Washington State Health Care Authority

Report to the Legislature

Targeted behavioral health provider rate increases

Engrossed House Bill 2584; Section 1(4); Chapter 285; Laws of 2020

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Executive summary

As directed in House Bill (HB) 2584, this report contains the results of the Health Care Authority's (HCA) process for verifying that targeted behavioral health provider rate increases have been passed through to providers, and whether the changes in Chapter 285, Laws of 2020 were implemented. The statute reads:

> (4) By November 1st of each year, the authority shall report to the committees of the legislature with jurisdiction over behavioral health issues and fiscal matters regarding the established process for each appropriation for a targeted behavioral health provider rate increase, whether the funds were passed through in accordance with the appropriation language, and any information about increased access to behavioral health services associated with the appropriation. The reporting requirement for each appropriation for a targeted behavioral health provider rate increase shall continue for two years following the specific appropriation.

To confirm that the rates paid by the managed care organizations (MCO) to providers were increased appropriately, HCA directed the actuaries responsible for developing the Medicaid managed care rates for behavioral health services to evaluate the encounter data reported to ProviderOne and supplemental data provided by the contracted MCO.

HCA directs the actuaries to make adjustments to the Medicaid managed care rates whenever the Legislature directs a targeted rate increase. Following the inclusion of a targeted rate increase in Medicaid managed care rates, the actuaries analyze the encounter data for the periods that were subject to the increase. The actuaries compare the MCO paid amounts in the period following the rate increase with the period prior to the effective date of the rate increase. This is to confirm that each MCO has appropriately adjusted their provider reimbursement rates to include the increase directed by the Legislature.

This report focuses on the following rate increase that meets the definition of a "targeted behavioral health provider rate increase" for the calendar year 2022 reporting period:

- Community behavioral health rate increase of two percent effective April 1, 2021.

HCA previously reported on Secure Withdrawal Managemnet and Stabilization (SWMS) facilities program rate increase. However, this rate increase has been in place for more than two years and is no longer being included in the report.

To confirm that the rates paid by MCOs to providers were increased appropriately, HCA directed the actuaries responsible for developing the Medicaid managed care rates for behavioral health services to evaluate the encounter data reported to ProviderOne and supplemental data provided by the contracted MCO.

Report highlights

- Four out of five contracted MCOs distributed funding to behavioral health providers that meets the two percent rate increase requirement per the contract.
- No increase in access to behavioral health services could be directly linked to the rate increase.
  - A workforce shortage plays a likely role in the inability to increase access to behavioral health services.
  - Pandemic-related constraints on providers also must be considered when analyzing the periods under review.

Background

The process of tracking and reporting "targeted behavioral health provider rate increases" is required under section (3)(a) of HB 2584 which states, "The authority shall establish a process for verifying that funds appropriated in the omnibus operating appropriations act for targeted behavioral health provider rate increases, including rate increases provided through managed care organizations, are used for the objectives stated in the appropriation." This analysis also confirms MCO compliance with the requirements in the managed care contracts.

Evaluation is also required by the Centers for Medicare & Medicaid Services (CMS) in 42 CFR 438.6 Special contract provisions related to payment. The State Directed Payment (SDP) rule 42 CFR 438.6(c)(2)(ii)(D) requires the state to demonstrate, in writing, that the arrangement "has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy in § 438.340." While CMS rules no longer require advance written approval of SDPs that direct MCOs to pay no less than the published state plan approved fee-for-service rates, the state must still have an evaluation plan for all SDPs.

Scope of analysis

The report provides information regarding the two percent rate increase for behavioral services contracted through MCOs, as required by proviso 56 in the 2021-2023 operating budget (ESSB 5092):

> (56) $8,197,000 of the general fund—state appropriation for fiscal year 2022, $8,819,000 of the general fund—state appropriation for fiscal year 2023, and $38,025,000 of the general fund—federal appropriation are provided solely to continue in the 2021-2023 fiscal biennium the two percent increase to medicaid reimbursement for community behavioral health providers contracted through managed care organizations that was provided in April 2021. The authority must employ mechanisms such as directed payment or other options allowable under federal medicaid law to assure the funding is used by the managed care organizations for a two percent provider rate increase as intended and verify this pursuant to the process established in chapter 285, Laws of 2020 (EHB 2584). The rate increase shall be implemented to all behavioral health inpatient, residential, and outpatient providers receiving payment for services under this section contracted through the medicaid managed care organizations.

In calendar year 2023 during the CY 2024 managed care rate development process, Milliman, HCA's contracted actuaries, monitoried the CY2022 managed care encounter claims data and supplemental data received directly from MCOs. This was done to ensure that the rate increases were passed through by MCOs to providers. Below are the findings provided by Milliman.

Key findings

Two percent rate increase observations

The two percent community behavioral health rate increase under ARPA (American Rescue Plan Act) became effective April 1, 2021.

The ARPA rate increase was approved after its effective date, so MCOs had to retroactively distribute lump sum payments to providers. MCOs transitioned from these lump sum payments to fee schedule increases reported in ProviderOne over a period of several months, with plans and providers transitioning at

different times. It is challenging to verify the increase directly from the claims data due to a variety of factors, including lack of comprehensive MCO fee schedules, complexity of payment arrangements, and variation of payment rates for the same service code. This, combined with changes in service mix from month to month, made it difficult to detect related unit cost increases in ProviderOne paid encounters.

Therefore, the actuaries relied upon MCO-reported payments for non-claims arrangements when checking for compliance with this directed payment. These payments were reported in a supplemental data request module as part of the annual managed care rate setting process. MCOs were instructed to report on their non-claims payments generally as well as the specific amount attributable to the two percent ARPA directed payment.

Based on this information, the actuaries observed that four of the five MCOs reported ARPA payments totaling close to two percent of their other non-claims payments. This indicates that those four plans likley distributed the two percent rate increase funding to providers as required by the contract. One MCO reported ARPA payments that were materially less than two percent of their other non-claims payments. This does not necessarily mean that the MCO is out of compliance with the directed payment. However, further follow-up is needed to understand whether the MCO is in compliance but failed to deliniate their payments in the supplemental data reporting modules correctly or if they are out of compliance with the directed payment. HCA intends to follow up with this MCO to better understand how the state directed payment was operationalized.

The two percent behavioral health rate increase could not be directly linked to an increase in access to behavioral health services. As reported by many behavioral health providers in the recent years, one of the biggest obstacles to increasing access to care is the workforce shortage that remains high even though the demand for behavioral health services is increasing. It is possible that some of the workforce shortatge may be alliviated in the future with the additional Legislative investment through this and other rate increases. Provider resitrictions and client behavior during the pandemic have also had an impact on access to care as provides may have been limited in the number of clients they were able to see, and clients may have been more hesitant to seek care due to reluctance to expose themselves to illness.

Conclusion and next steps

HCA validated that this type of analysis is both useful and necessary based on the results of the two percent behavioral health rate increase evaluation.

In the report due to the Legislature November 1, 2024, HCA intends to continue to provide the results of the analysis of the two percent rate increase distributed to providers by MCOs during the CY 2023. In addition to the ARPA rate increase, HCA will report on two additional rate increase initiatives that were implemeneted in CY 2023: the seven percent behavioral health rate increase and the 32 percent rate increase for opioid treatment provider services.