FINAL BILL REPORT
EHB 2584

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Synopsis as Enacted

Brief Description: Establishing rates for behavioral health services.

Sponsors: Representatives Caldier, Frame, Leavitt and Davis.

House Committee on Appropriations
Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means

Background:

Medicaid is a federal-state partnership with programs established in the federal Social Security Act, and implemented at the state level with federal matching funds. Apple Health is Washington's Medicaid program serving qualifying low-income clients and administered by the Health Care Authority (HCA). Apple Health provides eligible adults, children, pregnant women, and certain blind or disabled individuals with a complete benefits package including medical and behavioral health (BH) services. Apple Health services are implemented primarily through contracts between the HCA and managed care organizations (MCOs) and in some cases through direct fee for service agreements between the HCA and medical and BH providers. Funding for some crisis services and other BH services to individuals who are not eligible for Medicaid is implemented through contracts with BH administrative services organizations (BHASOs).

Managed Care is a health care delivery system intended to manage cost, utilization, and quality of care. Medicaid managed care provides for the delivery of Medicaid physical and BH benefits including preventive, primary, specialty, and ancillary services through contracted arrangements between state Medicaid agencies and MCOs that accept a set per member per month (PMPM) capitation payment for these services. For some specialty services, the HCA pays MCOs a monthly case rate based on the number of people receiving the specialty service in addition to a PMPM capitation payment.

The MCOs are contractually responsible for provision of all medically necessary services to the populations covered under their contracts, and they do this through subcontracts with a network of medical and BH providers. There are five MCOs participating in Apple Health. In most cases, MCOs establish their own provider reimbursement methods and payment rates. The HCA establishes provider payment rates primarily in cases where the HCA is

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paying for services directly to providers rather than through MCO contracts. The ability of the HCA to direct how much MCOs pay providers for a service is limited under federal Medicaid managed care regulations.

Wraparound with Intensive Services (WISe) is a program model designed to provide intensive mental health services to assist youth and families. The HCA pays MCOs for WISe services through a case rate which MCOs receive in addition to their monthly PMPM capitation payments.

Summary:

The HCA must work with actuaries and MCOs in implementing funded BH rate increases to assure appropriate adjustments are made to the WISe case rate, as well as any other BH services in which a case rate is used. The HCA must establish a process for verifying that funding appropriated for targeted BH provider rate increases, including rate increases provided through MCOs, is used for the objectives stated in the appropriation. The process must:

- establish which BH provider types the funds are intended for;
- include transparency and accountability mechanisms to demonstrate that appropriated funds for targeted BH provider rate increases are passed through to BH providers in the manner intended;
- include actuarial information provided to MCOs to ensure the funds directed to BH providers have been appropriately allocated and accounted for;
- include the participation of representatives from the MCOs, BHASOs, providers, and provider networks that are the subject of the targeted BH provider rate increases; and
- include a quantitative or other method for determining if the funds have increased access to the BH services offered by the providers who are the subject of the targeted provider rate increases.

The process may:

- ensure the viability of pass-through payments in a capitated rate methodology; and
- ensure that Medicaid rate increases account for the impact of value-based contracting on provider reimbursements and implementations of pass-through payments.

By November 1 of each year, the HCA must report to the Legislature regarding the established process for each appropriation for a targeted BH provider rate increase. The report must identify whether the funds were passed through in accordance with the appropriation language and provide information about increased access to BH services associated with the appropriation. The reporting requirement for each appropriation for a targeted BH provider rate increase must continue for two years following the specific appropriation.

Votes on Final Passage:

House	98	0	
Senate	48	0	(Senate amended)
House	96	0	(House concurred)

Effective: June 11, 2020