Washington State Health Care Authority

Report to the Legislature

Targeted behavioral health provider rate increase

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:

> 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 managed care organizations (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 (P1) 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 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 increases that meet the definition of a "targeted behavioral health provider rate increase" for the calendar year (CY) 2023 reporting period:

- Community behavioral health rate increase of 7% effective January 1, 2023.
- Opioid Treatment Program (OTP) rate increase of 32% effective January 1, 2023.

HCA directed the actuaries responsible for developing the Medicaid managed care rates for behavioral health services to evaluate CY 2023 encounter data reported to P1 and supplemental data provided by the contracted MCO, in order to confirm that the rates paid by the MCOs to providers were increased appropriately.

Report highlights

- All five contracted MCOs distributed funding to behavioral health providers that met the 7% rate increase requirement per the contract for CY 2023.
- All contracted MCOs failed to increase their OTP unit costs by the expected 32% between 2022 and 2023.

Background

The process of tracking and reporting "targeted behavioral health provider rate increases" is required in HB 2584 (2020); Section 3(a):

> 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

This report provides information regarding the 7% rate increase for behavioral services contracted through MCOs, as required by proviso 58 in the 2021-2023 supplemental operating budget (ESSB 5693):

> $17,128,000 of the general fund—state appropriation for fiscal year 2023 and $32,861,000 of the general fund—federal appropriation are provided solely to implement a 7% increase to medicaid reimbursement for community behavioral health providers contracted through managed care organizations to be effective January 1, 2023. 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 7% 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 contracted through the medicaid managed care organizations. Providers receiving rate increases under other subsections of this section must be excluded from the rate increase directed in this subsection.

This report also provides information regarding the 32% rate increase for Opioid Treatment Program (OTP) services as required by Engrossed Substitute Senate Bill 5693, Section 215, Proviso 91, providing funding for a 32% rate increase for OTP services billed through OTP providers covered under the behavioral health package within the managed care contract, effective January 1, 2023. This rate increase does not apply to providers that are already paid an enhanced rate or providers/services that are eligible for supplemental payments such as tribal facilities. MCOs are required to pay at least 32% more than their rates as of December 31, 2022, for applicable services.

During the CY 2025 managed care rate development process, Milliman, HCA's contracted actuaries, monitored the CY 2023 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. The main method of assessment for the 32% OTP increase SDP was comparing the unit cost on OTP encounters that occurred in CY 2022 and CY 2023 (reported through September 30, 2024) at the provider and MCO level.

The following are the findings provided by Milliman.

Key findings

7% rate increase observations

The 7% community behavioral health rate increase became effective January 1, 2023.

It is challenging to verify the 7% rate increase directly from the claims data due to a variety of factors, including differences in MCO proprietary fee schedules, complexity of payment arrangements including non-claims 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 P1 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 atrributable to the 7% directed payment.

Based on this information, the actuaries observed that all five MCOs reported payments totaling close to 7% of their other non-claims payments. This indicates that all those plans likely distribubted close the 7% rate increase funding to providers as required by the contract.

Table 1: CY 2023 7% rate increase payment reporting

Plan	Pre-SDP Base	SDP Paid	SDP Paid as % of Base	SDP Paid as % of expected
WLP	$169.9 M	$13.1 M	7.7%	109.9%
CCW	$186.0 M	$14.0 M	7.5%	107.5%
CHPW	$162.8 M	$11.4 M	7.0%	100.0%
MHC	$550.7 M	$38.2 M	6.9%	99.0%
UHC	$166.8 M	$12.3 M	7.4%	105.7%
Total	**$1.2362 B**	**$89.0 M**	**7.2%**	**102.8%**

32% OTP increase observations

All MCOs reported paying increases consistent with the 32% OTP increase in 2023 in the supplemental data modules/data. However, Milliman assessed the changes in average unit cost between 2022 and 2023 (incurred dates) by MCO and provider for paid OTP services reported with Healthcare Common Procedure Coding System (HCPCS) code H0020 in P1. The results are summarized in the following table. Note that some OTP providers are paid through non-claims payment arrangements, which the table does not

include as Milliman is not able to assess unit costs for non-claims arrangements. Relying on paid claims through P1 only, all MCOs did not increase their OTP unit costs by the expected 32% between 2022 and 2023. One MCO increased their rates by less than half of the expected amount, while all other MCOs fell short of the expected increases by 10–15%.

Table 2: CY 2023 32% OTP increase payment reporting

Limited to P1 Paid Encounters

Plan	Pre-SDP Base	SDP Paid	SDP Paid as % of Base	SDP Paid as % of expected
WLP	$5.6 M	$1.5 M	26.7%	86.3%
CCW	$2.6 M	$0.3 M	12.8%	40.3%
CHPW	$3.6 M	$1.0 M	28.5%	90.2%
MHC	$18.4 M	$5.0 M	27.4%	86.6%
UHC	$4.1 M	$1.1 M	27.5%	87.6%
Total	**$34.4 M**	**$9.0 M**	**26.3%**	**83.6%**

Conclusion and next steps

HCA validated that this type of analysis is both useful and necessary based on the results of the 7% and the 32% OTP rate increase evaluation. Regarding discrepancy of the 32% OTP increase, HCA intends to follow up with the MCOs to ensure compliance of the increase.

The November 2025 report on rate increases in effect during CY 2024 will continue providing results of the analysis of the rate increases covered in this report, and will include analysis of the 15% rate increase distributed to providers by MCOs during CY 2024.