

BHT Partner Guidance: Managing CCH/HRSN & Medicaid / FCS Funding
How to avoid duplicative billing of the same
service to more than one Medicaid-funded source while supporting whole-person care

Background:

BHT's Community Care Hub is funded by the Medicaid 1115 Waiver, an agreement between Washington State Health Care Authority and the Center for Medicare and Medicaid Services. This also means partners through BHT's Community Care Hub are funded through this Waiver and cannot bill for Medicaid expenses to both their BHT contract and Medicaid independently.

Purpose of This Guidance:

This guidance aims to ensure that organizations ("partners") funded to provide care coordination under BHT's Community Care Hub maintain clear, consistent practices that prevent duplicative billing of the same service, delivered to the same client, billed to more than one Medicaid-funded source (referred to as "double billing" or "duplicative billing"). This guidance is intended to support partner compliance with Medicaid billing requirements and HCA awarding agency requirements while enabling flexible, whole-person care.

The following guidance is provided to organizations that do not currently have a procedure for managing one service across multiple-Medicaid funded sources. The guidance given is based on best practices from organizations within the Network that are braiding multiple Medicaid contracts to support whole person care.

If the provider's MCO Medicaid contract covers the same service as provided by the BHT funded CBW, only one contract is to be billed.

Please note: This is intended as general guidance only. Partners should consult with their own finance and legal teams on their internal processes and practices.

Communication from HCA on Feb 4, 2026:

"Future Billing Guide Update: The HCA will draft a memo to confirm a person can access and receive services with the CCHs and with FCS and/or AAA HRSNs, and it will not be duplicative. The memo will be shared with ACHs, FCS, and AAA. At the next billing guide update in June, HCA will update the billing guide to reflect this and post on their website."

Consequences of not following this guidance

If this guidance is not followed, and organizations duplicative billing of the same service, delivered to the same client, to more than one Medicaid-funded source, billing both their BHT contract and Medicaid for services rendered, the resulting action could be loss of contract for both the organization and the Community Care Hub overall, having a severe impact on our region and all 16 partners who rely on this funding. Please help us continue to support this region through due diligence in your billing practices.



If Medicaid fraud is determined to have occurred in an agency and tied to services they provided, the individual's DOH certification can be negatively impacted. In other words, it is not only the agency that is precluded from receiving further federal funding but at times the individual provider is precluded from working in any agency that receives federal funding.

In most cases corrective action, repayment, or technical assistance would typically precede contract loss unless there is intentional misconduct.

Required Reassurance

If you can answer **yes** to the following, you are in good shape:

- ✓ We understand what each of our contracts covers
- ✓ We do not bill the same service twice
- ✓ We have a documented approach for allocating staff effort/time
- ✓ We apply it consistently

Core Principles: What we need you to know

1. **Same client = OK**
Clients may receive services supported by multiple funding sources.
2. **Same staff = OK**
Staff (e.g., CHWs, CBCCs) may work across programs.
3. **Same service billed twice = NOT OK**
The same activity or service cannot be paid for by more than one Medicaid-funded source.
4. **Process matters more than precision**
Auditors look for a reasonable, consistent, documented process, not minute-by-minute tracking.

Core Principles: What we are NOT expecting you to do

What Partners Are *Not* Expected to Do

Partners are not expected to:

- Track staff time in 15-minute increments
- Separate clients into rigid funding “buckets”
- Create parallel documentation systems
- Achieve perfect precision

The expectation is good-faith compliance.

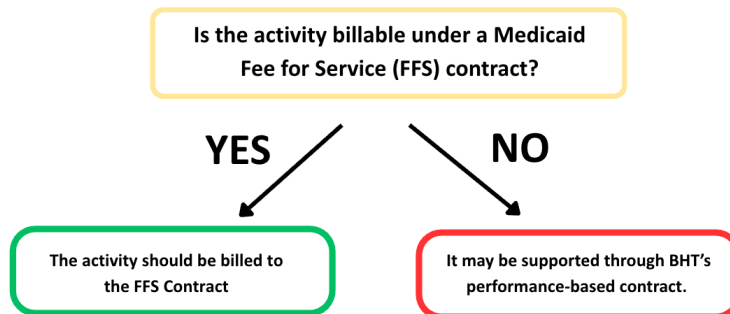
Understanding the Difference in Funding Types

Organizations currently funded to provide community-based care coordination are funded through federal and state Medicaid dollars. To support demonstrations of quality care coordination services, BHT is providing performance-based payments for services. Organizations providing care coordination services may also receive more traditional fee-for-service funding.

The following is a guide to help you manage similar services and funding sources:

Method 1: Start With the Service (Not the Person)

Ask:



Example:

- **Organization is contracted to provide FCS services.**
 - For employment and housing supports funded through FCS, these activities are billed to FCS
 - For all other, non-FCS covered activities (e.g. navigation to other resources, ongoing care coordination, etc.), these activities can be supported through BHT's performance-based contract

In this use case, one client continues to receive full care coordination services. Funding is allocated based on the activities covered within the contracted service.

Method 2: Managing Overlap When Staff Wear Multiple Hats

Recommended Approach: *Reasonable Allocation*

When staff work across multiple Medicaid contracts, organizations use a **reasonable allocation method** to divide staff time and funding responsibility. This is not minute-by-minute tracking. Instead, it is a structured estimate based on: by minute tracking. Instead, it is a structured estimate based on:

- Number of clients served under each contract
- Types of services provided
- Expected workload distribution
- Historical patterns
- Example: Estimate the percentage of effort attributed to each funding stream
 - Example: 35% FCS / 65% HRSN

Documentation Expectations (Simple & Sufficient)

Partners should maintain:

- A short written description of their allocation approach
- A record of how estimates are made (monthly or quarterly)
- Awareness of what each contract covers
- An attestation that services are not duplicative (billing of the same service to more than one Medicaid-funded source).

This documentation is for your protection and does not need to be submitted unless requested.

All documentation (i.e., timesheets, mileage expenses as per program billed) must be saved internally for fiscal audits.

Performance-Based Payments & Risk

2026-27 Community Care Hub performance-based contract payments:

- Are not tied to individual clients
- Are not fee-for-service
- Are designed to support flexibility and whole-person care

This reduces risk, especially when paired with:

- A clear internal process
- Peer-aligned practices
- Consistent application over time

Our Commitment

BHT is committed to supporting whole-person care and reducing the administrative burden on our partners wherever possible. If you are struggling to keep your processes aligned with billing, please reach out to our team and we will provide resources to support reasonable due diligence.

Peer Alignment & Shared Learning

The Hub will also support peer-to-peer learning so organizations can share practical approaches that work in real settings.

Partners are encouraged to:

- Learn from one another
- Adapt guidance to fit their organization
- Ask questions early

Final Reassurance

If you can answer **yes** to the following, you are in good shape:

- ✓ We understand what each of our contracts covers
- ✓ We do not bill the same service twice



- ✓ We have a documented approach for allocating staff effort
- ✓ We apply it consistently