**National Council Public Policy Committee**

**How Are States Using COVID-Relief Funds?**

*October 18, 2021*

|  |  |
| --- | --- |
| **Alabama** | Stated they anticipate funding for retention payments and gave an overview of funding the state received from block grants and for CCBHCs |
| **Connecticut** | State agency paying hazard pay, retrofitting offices, 4% Medicaid rate increase in the works – not final yet. Not implementing CCBHCs – providers left to draw on SAMHSA money, grant cliffs coming up. Connecticut keeping as much as possible for rainy day. ($1.7 billion in pension obligations) HHS provider pot most significant because of loss of volume. Discouraged with slowness of distro – lack of shoring up the fundamentals. Had to stop hazard pay. |
| **Florida** | Noted that state decided to focus largely on system modernization. |
| **Maine** | [Overview of State Expenditures](https://www.dropbox.com/s/gla369hxt9qo76p/FY%2022%20Investment.%20BH%20Investments%20for%20AFA.pdf?dl=0)  No rate increases yet. $100 million retention and recruitment ($40 million of that toward behavioral health) in the works – not CMS finalized yet  Funding for peer navigators, EBP training for workforce, youth services, crisis services, infrastructure grants. Workforce is primary threat – programs closing, wait times, etc. |
| **Maryland** | Mandated 4% rate increase  State commitment for 75% of the enhanced FMAP will go to 1-time, temporary rate increase. Piecemeal projects enhanced thru more block grant funds; (4) governor has announced desire to put $ in rainy day fund and tax relief. |
| **Nebraska** | The state is currently discussing how they want to spend. The state divided the plans into five topics and the state association has made recommendations. They expect further action in January when the legislature meets and begins working on the budget. |
| **New Jersey** | Rate increases on the children's side, we also funding from DMHAS for limited funding for covid rated purchases PPE, IT, etc. |
| **New York** | Workforce – creating opportunities to supplemental compensation, student loans, tuition assistance, retention/recruitment bonuses, salary adjustments. People leaving for other health care jobs, COVID related reasons. Fiscal viability – shoring up programs experiencing loss of revenue/program volume. Prevention – protecting nation gains more permanent. NY capped bonuses - $ cap, not percentage, so larger employers were hurt as compared to smaller. |
| **Rhode Island** | Haven’t been spent, no money allocated.  Talk of training money, outreach to BIPOC – all has to go through the legislature.  CCBHC implementation – IT infrastructure.  Workforce – no hard plans but looking at salary bonuses. |
| **Texas** | Said they have benefitted from PRF, PPP and FMAP bumps. She also said that lots are benefitting from the local funds from ARPA. I think she said there was block grant funding for CCBHCs. |
| **Vermont** | 3% rate increase – money freed up because of ARPA. Keeping that over time  $4 million in on cost updates, $850,000 – outreach grants, $150,000 training and wellness activities  Volume still down – flexibility to receive same funding even though volume was down. PRF led to surpluses.  Workforce shortage horrendous. Frontline staff more than 50% vacant.  Vermont wants to do recruitment and retention bonuses – not long-term funding so we can’t raise salaries. |
| **Washington, D.C.** | For ARPA: direct care worker vaccination initiative, behavioral health / developmental disability co-occurring consultation and ABA Positive Behavior Supports training, a remote patient monitoring pilot, and a flex fund for model innovation to bring together medical, behavioral, and long-term care.  EHR incentive program that will include behavioral health providers and a T.A. program for adoption of Certified EHR technology.  Our SUD outpatient providers are still receiving a 20% rate bump during the federal PHE. The Medicaid authority is still seeking a path to a rate bump for SUD residential providers. We've been told that since mental health utilization is even or up from pre-covid, no enhanced rates are justified, even though more utilization at negative margins just means our members are doing more work that drives them into the red more quickly.  Our Medicaid authority is also saying they can't do anything to adjust rates that have an impact on front-line workers unless they make similar policy changes for all organizations / provider types who employ people who are equally well-qualified (especially for direct service providers / front-line paraprofessionals). The rationale is the Medicaid authority doesn't want to raise rates that cause people to quit working for one type of provider organization just to get a raise by working for a different type of provider organization. Of course, we all have different rate setting methodologies (or just go years between rate setting with no methodology), only partially tied to (direct service) pay, so the 'nothing for anyone until something for everyone' model could substantially delay making any meaningful changes to rates across the entire Medicaid provider network exactly when we're all competing with retail and food services. |
| **West Virginia** | First year only - 70% rate increase for behavioral health rehab services; 50% rate increases for IDD programs, 5% rate increase for both moving forward.  One time recruitment and retention bonuses. Sustaining that moving forward. Client facing staff in HCBS program. State Medicaid using $13 million toward CCBHC expansion. |