									$139,622
Apr-Jun 2020	$78,915	$30,860									$109,775
Greater Columbia							**$217,308**				**$217,308**
Jan-Jun 2020							$217,308				$217,308
King				**$808,817**	**$563,040**						**$1,371,857**
Jan-Mar 2020				$569,106	$271,400						$840,506
Apr-Jun 2020				$239,711	$291,640						$531,351
North Sound							**$142,439**				**$142,439**
Apr-Jun 2020							$142,439				$142,439
Salish									**$109,956**		**$109,956**
Jan-Mar 2020									$54,978		$54,978
Apr-Jun 2020									$54,978		$54,978
Spokane										**$130,555**	**$130,555**
Jan-Mar 2020										$98,687	$98,687
Apr-Jun 2020										$31,868	$31,868
Thurston Mason									**$73,000**		**$73,000**
Jan-Aug 2020									$73,000		$73,000
Grand Total	**$206,425**	**$42,972**	**$237,000**	**$808,817**	**$563,040**	**$61,000**	**$359,747**	**$40,000**	**$182,956**	**$132,241**	**$2,634,198**

** Note Gr**eat Rivers is not listed** as it reported no **expenditures** thus far due to the integrated managed care transition an**d adjusting to COVID-19 impacts. They indicated they will be disbursing the funds in the 3rd and 4th quarter of 2020.***

Table 3 - Percentages by identified funding delivery mechanism

	Adult Mobile Crisis	Commun. Support Teams - PACT	Fee Schedules	HCA Non-Medicaid	HCA-6032	Regional Jail Services	Sub-capitated Rates	TCAT	Lump Sum	Other	Grand Total
North Central	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	100.00%
Pierce	0.00%	0.00%	85.04%	0.00%	0.00%	0.00%	0.00%	14.35%	0.00%	0.60%	100.00%
Southwest	82.77%	17.23%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
Greater Columbia	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	100.00%
King	0.00%	0.00%	0.00%	58.96%	41.04%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
North Sound	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	100.00%
Salish	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	100.00%
Spokane	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%
Thurston Mason	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	100.00%
Grand Total	**7.84%**	**1.63%**	**9.00%**	**30.70%**	**21.37%**	**2.32%**	**13.66%**	**1.52%**	**6.95%**	**5.02%**	**100.00%**

MCO funds

The MCOs reported $27,510,442 in expenditures for January 2020 through June 2020. As with the BH-ASOs, the largest share that was specifically categorized was sub-capitated rates, at 21.32% of the funding. General expansion of provider services was reported at 25%.

Table 4 - Amounts by identified funding delivery mechanism

	Budget Payments	Contracted WISe Amt Over State Case Rate	Encounter Payment	Enhance-ment Funds	Expansion Funds	Fee Schedules	Lump Sum	Cost Reimburse-ment	Sub-capitated Rates	Grand Total
Amerigroup			**$3,199,195**						**$202,518**	**$3,401,713**
Jan-Mar 2020			$1,324,670							$1,324,670
Apr-Jun 2020			$1,874,525						$202,518	$2,077,043
CHPW	**$39,459**					**$1,643,028**	**$3,458,652**			**$5,141,140**
Jan-Mar 2020	$19,730					$821,514	$1,729,326			$2,570,570
Apr-Jun 2020	$19,730					$821,514	$1,729,326			$2,570,570
CCW		**$592,264**					**$1,325,254**		**$1,082,657**	**$3,000,175**
Jan-Mar 2020		$296,132					$662,627		$541,328	$1,500,088
Apr-Jun 2020		$296,132					$662,627		$541,328	$1,500,088
Molina				**$6,876,604**	**$1,781,556**	**$2,440,049**		**$289,320**	**$1,681,567**	**$13,069,096**
Jan-Mar 2020				$3,512,957	$1,047,085	$1,168,683		$148,112	$822,254	$6,699,091
Apr-Jun 2020				$3,363,647	$734,472	$1,271,366		$141,208	$859,313	$6,370,006
United									**$2,898,318**	**$2,898,318**
Jan-Jun 2020									$2,898,318	$2,898,318
Grand Total	**$39,459**	**$592,264**	**$3,199,195**	**$6,876,604**	**$1,781,556**	**$4,083,077**	**$4,783,906**	**$289,320**	**$5,865,060**	**$27,510,442**

Table 5 - Percentages by identified funding delivery mechanism

	Budget Payments	Contracted WISe Amt Over State Case Rate	Encounter Payment	Enhance-ment Funds	Expansion Funds	Fee Schedules	Lump Sum	Cost Reimburse-ment	Sub-capitated Rates	Grand Total
Amerigroup	0.00%	0.00%	94.05%	0.00%	0.00%	0.00%	0.00%	0.00%	5.95%	100.00%
CHPW	0.77%	0.00%	0.00%	0.00%	0.00%	31.96%	67.27%	0.00%	0.00%	100.00%
CCW	0.00%	19.74%	0.00%	0.00%	0.00%	0.00%	44.17%	0.00%	36.09%	100.00%
Molina	0.00%	0.00%	0.00%	52.62%	13.63%	18.67%	0.00%	2.21%	12.87%	100.00%
United	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	100.00%
Grand Total	**0.14%**	**2.15%**	**11.63%**	**25.00%**	**6.48%**	**14.84%**	**17.39%**	**1.05%**	**21.32%**	**100.00%**

Regional plans

In August of 2019, the Health Care Authority (HCA) requested that Behavioral Health - Administrative Service Organizations (BH-ASOs) and Managed Care Organizations (MCOs) develop plans to distribute ESHB 1109 (2019) Enhancement funding to providers beginning January 1, 2020. Entities are expected to distribute these funds in accordance with their plan.

In December 2019, all regions received reminder letters from HCA with 2020 action steps. Each region took the following actions steps:

Action Steps

ESHB 1109 (2019) Enhancement Plans – Beginning January 2020 and beyond

- Operationalize MCO/BH-ASO regional plan to deploy 2020 enhancement funds/First week of January 2020.
- MCOs/BHO-ASOs will develop a clear communication plan with providers/January 2020
- Notify your providers of their rate increases in your communication plan/No later than January 10.
- Conduct quarterly internal reviews to ensure that funds are being dispersed to providers as outlined in your communication plan/First review to be completed by January 31, 2020.
- Submit quarterly fiscal templates to HCA per contract schedule.

Contract language

Contract language was added to MCO and BH-ASO contracts requiring submission of fiscal expenditures per quarter.

January to March, 2020

April to June, 2020

July to September, 2020

October to November, 2020

Conclusion

This report provided a statewide summary of the Community Based Behavioral Health projects that utilized Enhancement funding, as outlined in the ESHB 1109 (2019), section 215(23):

- **$23,090,000 of the general fund** — state appropriation for FY 2020
- **$23,090,000 of the general fund** — state appropriation for FY 2021
- **$92,444,000 of the general fund** — federal appropriation are provided solely to maintain the enhancement of community-based behavioral health services that was funded in FY 2019. Twenty percent of the general fund — state appropriation amounts for each regional service area must be used to increase their non-Medicaid funding and the remainder must be used to increase Medicaid rates above FY 2018 levels.

After ESHB 1109 (2019) proviso language was authorized by the legislature for enhanced funding to start on January 1, 2020, regions began to identify critical regional needs for behavioral health services. As funds were distributed from the legislature, HCA provided the enhanced funding to the MCOs, BH-ASOs and BHOs, who in turn worked to contract with providers to deliver direct behavioral health services to clients.

A primary challenge in carrying out the legislature's intent with the Behavioral Health Enhancement funding was to achieve a common understanding among stakeholders about the amount of the available funding and how it was distributed. Complexities in the rate setting process raised challenges in identifying exactly how much the rates had increased.

BH-ASOs reported $2,634,198 in expenditures over the period from January 2020 through June 2020 (Thurston Mason included August expenditures in its template). The largest share of the funding that was specifically categorized was expended through sub-capitated rates. The majority (52.07%) was reported as other expenditures for "the expansion of provider facilities and services."

The MCOs reported $27,510,442 in expenditures for January 2020 through June 2020. As with the BH-ASOs, the largest share that was specifically categorized was sub-capitated rates, at 21.32% of the funding. General expansion of provider services was reported at 25%.

The authority developed metrics for tracking progress for local area projects and provided fiscal templates to all of the entities. The data provided by the entities outlined how they utilized the enhancement funding in specific areas of focus in the behavioral health continuum of care. .

The legislative intent was to assist behavioral health providers in maintaining local community-based behavioral health services.

Appendix A: Quarterly report data provided by BH-ASOs and MCOs

Payment mechanism detail (BH-ASOs)

North Central

Jan-March & April-May

		Adult mobile crisis	Community support teams - PACT	Regional jail services
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	We continued to expand the Adult Mobile Crisis service by adding in-house peers to provide onsite, face to face therapeutic response to individuals experiencing a behavioral health crisis.	We expanded the PACT team's capacity to assist individuals with a history of challenges in accessing traditional outpatient services and who may have a high risk of re-hospitalization or arrest.	We continued to fund the Regional Jail Services program which addresses service needs for individuals detained in preparation for discharge and to minimize likelihood for recidivism.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	SeaMar was awarded the Adult Mobile Crisis service through and RFP process in early 2018.	SeaMar is the PACT provider in Clark County in the SW region.	A centralized liaison function under one provider, Catholic Charities, allows for streamlined coordination efforts for individuals who have multiple incarcerations across the jails in the North Central region.
3	*When was this mechanism implemented?*	Adult Mobile Crisis was launched in July 2018 with the addition of CBEHF to expand in-house peer services in Jan 2020.	Expansion of PACT services was implemented in Jan 2020 using CBEHF.	Regional Jail Services program was launched Dec 2018 under previous ESSB 6032 funds and then maintained Jan 2020 under CBHEF.
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur?*	Provider was notified on January 10, 2020 via email.	Provider was notified on January 10, 2020 via email.	Provider was notified on January 10, 2020 via email.

	Please share any other pertinent details regarding your initial or ongoing communication plan.			
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	SeaMar receives these funds to implement the Adult Mobile Crisis services for Clark County.	SeaMar receives these funds to increase the capacity of the PACT team in Clark County.	Catholic Charities is the only provider in NC region to receive these funds to implement the regional jail services program in North Central region.
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	SeaMar is required to provide daily crisis logs and monthly summary of services.	SeaMar is required to provide monthly service summary and semi-annual report on PACT services.	Catholic Charities is required to report out monthly on jail transition services at the regional Crisis Collaborative meetings

Pierce

Jan-March & April-June

		New provider	**Service expansion**	**Mobile diversion**
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	Castelle and Associates was brought on as faith based organization to serve individuals with behavioral health needs in the African American community.	Consejo Counseling Services was brought in to serve a larger portion of the Hispanic community including youth in schools.	TCAT is a mobile diversion unit assisting individuals with resources and access to services prior to hospitalization or being sent to an E&T. They also assist with services after such a stay.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	New provider to address current needs.	Current provider serving Hispanic/Latino populations in Pierce.	Provider is serving all behavioral health clients that need support in Pierce County with diversion options.
3	*When was this mechanism implemented?*	1-Jul-19	Jan-20	15-Jul-19

4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	Providers were notified in July 2019 via email.	Providers were notified in August 2019 via email	Provider were notified in July via email as well as by TCAT via Telecare.
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	This organization received these funds in order to provide services in an underserved area of Pierce County.	Funds were provided to expand services to Hispanic/Latino mental health needs as well as serving youth in local school districts.	Funds were provided to assist the Pierce community with a mobile diversion unit.
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	This organization is required to submit monthly reports on the individuals served.	This organization submits monthly reports on number of individuals served.	This organization provides monthly reports on number of individuals served.

Southwest

Jan-March & April-June

		Adult Mobile Crisis	**Community Support Teams - PACT**	**Regional Jail Services**
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	We continued to expand the Adult Mobile Crisis service by adding in-house peers to provide onsite, face to face therapeutic response to individuals experiencing a	We expanded the PACT team's capacity to assist individuals with a history of challenges in accessing traditional outpatient services and who may have a high risk of re-hospitalization or arrest.	We continued to fund the Regional Jail Services program which addresses service needs for individuals detained in preparation for discharge and to minimize likelihood for recidivism.

		behavioral health crisis.		
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	SeaMar was awarded the Adult Mobile Crisis service through and RFP process in early 2018.	SeaMar is the PACT provider in Clark County in the SW region.	A centralized liaison function under one provider, Catholic Charities, allows for streamlined coordination efforts for individuals who have multiple incarcerations across the jails in the North Central region.
3	*When was this mechanism implemented?*	Adult Mobile Crisis was launched in July 2018 with the addition of CBEHF to expand in-house peer services in Jan 2020.	Expansion of PACT services was implemented in Jan 2020 using CBEHF.	Regional Jail Services program was launched Dec 2018 under previous ESSB 6032 funds and then maintained Jan 2020 under CBHEF.
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	Provider was notified on January 10, 2020 via email.	Provider was notified on January 10, 2020 via email.	Provider was notified on January 10, 2020 via email.
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	SeaMar receives these funds to implement the Adult Mobile Crisis services for Clark County.	SeaMar receives these funds to increase the capacity of the PACT team in Clark County.	Catholic Charities is the only provider in NC region to receive these funds to implement the regional jail services program in North Central region.
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of*	SeaMar is required to provide daily crisis logs and monthly summary of services.	SeaMar is required to provide monthly service summary and semi-annual report on PACT services.	Catholic Charities is required to report out monthly on jail transition services at the regional Crisis

	funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.			Collaborative meetings

Greater Columbia

Jan-March

		Sub-capitated rates
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	GCBH took the January - June 2020 allocated amount and sent a one-time payment out to its Contracted Providers using the funding allocation for Non-Medicaid Funding. The Funding formula is based on the total population of RSA and each county.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	It is the same funding formula used on those Contracted Network Providers that received this funding.
3	*When was this mechanism implemented?*	Jan-19
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	Contracted Network Providers were involved in the development of the 2020 Plan to utilize these funds as well as the process in which the funding would be dispersed, during our Fiscal July 2019 Meeting. During the February 2020 Fiscal Meeting discussion of the January - July 2020 Funding disbursement that occurred on January 27, 2020 was presented. As well as an email was sent to our Contracted Network Providers on February 5, 2020 with a copy of the Plan and other information in regards to this funding usage.
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	GCBH provided this additional funding out to our Contracted Crisis Providers to help retain and recruit Crisis Staff.
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	N/A

April-May

		Sub-capitated rates
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	GCBH took the January - June 2020 allocated amount and sent a one-time payment out to its Contracted Providers using the funding allocation for Non-Medicaid Funding. The Funding formula is based on the total population of RSA and each county.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	It is the same funding formula used on those Contracted Network Providers that received this funding.
3	*When was this mechanism implemented?*	Jan-19
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	Contracted Network Providers were involved in the development of the 2020 Plan to utilize these funds as well as the process in which the funding would be dispersed, during our Fiscal July 2019 Meeting. During the February 2020 Fiscal Meeting discussion of the January - July 2020 Funding disbursement that occurred on January 27, 2020 was presented. As well as an email was sent to our Contracted Network Providers on February 5, 2020 with a copy of the Plan and other information in regards to this funding usage.
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	GCBH provided this additional funding out to our Contracted Crisis Providers to help retain and recruit Crisis Staff.
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	N/A

Great Rivers

Jan-March & April-June

		Quarterly installment payments
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	We will setup a quarterly invoice for each crisis service provider and have them submit quantitative and qualitative information regarding the ESSB 6032 funds, such as expenditure type, staff turnover rates, barriers, and success

2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	No
3	*When was this mechanism implemented?*	Due to transition into IMC, adjusting operations due to COVID-19 , we plan to implement the mechanism by the end of September 2020
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	We plan to send an email by 8/13/20 to our service providers requesting updated ESSB 6032 plans to be submitted by 8/31/20. Once plan has been approved we will start issuing the outstanding quarterly installment payments.
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	Our Crisis Service Providers including our DCRs
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	Please see attached invoice and supporting documentation that we are asking our Service Providers to submit.

King

Jan-March & April-June

		HCA Non-Medicaid	**HCA-Secure Detox**	**HCA-6032**
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	This is the expansion of provider facilities and services.	This is the expansion of provider facilities and services.	This is the expansion of provider facilities and services.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*			
3	*When was this mechanism implemented?*			
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details*			

	regarding your initial or ongoing communication plan.			
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*			
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*			

North Sound

Jan-March

		Sub-capitated rates
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	We increased our two crisis provider budgets by 11% per provider with ESHB 1109 funds. This funding is for maintaining current capacity and recruiting additional staff, specifically DCR staff.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	No
3	*When was this mechanism implemented?*	Jan-19
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	A survey went out to our crisis providers asking for their intended use/need for the ESHB 1109 funds. The survey indicated funding as needed to maintain current DCR capacity, to be used for recruitment efforts, such as hiring bonuses, moving costs, etc.
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	Our two crisis outreach providers. Providing voluntary and involuntary crisis services.
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	The funds are cost reimbursement. The invoices are reviewed for appropriateness and whether the funding is being utilized. If they are not billing for

Salish

Jan-March & April-June

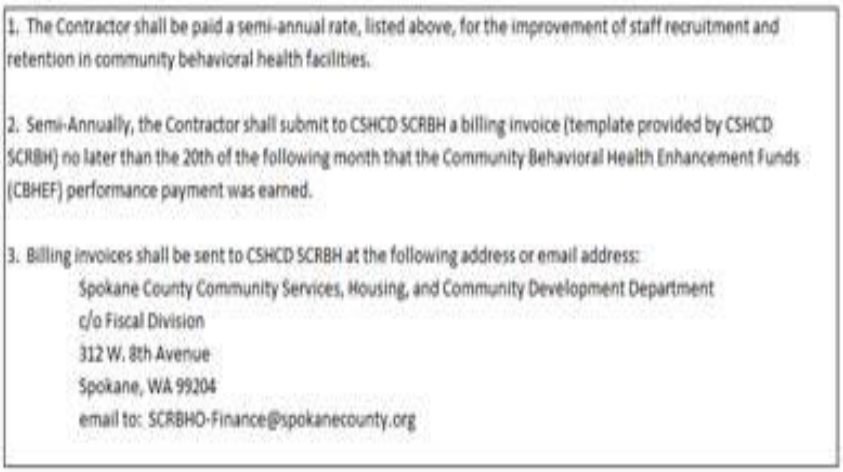
		Lump monthly sum
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers").*	We increased mental health providers' base monthly non-Medicaid compensation via a lump sum monthly payment.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	No, the mechanism does not vary by provider type of contracting arrangement.
3	*When was this mechanism implemented?*	The existing mechanism for non-Medicaid Enhancement Funds was previously established under the BHO structure in 2018. The mechanism was carried forward when the BH-ASO began operations on January 1, 2020.
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	Mental Health provider leadership was convened back in 2018 and they contributed to the development of the plan for expending Enhancement Funds. Mental Health Providers continue to report the existing plan meets their agency's needs for supporting staff recruitment and retention.
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	Only Mental Health Providers within the Salish Region have received Enhancement Funds.
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	Mental Health Providers must use the funds for improving staff recruitment and retention. Examples of expenses include: hiring bonuses, providing additional staff training, providing employees with supplies to enhance the work environment, etc. SBH-ASO conducts annual provider reviews which include a fiscal review. If a provider fails to provide sufficient documentation to substantiate the appropriate use of Enhancement funds, then the funds can be recovered, if necessary.

Spokane

Jan-March & April-June

		Lump monthly sum
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	Each contracted provider receives a portion of Non-Medicaid community behavioral health enhancement funds (CBHEF) funds from the SCRBH (ASO). The amounts were determined based on historical amounts under ESSB 6032 for three providers and the remainder equally distributed to the remainder of the contractors.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	Enhancement funds were disbursed during the first quarter of 2020 in a one-time payments for the first half of 2020 for all two providers which must submit a monthly invoice because they are funded via cost reimbursement model vs. fee for service model for behavioral health services.
3	*When was this mechanism implemented?*	Enhancement funds were included within the 2020 contracts with behavioral health providers, which will be disbursed in two one-time payments in the calendar year for most providers but two providers which submit monthly invoices because they are funded via cost reimbursement model vs. fee for service model for behavioral health services. Each contractor's funding exhibited, Exhibit F, in their contract clearly identified in the payment model and the SCRBH (ASO) provided an invoice for reimbursement.
4	*How providers were notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	During the first week of January 2020, enhancement funds were included within the 2020 contracts with behavioral health providers, which will be disbursed in two one-time payments, which are clearly identified in the providers' funding exhibits. Providers were notified when the contracts were delivered to each agency, and funds identified in their funding exhibit. The following language was included:
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	Contracted community behavioral health agencies, one of which is also a FQHC. One agency is a recovery oriented agency that trains Recovery Coaches, operates the recovery café, and the CCAP
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or*	Must be a contracted provider and use funds to support the recruitment and retention of the behavioral health workforce. Must submit an invoice to the BHASO. See attached example.

	documentation is required for the funding, please attach a copy of the report.	



1. The Contractor shall be paid a semi-annual rate, listed above, for the improvement of staff recruitment and retention in community behavioral health facilities.

2. Semi-Annually, the Contractor shall submit to CSHCD SCRBH a billing invoice (template provided by CSHCD SCRBH) no later than the 20th of the following month that the Community Behavioral Health Enhancement Funds (CBHEF) performance payment was earned.

3. Billing invoices shall be sent to CSHCD SCRBH at the following address or email address:
Spokane County Community Services, Housing, and Community Development Department
c/o Fiscal Division
312 W. 8th Avenue
Spokane, WA 99204
email to: SCRBHO-Finance@spokanecounty.org

Thurston Mason

Jan-August

		Lump Sum Payment upon approved Plan Submission
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	TM BHASO allocated funds to core contracted BH providers within our region. Allocations were based on a % of total funding available and the % of regular funding contracted. Providers were required to submit a plan for how the funds would be used to meet the requirements of the proviso. A lump sum amount equal to 1/2 of their allocation was paid upon submission and approval of their plan. A pool of funds were retained at the ASO level for region wide training and initiatives that have not yet been implemented due to COVID-19 restrictions.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	There is no variance. All providers were paid using the same mechanism.
3	*When was this mechanism implemented?*	July of 2020
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	Providers were notified by email in July of 2020 of their allocations and the regional plan for the proviso funding. Instructions and a plan template were provided for them to fill out and return to TM BHASO for approval and an invoice template was sent for their signature. Future communication will request a progress report using the plan template that will

		need to be submitted and approved prior to the second half of the provider allocation being paid.
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	Core Behavioral Health Providers contracted with the ASO in our region were eligible for the funds.
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	Provider were required to submit a plan for the use of the funds and provider some baseline information on workforce issues and employee retention. We did not include requirements to permit the recovery of funds and have encouraged providers to continue to use funding provided for the plan implementation even if not accomplished during this calendar year. Providers will be required to submit a progress report using the plan templates and their goals so we can determine what progress has been made. The report will include the agency's workforce retention measurement.

Payment Mechanism Detail (MCOs)

MCOs were asked to report in each region in which they operate as shown in the following graphic.

Amerigroup

Jan-March

		Encounter payment
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	AMG created an encounter based payment methodology for enhancement funds starting in January 2020. Using historical encounter data for 2019 regions and projected enhancement funding amounts per region, AMG calculated a MH and SUD encounter rate by region. The methodology is described below: • Encounters are tallied by a paid (accepted) claim in Q1 of 2020 with a date of services in 2020; Enhanced funding per this methodology is only for services in CY2020 • Only Medicaid IMC claims are tallied (excludes FCS/non-Medicaid) • If valid claims denied, they would be included in subsequent quarter payouts (when provider rebills or we reprocess) as we pull the data by paid claim date • MH and SUD Encounters are determined by DX code submitted with the procedure code Since funds are rooted in out premium, we wanted to ensure sustainability of funds by distributing to

		providers based on actual services rendered. For Q1, AMG did apply a percent adjustment to prospectively pay out funds for inappropriate claim denials due to global configuration issues internal to AMG provider data as well as to adjust for decrease in services due to COVID. Essentially, keeping providers "whole" for enhancement funding.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	No
3	*When was this mechanism implemented?*	1/1/2020
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	Providers were notified via our contracts team. Each provider received an MOU outlining the new methodology and encounter rate per region. Providers received MOU in Feb. 2020
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	Any AMG contracted BHA
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	Requirements are outlined in section 1. Recoupments could apply for any overpayments based on the prospective payments made due to COVID.

April-June

		Encounter Payment
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	AMG created an encounter based payment methodology for enhancement funds starting in January 2020. Using historical encounter data for 2019 regions and projected enhancement funding amounts per region, AMG calculated a MH and SUD encounter rate by region. The methodology is described below: • Encounters are tallied by a paid (accepted) claim in Q1 of 2020 with a date of services in 2020; Enhanced funding per this methodology is only for services in CY2020

		• Only Medicaid IMC claims are tallied (excludes FCS/non-Medicaid) • If valid claims denied, they would be included in subsequent quarter payouts (when provider rebills or we reprocess) as we pull the data by paid claim date • MH and SUD Encounters are determined by DX code submitted with the procedure code Since funds are rooted in out premium, we wanted to ensure sustainability of funds by distributing to providers based on actual services rendered. Similar to Q1, AMG applied a percent adjustment to prospectively pay out funds for inappropriate claim denials due to global configuration issues internal to AMG provider data as well as to adjust for decrease in services due to COVID. Essentially, keeping providers "whole" for enhancement funding.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	No
3	*When was this mechanism implemented?*	1/1/2020
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	Providers were notified via our contracts team. Each provider received an MOU outlining the new methodology and encounter rate per region. Providers received MOU in Feb. 2020 Three providers reverted back to their 2019 contract methodology as it was discovered that their contract superseded the 2020 MOU. Those providers are paid on a sub-capitated basis and this is reflected in the expenditures tab.
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	Any AMG contracted BHA
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	Requirements are outlined in section 1. Recoupments could apply for any overpayments based on the prospective payments made due to COVID.

CCW

Jan-June

		Sub-capitated rates	Lump sum payment	Contracted WISe Amt over state case rate
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	% of Premium	Funding from rates allocated to provider based on % of OP/Residential Spend in the associated region	Dollars used to fund providers who are receiving WISe amounts in excess of the case rate premium amount we are paid for the associated members
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	Just the few providers have % of premium contracts	Same methodology applied for every region, however certain providers are on % of BH premium contracts so they are getting their enhancement payment as part of their typical monthly payment	Solely based on the individual contracts that pay at the higher rates
3	*When was this mechanism implemented?*	1/1/2020	MOUs sent to providers in April 2020	1/1/2020
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	N/A	April 2020 / MOU Process	April 2020 / MOU Process

5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	Those with % premium arrangements (detail on Expenditures tab)	BH Agencies (those providers who were carved out prior to BH integration) - The accounting is on the Instructions tab	WISe Providers
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	No	No	No

CHPW

Jan-June

		Fee schedules	**Lump sum payments**	**Budget payments**
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	Certain provider agreements outlined payment as a percentage above 100% Fee For Service. KCICN increased reimbursement rates for their provider network.	The majority of payments were made as lump sum payments, based on each provider's historical share of enhancement funds.	Certain provider agreements outlined budget-based arrangements where the budgeted amount was inclusive of enhancement funds.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	Yes, the amount paid above 100% Fee For Service could vary by provider.	No, where this mechanism was used, it was used in the same manner across regions, provider types and arrangement.	No.
3	*When was this mechanism implemented?*	We implemented payment in January 2020 per the HCA schedule	We implemented payment in January 2020 per the HCA schedule	We implemented payment in January 2020 per the HCA schedule

4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	Providers were sent communications in the beginning of January 2020 which included details on: - Funds would not be decreasing - Reference to updated proviso language which directs funds for recruitment and retention - Notification of incoming agreement to be signed	Providers were sent communications in the beginning of January 2020 which included details on: - Funds would not be decreasing - Reference to updated proviso language which directs funds for recruitment and retention - Notification of incoming agreement to be signed	Providers were sent communications in the beginning of January 2020 which included details on: - Funds would not be decreasing - Reference to updated proviso language which directs funds for recruitment and retention - Notification of incoming agreement to be signed
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	CHPW continued to pay enhancement funds to the legacy providers that were paid by the BHOs through the Enhancement Plans developed by BHOs (or in SW by ASO and MCOs) in their respective regions. This included behavioral health agencies who provided both outpatient/Intensive outpatient, as well as more intensive inpatient and residential services. Since taking over the administration of enhancement funds for all our regions, CHPW has added a few providers who have requested these funds. For 2021 implementation of BH Enhancement funds, CHPW will assessment	CHPW continued to pay enhancement funds to the legacy providers that were paid by the BHOs in their respective regions. This included behavioral health agencies who provided both outpatient/Intensive outpatient, as well as more intensive inpatient and residential services. Since taking over the administration of enhancement funds for all our regions, CHPW has added a few providers who have requested these funds. For 2021 implementation of BH Enhancement funds, CHPW will assessment the landscape of which BHAs are receiving these funds and determining whether to	CHPW continued to pay enhancement funds to the legacy providers that were paid by the BHOs through the Enhancement Plans developed by BHOs (or in SW by ASO and MCOs) in their respective regions. This included behavioral health agencies who provided both outpatient/Intensive outpatient, as well as more intensive inpatient and residential services. Since taking over the administration of enhancement funds for all our regions, CHPW has added a few providers who have requested these funds. For 2021 implementation of BH Enhancement funds, CHPW will assessment

		the landscape of which BHAs are receiving these funds and determining whether to increase or decrease the scope to ensure equity across our network	increase or decrease the scope to ensure equity across our network.	the landscape of which BHAs are receiving these funds and determining whether to increase or decrease the scope to ensure equity across our network.
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	In order to receive funds, CHPW asked providers to sign an agreement detailing the following: - The amount of monthly funds to be received - The need to submit data on spending of BH enhancement funds based on future reporting needs directed by HCA Changes in the estimations and assumptions used to develop Provider's Enhancement Fund payments may trigger payment adjustments, including retroactive adjustments. In the event of a retroactive payment adjustment, CHPW will provide written notice to Provider describing the nature of the retroactive payment adjustment	In order to receive funds, CHPW asked providers to sign an agreement detailing the following: - The amount of monthly funds to be received - The need to submit data on spending of BH enhancement funds based on future reporting needs directed by HCA Changes in the estimations and assumptions used to develop Provider's Enhancement Fund payments may trigger payment adjustments, including retroactive adjustments. In the event of a retroactive payment adjustment, CHPW will provide written notice to Provider describing the nature of the retroactive payment adjustment	In order to receive funds, CHPW asked providers to sign an agreement detailing the following: - The amount of monthly funds to be received - The need to submit data on spending of BH enhancement funds based on future reporting needs directed by HCA Changes in the estimations and assumptions used to develop Provider's Enhancement Fund payments may trigger payment adjustments, including retroactive adjustments. In the event of a retroactive payment adjustment, CHPW will provide written notice to Provider describing the nature of the retroactive payment adjustment

Molina
Jan-June

		Fee Schedules	Sub-capitated Rates	Value-based Purchasing	Enhancement Funds	Expansion Funds	Paid via Cost Reimbursement
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	1. Molina is continuing to honor the 10% rate increase put in place by the Optum BHO in Pierce region and the 5% rate increase given to some providers in Thurston Mason region. 2. Molina had previously disbursed enhancement funds via lump sums in Southwest region. Molina moved to passing through enhancement via a fee schedule in 05/01/2020 retroactive to 1/1/2020	1. In Greater Columbia, North Central and Salish regions Molina disburses enhancements through capitated arrangements. 2. In King County Molina passes through all enhancements to King County via a capitated arrangements so King County can honor all enhancement funding put in place in July 2018.	Molina is in process of implementing 2 VBC arrangements with Family Solutions and Lifeline in the SW region starting 2020.	1. King County increased rates by 6% to all Behavioral Health Providers in July 2018. 2. In Spokane and Thurston Mason BHOs increased provider budgets and Molina is continued to honor the increased budgets. 3. In Great Rivers and North Sound regions Molina disburses enhancements in Lump sums at present and hope to move to rate increases as our experience develops.	1. King County - These funds represent the expansion of programs (adding beds) and new facilities. 2. In the North Sound region the BHO doubled the size of the Skagit PACT team and the Geriatric program operated by Sunrise. Further Molina is utilizing enhancement funds in this region to support a new WISe team. 3. Catholic Community Services in Southwest region will continue to receive enhancement funds via lump sums in Southwest region	In Southwest region Molina will be disbursing some enhancements to providers on cost reimbursement agreements.

2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	Molina replicated BHO terms and hence enhancement funds are disbursement methods vary by region.	Molina replicated BHO terms and hence enhancement funds are disbursement methods vary by region.		Molina replicated BHO terms and hence enhancement funds are disbursement methods vary by region.		
3	*When was this mechanism implemented?*	Most mechanism we implemented in 2018 by BHO. Molina has been passing enhancement funds in lump sums in Southwest but moved to a Fee Schedule on 05/01/2020		Implemented in 2020.			Implemented in 2020.
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	Providers in Southwest region received information regarding the fee schedule change in late 2019 and contracts revised in early 2020. Pierce providers were notified of their enhancements in the 2nd quarter of 2020.		Providers in Southwest region received information regarding the fee schedule change in late 2019 and contracts revised in early 2020.	Spokane and Thurston Mason providers had enhancement funding built into budgets by the BHO before integration.		Providers in Southwest region received information regarding the fee schedule change in late 2019 and contracts revised in early 2020.

5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	In Pierce and Southwest regions, all providers contracted previously with the BHOs received the increase.	All providers who had capitated arrangements with the BHO in Greater Columbia, North Central and Salish regions received enhancement funds	All providers contracted with BHOs previously received the rate increase.	King County - All Behavioral Health Providers.	King County - Telecare (E&T), Valley Cities (E&T, Detox, Secure Detox, SUD Residential), SeaMar (SUD Residential, Youth Psychiatric, Geriatric Facility).	
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	Providers need to submit clean claims on a timely basis.	Providers need to submit clean encounters on a timely basis	Providers will need to meet quality measure to receive VBC payouts.	Providers need to submit clean invoices on a timely basis.	Providers need to submit clean invoices on a timely basis.	Providers need to submit clean invoices on a timely basis.

United

Jan-June

		Sub-capitated Rates
1	*Basic description of mechanism for increased provider payments (for example "We increased fee schedules by 10% for all behavioral health providers.")*	Enhancement funds were distributed to behavioral health providers based on their proportion of paid claims.
2	*Does the mechanism vary by region, provider type, or contracting arrangement? Please explain.*	No

3	*When was this mechanism implemented?*	April , 2020
4	*How were providers notified that this change of funding was directly related to state proviso requirements? Approximately what month did this communication occur? Please share any other pertinent details regarding your initial or ongoing communication plan.*	E-mail notifications went out the same day of payment processing. Letter notification followed a day later.
5	*What specific types of providers, or what groups of providers received this increase? Please explain.*	We limited the distribution of funds to providers in our BH network and those historically contracted with the BHO, excluding medical providers.
6	*Are there particular requirements that must be met by providers to receive the new funds? Do any of these requirements permit the recovery of funds? If additional reporting or documentation is required for the funding, please attach a copy of the report.*	The requirements were in line with the HCA and State Legislature guidelines. The provider notification letters provided an "opt-out" clause to be submitted in writing, with the acceptance of funds indicating an agreement to the reporting requirements, outlined under separate cover. No report is attached. In keeping with prior practices of not wanting to burden providers with administrative requirements we will join with other MCOs to create a reporting document that gather information on how they used the Enhancement dollars to strengthen their workforce.

Graphic 9: Integrated Managed Care Transition Chart