12. FINANCIAL MANAGEMENT

1.0 POLICY TITLE: Financial Management of the King County Behavioral Health Organization (KCBHO)

1.1 Officially Adopted: March 1, 2018

1.2 Effective Date: April 1, 2018

1.3 Signed: _____
Kelli Nomura, Behavioral Health Organization Administrator

2.0 PURPOSE: To describe the financial model for the fiscal management of the KCBHO and the policies governing provider billing and reimbursement.

3.0 POLICIES/PROCEDURES/RESPONSIBILITIES:

3.1 Case Rate Model

3.1.1 Financial management of the KCBHO outpatient system is based on a case rate model that specifies the case rate based on the case rate criteria (see Section 05: Outpatient Services, Attachment D).

A. There are different case rates for each of the two population groups to be served:

1. Children; and

2. Adults (including older adults).

B. The case rate payment is based on the individual's age at the beginning of the case rate authorization period.

C. If an 18- to 20-year-old is assessed as an adult, the adult case rate will be paid.

3.1.2 The hourly rate, which forms the basis of case rate payments, is established by the KCBHO.

3.1.3 The current case rates are included in this Section as Attachment A, Case Rates.

3.2 Benefit Package

3.2.1 An authorized benefit is an agreement between the provider and the KCBHO that, in return for a case rate payment, the provider shall assume the risk of providing all necessary outpatient treatment services for a client for the period of the benefit. The case rate the provider receives is based on case rate criteria.

3.2.2 An authorized benefit includes the following elements:

A. Case rate;

B. Duration; and

C. The range of available core services.

3.2.3 Any of the elements may change when a new benefit is authorized.

3.2.4 When changes are made to case rates, the authorized existing benefit shall continue and shall be paid under the new case rates.

3.3 Provider Case Rate Reimbursement

3.3.1 The approved case rate benefit shall start on the date of assessment except as follows:

A. For clients who need services to be continued beyond an existing benefit period a new authorized benefit begins no earlier than the day following the expiration of the previous authorized benefit; and

B. A non-Medicaid client's benefit begins on their date of assessment.

3.3.2 An approved case rate benefit ends 364 days after its start date for a benefit with a duration of 12 months, unless it is terminated at an earlier date.

3.3.3 Payments shall be made for the duration of an authorized benefit, except when a Medicaid client loses Medicaid.

A. No Medicaid payment shall be made on behalf of a Medicaid client beyond the month in which Medicaid coverage expired.

B. If the expiration date has changed and a Medicaid payment has been made, an adjustment shall occur.

3.4 Cultural Differential and Language Differential

3.4.1 Cultural Differential

A. A case rate that includes additional payment for a cultural differential shall be paid for the care of any individual who receives a mental health specialist evaluation or consultation and:

1. Identifies as a member of an ethnic minority;

2. Identifies as a member of a sexual minority;

3. Is a person who is homebound due to medical problems and not living in a facility; or

4. Is a person who is deaf or hard-of-hearing.

B. Payment occurs when all of the following are submitted to KCBHO:

1. For ethnic minorities, either codes:

a. 21 through 871 if ethnicity is non-Caucasian/white; or

b. 000 through 799 if Hispanic origin is identified; or

2. For sexual minority, sexual orientation code is 3 (Gay/Lesbian/Queer/Homosexual) or 4 (Bisexual) or gender code is 5 (Transgender); or

3. For non-facility-based medically compromised homebound:

In a qualifying residential arrangement code:

a. 01 “Permanent housing unassisted;”

b. 02 “Permanent housing assisted;”

c. 03 “Temporary housing unassisted;”

d. 04 “Temporary housing assisted;”

e. 05 “Temporary housing dependent;”

f. 06 “Transitional housing;”

g. 22 “Adult Family Home;”

h. 26 “Foster Care for children;” or

i. 82 “Homeless;” or

4. For deaf or hard-of-hearing persons, impairment kind is code:

a. 32 “deaf”; or

b. 33 “hard-of-hearing.”

3.4.2 Language Differential

A. The language differential is an additional payment for individuals whose services are delivered in a language other than English.

B. This differential case rate exists to fund the specialized care needed to provide adequate services to members of these populations.

3.4.3 The cultural differential is separate from the language differential, so an individual may qualify for the both the cultural differential and the language differential.

3.4.4 No differential shall be paid for clients identified as requiring a cultural differential or language differential but for whom the data requirements as described in Section 15: Information Management, are incomplete.

3.4.5 The Client Demographics transaction data must be processed successfully on or prior to the second month cutoff date in order to update the Case Rate Reason Code resulting in the Cultural Differential additional payment to apply.

3.5 Case Rate Incentives

3.5.1 The incentives will be provided primarily as an enhancement to outpatient cases rates.

3.5.2 The KCBHO may also, at its discretion, provide certain incentives on a fee-for-service basis.

3.6 Case Rate Changes

3.6.1 Case Rate changes are allowed as specified in Section 05: Outpatient Services.

3.6.2 For a case rate change that takes place within the initial time frames outlined in Section 15: Information Management, an adjustment to the payment is made, subsequent to the case rate change but retroactive to the assessment date, which shall take place in the next scheduled payment cycle.

3.6.3 If a payment made to a provider is found to be incorrect, an adjustment to the payment amount shall be made according to adjustment procedures noted in this Section.

3.6.4 For any approved change that is initiated by KCBHO as part of concurrent or retrospective review, a new payment amount based on the new benefit shall be calculated in the next scheduled payment cycle.

3.6.5 For approved changes due to catastrophic and permanent change as outlined in Section 05: Outpatient Services, a new full benefit shall be authorized on the date of the new assessment. The existing benefit shall expire one day prior to the new assessment date.

3.7 Provider Changes

3.7.1 Changes between providers for an authorized client during a benefit period shall start a new benefit period.

3.7.2 When a client changes providers mid-benefit, the existing benefit ends and a new authorized benefit is given. The receiving provider is required to submit a new authorization, flagged as a provider change as stated in Section 15: Information Management.

3.7.3 Payment to the new provider shall begin when all data required for a new benefit have been submitted as outlined in Section 15: Information Management. The first authorized benefit shall expire the day before the new date of assessment. Payments made to the first provider subsequent to the new assessment date shall be adjusted. Both fiscal actions shall occur in the next scheduled payment cycle.

3.8 Provider Reimbursement

3.8.1 Payments to providers for every authorized outpatient benefit or supportive housing benefit record in the system are based on case rate code, coverage, and the case rate table.

3.8.2 "Payment" is the monthly prospective and retrospective transfer of the case rate authorized to a provider according to their current case rate records.

A. Payment shall begin when an authorization has met the necessary data requirements as outlined in Section 15: Information Management.

B. Payment is prospective to the last day of the calendar month of payment or the expiration date of the benefit, whichever comes first.

C. Payment amount is based on the case rate code assigned to the authorization record at the time of the payment run, the client's coverage status in the payment month as known at the time of the payment run, and the dollar amount payable for that case rate code for the payment month described in the case rate table.

3.8.3 The payment process is set up on a monthly schedule based on the electronic information on record in the Behavioral Health and Recovery Division (BHRD) Information System (IS) at the time the benefit authorization.

A. The payment shall be calculated using the daily case rate on the first working day of the month prospectively for a calendar month.

B. The payment shall be remitted to providers no later than the end of each calendar month.

3.8.4 Payment is due to the provider for each day in the calendar month during the benefit period that the provider-of-record was responsible for the client.

3.8.5 The start and expiration dates are counted as days for purposes of payment.

3.8.6 The provider shall maintain acceptable levels of all insurance required by contractor. Coverage shall be in effect for all days of the month in order for a prospective benefit payment or non-case rate payment to be made for that month. Coverage information shall be received and approved by KCBHO before a payment shall be made.

3.8.7 If an authorization is not on record in the BHRD IS at the time that the prospective monthly payment is calculated, payment for that authorization shall begin as of the next payment cycle. A retroactive payment shall be made for benefit days provided prior to the calculation date.

A. Payment is retroactive where a payment was missed for an authorized benefit except for:

1. Any month where a suspended payment status is in effect for that month; and

2. Changes in coverage.

B. The time limit on retroactive payments is 18 months.

3.8.8 Payments for non-case rate residential services and all additional services are processed manually.

3.8.9 The payment audit process takes approximately 15 calendar days to complete. If KCBHO is not able to ensure payment to providers by the 15th of the month, providers shall be notified 10 days in advance of the 15th with a revised anticipated payment date.

3.8.10 The payment audit verification process is as follows:

A. A payment report for reimbursement is generated by the BHRD IS on the first working day of the month; and

B. KCBHO shall verify this report for compliance with policies.

3.8.11 KCBHO shall review and approve the total payment request.

3.8.12 Upon payment approval, KCBHO shall authorize providers to have online access to all payment information.

3.8.13 KCBHO payments and payment information shall be transferred to each provider. The fund transfer process between financial institutions shall occur within 48 hours.

3.9 Payment of Invoices

Providers shall submit invoices for additional services and residential services that are not paid through the case rate process.

3.9.1 Invoices shall be processed by KCBHO within 15 working days of receipt of invoice. If KCBHO is not able to process the invoice by the fifteenth working day, KCBHO shall notify providers no later than three days prior to the original deadline, with a revised anticipated approval date.

3.9.2 If the invoice requires communication with a provider to resolve discrepancies, KCBHO shall send a Provider Notice of Pended Invoice via email within three working days of the invoice being pended. KCBHO shall also initiate contact with the provider to begin resolution of the discrepancy.

3.9.3 KCBHO shall maintain a billing contact list for each provider that has at least two contacts identified for resolution of billing discrepancies.

3.10 Financial Adjustment

3.10.1 The KCBHO shall make adjustments to provider case rate payments when a case rate change is made in accordance with Section 05: Outpatient Services or when data submission requirements for authorizations are not met in accordance with Section 15: Information Management.

A. There is no limit on the number of adjustments a benefit may have.

B. An adjustment may be a positive or negative dollar amount.

1. The amount of the adjustment for an interim benefit change is the difference between payments made under the previous case rate and the new case rate.

2. The amount of the adjustment for a canceled benefit is for every payment made from the start date of the authorized benefit.

3. The amount of the adjustment for a terminated benefit is for all payments made for the period after the termination date.

3.10.2 Cancellation

A. If the required case rate validation data is not received by the KCBHO by the end of the first calendar month following the month of assessment, all payments made to date shall be adjusted and the authorization canceled.

B. If the provider continues to require an authorization for this client, a new request shall be submitted and all data timelines/requirements shall begin again.

3.10.3 Suspension

A. If the required complete outcome data set is not received by the KCBHO by the end of the second month following the month of assessment, payment shall stop and the authorization shall be suspended.

1. When the outstanding data elements are received by the KCBHO, payment shall begin to calculate on the next scheduled payment cycle.

2. Retrospective partial months shall not be paid.

B. When a Medicaid client loses their Medicaid coverage, payment is suspended upon loss of coverage.

3.10.4 Termination

A. Adjustments shall be made and payments terminated when the circumstances described below occur, or in accordance with the criteria outlined in Section 05: Outpatient Services; the benefit shall end as of the date of termination.

B. Payments made subsequent to the termination date shall be adjusted in the next scheduled payment cycle.

C. Death of Client

When a client dies during an authorized benefit period, the authorized benefit shall end on the date of death.

D. Long-Term Rehabilitative (LTR) Placement

When a client is authorized for LTR placement, payment for any open benefit shall cease on the day before LTR residency begins.

E. Client Moves Out of King County

The authorized benefit shall end on the date the client moves out of King County.

F. Client Gains Resources

When an authorized client gains enough resources during his or her benefit period to be treated as a private-pay client by the provider.

G. Co-Occurring Disorder (COD) Placement

1. When a client is authorized for COD/Integrated Dual Disorder Treatment (IDDT) placement, payment for any open benefit shall cease on the day before the COD benefit begins.

2. The provider initiating the COD benefit shall contact KCBHO Clinical Services to coordinate the termination of the previous benefit.

H. If a provider requests and is approved for an optional termination of an authorized benefit, the payment shall cease on the date of termination.

3.10.5 If the KCBHO determines that payments have been made for one client with two simultaneous Mental Health Outpatient authorizations or two simultaneous Substance Use Disorder (SUD) Outpatient authorizations, all providers involved shall be contacted. KCBHO shall review the circumstances of the simultaneous authorizations and the clinical appropriateness of the benefits. A financial adjustment shall occur so that only one mental health case rate and one SUD case rate at most is paid for a client.

3.10.6 A fiscal adjustment is made to a benefit payment when a change in the authorization results in the need to adjust the amount paid to the provider.

3.10.7 Providers shall receive an adjustment file each month listing all adjustments.

3.10.8 The adjustment verification process is as follows:

A. An adjustment report is generated by the BHRD IS on the first working day of the month;

B. KCBHO shall verify this report for compliance with policies;

C. KCBHO shall include the adjustment amount with the total KCBHO payment amount;

D. KCBHO shall coordinate adjustments to be deducted or added to payment amounts prior to funds being transferred; and

E. KCBHO shall send payment notification to each provider. This notification shall include amount of payment, amount of adjustment, and expected date of transfer.

3.11 Financial Exception to Policy

3.11.1 Providers may apply for an exception to policy for reimbursement. The KCBHO shall consider requests:

A. When events have occurred beyond the control of the KCBHO and its providers; or

B. Where KCBHO actions have prevented a provider from complying with standard policy and the provider has made efforts to mitigate the impact of the action where possible.

3.11.2 Prior to the review of any exceptions, providers must designate those employees who are authorized to request an exception to policy. Thereafter, exceptions shall only be considered when submitted by those identified staff. All other requests shall be returned without review.

3.11.3 All requests for an exception to policy must be submitted in writing to the KCBHO. The request shall include:

A. Name, title, and phone number of provider staff requesting the exception;

B. King County ID (as identified in the BHRD IS) and provider ID;

C. Authorization number of the benefit involved;

D. Name of KCBHO staff involved in authorization;

E. Date of requested exception to policy (e.g., assessment/transfer date);

F. Type of exception being requested in detail; and

G. The reason for the request, the actions taken by the provider to resolve the particular issue and a statement on measures the provider is taking to ensure the problem is addressed in the future.

3.11.4 KCBHO shall review all exception to policy requests. Various KCBHO staff may be asked to comment if the situation requires additional feedback.

A. A request for an exception does not guarantee that an exception shall be approved. Approval for an exception to policy is solely a KCBHO decision.

B. Providers shall be notified in writing by KCBHO of a denial to an exception request within 10 calendar days of receiving the complete request. Providers shall be notified of all approvals through existing standard error reports and authorization response tables.

C. KCBHO shall maintain a log of exception to policy requests.

D. Exception to policy requests received after the 25th day of any given month shall not be processed until the following month.

E. When an exception to policy is approved, any payment and/or adjustment needed shall take place in the next scheduled payment cycle.

F. Exception to policy payments and/or adjustments shall be identified as such in the BHRD IS.

3.12 Mental Health Non-Medicaid Resources

3.12.1 The amount of system-wide resources for non-Medicaid clients shall be determined on a periodic basis, based on the financial model forecast.

3.12.2 KCBHO shall determine the system-wide dollar amount that is available for non-Medicaid outpatient benefits in each calendar year.

3.12.3 KCBHO shall make an estimate of the amount of this resource that is encumbered by benefits authorized in the previous calendar year that shall continue to require reimbursement in the current calendar year.

3.12.4 Based on that estimate, KCBHO shall determine the dollar amount that is available for new non-Medicaid benefit authorizations each quarter.

3.12.5 The dollar amount shall be updated as non-Medicaid expenditures are authorized for regular benefits and benefits authorized through the exception policy (see Section 05: Outpatient Services).

3.12.6 KCBHO may change the amount of total dollars available for non-Medicaid benefits at any time during the calendar year.

3.12.7 Providers shall convert all non-Medicaid clients who are eligible for Medicaid before the beginning of the client's next benefit. Providers shall document activities undertaken to evaluate eligibility and efforts made to effect conversion.

3.12.8 In order to maximize the appropriate utilization of the limited non-Medicaid resource, providers shall update the client funding source upon change, as specified in Section 15: Information Management.

3.13 Coordination of Other Resources

3.13.1 Third-Party Benefits

A. Providers shall retain any third-party reimbursement (Medicare and private insurance) they collect on authorized clients. For that reason, the case rate includes a coordination of benefits discount.

B. Providers shall develop policies and procedures to aggressively pursue collection and documentation of all third-party benefits. Providers shall utilize separate coding in their accounting system to clearly segregate third-party payments from other payments.

3.13.2 First-Party (Private Pay) Payments by Non-Medicaid Clients

A. Providers shall implement a sliding fee scale according to Revised Code of Washington (RCW) 71.24.215.

B. Funds collected from a client without Medicaid must be refunded if the client subsequently receives retrospective Medicaid coverage.

C. Services funded by KCBHO may not be withheld by a provider due to the failure of a client without Medicaid to make a first party payment.

3.13.3 First-Party Payments by Medicaid Clients

A. Providers (and subcontractors) shall not collect first-party payments from Medicaid clients for any Medicaid covered services, even if KCBHO fails to provide payment. A Medicaid client cannot be held liable for any Medicaid-covered service in the event of:

1. The KCBHO's insolvency;

2. The State's failure to pay the KCBHO;

3. KCBHO's failure to pay a provider;

4. A provider's failure to pay a subcontractor;

5. The cost of a service provided on referral by KCBHO to an out-of-network provider exceeds what KCBHO would cover if provided within the KCBHO provider network; or

6. A community psychiatric hospital's insolvency.

B. Upon approval by KCBHO, providers may collect first-party payment from a Medicaid client:

1. For covered services if services are provided pending a client-initiated appeal of an adverse authorization decision and the client loses the appeal; and

2. For non-covered services if the requirements of Washington Administrative Code (WAC) 182-502-0160 or its successor are met and, prior to the provision of services, KCBHO has made a written determination that KCBHO does not cover these services. Inquiries should be directed to the KCBHO Fraud, Waste, and Abuse Compliance Officer.

C. Providers are required, per Medicaid rules, to refund to Medicaid-enrolled clients any first-party payments made by the client to the provider during any period the client had a KCBHO benefit.

D. Under no circumstances may a publicly funded client be billed for a failure to keep a scheduled appointment.

3.14 Spenddown

3.14.1 Spend down Definition

Spenddown refers to the amount of medical expense for which the client is responsible. Spend down occurs when the client's income and resources are above the limits set by the state for receiving Medicaid coverage.

3.14.2 Provider Responsibility regarding spend down and Medicaid Coverage

Providers are expected to actively work with clients on spend down so that the clients may regain their Medicaid coverage as soon as possible.

3.15 Client Participation Payments

3.15.1 Clients shall pay a portion of their costs for food, lodging, and care when they are authorized to KCBHO residential facilities.

3.15.2 The provider shall be responsible for ensuring an accurate calculation of client participation to ensure that clients contribute an appropriate amount towards the cost of residential care.

3.16 Extraordinary Treatment Plan Payments

3.16.1 Extraordinary Treatment Plan (ETP) requests shall be approved by KCBHO as outlined in Section 05: Outpatient Services.

3.16.2 Payments for actual costs as approved in the ETP request authorization notice shall be disbursed monthly upon receipt and approval of invoice for actual costs.

3.17 Homeless Outreach Stabilization and Treatment (HOST) Clients

Clients who are part of the HOST program shall not be authorized to an outpatient level of care and paid a case rate except as described in Section 07: Additional Outpatient and Support Services.

3.18 Medicaid Personal Care

3.18.1 Release of funds shall be made when actual expenditures have been incurred and invoiced to the KCBHO, and validated.

3.18.2 KCBHO will make payment to the state for these services.

3.19 Claims for Out-of-Area Emergency Services and Out-of-Network Services

3.19.1 Claims shall be submitted to KCBHO for payment consideration for:

A. Emergency services provided to KCBHO Medicaid clients when out of the KCBHO service area (see Chapter 388-865 WAC or its successor).

B. KCBHO pre-approved services provided outside the provider network when the network does not have capacity and/or specialty services available.

3.19.2 If deemed valid, the client shall be reimbursed on a fee-for-service basis as determined by the KCBHO on a case-by-case basis.

3.20 Audited Annual Financial Statements

Providers must send a copy of their audited annual financial statements to the County within a month of receiving them from their auditor or nine months after the end of their fiscal year, whichever is sooner.

3.21 Medicaid Fraud, Medicaid Waste, and Medicaid Abuse

The KCBHO, its providers, and their subcontractors:

3.21.1 Are required to guard against Medicaid fraud, Medicaid waste, and Medicaid abuse through prudent fiscal and record keeping policies, procedures, and/or practices;

3.21.2 Shall comply with all reporting and other anti-fraud, anti-waste, and anti-abuse requirements, including the KCBHO Fraud, Waste, and Abuse Plan (see Section 14 and related Attachments); and

3.21.3 Shall cooperate with the KCBHO and the Washington State Attorney General's Medicaid Fraud Control Unit relevant to any investigation of alleged fraud, waste, or abuse.

3.22 Administrative Services

The KCBHO and its providers shall ensure that the majority of its funds are used for direct services and related activities provided to or for clients' behavioral health needs.

3.23 KCBHO Reserve Accounts

3.23.1 The KCBHO shall maintain reserve accounts as required by both the State and the County that shall be spent as necessary on the following:

A. Close-out expenditures should the County terminate KCBHO operations; and

B. When system expenditures exceed the available revenue and undesignated fund balance and the imbalance of revenues and expenditures has not been reversed by the end of the calendar year.

3.23.2 The KCBHO shall maintain reserves as required by contract and per King County policy. If expenditures are made from the reserves during a calendar year and the KCBHO is not terminating operations in that calendar year, the reserve levels shall be built back to the required levels in the subsequent calendar year.

4.0 LIST OF ATTACHMENTS:

Attachment A: 2018 Case Rates

5.0 REFERENCES:

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- Chapters 388-865, WAC – Department of Social and Health Services (DSHS) – Mental Health – Community Mental Health and Involuntary Treatment Programs
- RCW 71.24.215 – Mental Illness – Community Mental Health Services Act – Clients to be Charged for Services

Other

- The DSHS BHO Behavioral Health State Contract (BHSC) and any subsequent amendments
- The DSHS BHO Prepaid Inpatient Health Plan (PIHP) Contract and any subsequent amendments