



CalAIM Behavioral Health Payment Reform

CBHDA, CalMHSA, DHCS

May 26, 2023

Agenda



- Overview of Behavioral Health Payment Reform
 - Rate Methodology Review
 - Long-term Vision
 - FAQ/Questions
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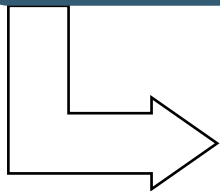
A person's hands are shown holding a pen over a document, with a blue overlay and a white text box. The text box contains the title "Overview of Behavioral Health Payment Reform".

Overview of Behavioral Health Payment Reform



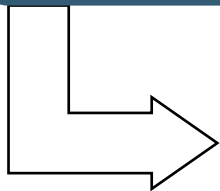
CMS

- Approves Rate methodology



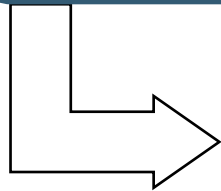
STATE/DHCS

- Develops Rate methodology and Plan level rates for counties



**COUNTY
MANAGED
CARE PLANS**

- Responsible for managing benefits to Medi-Cal population within the plan rate structure



**NETWORK OF
PROVIDERS**

- Consists of county staff and network of contracted providers that serve community

The Problem

- County behavioral health plans use Certified Public Expenditures (CPE) to pay for non-federal share of Medi-Cal
 - Existing reimbursement methodology requires:
 - Extensive documentation of allowable costs
 - Volume-based, FFS claiming by the minute or fifteen-minute increment
 - Complexity increases state and federal audit liability
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Outcomes of Current Method = Need for Reform

Counties at high risk for recoupment, creates risk for contract providers in turn

Public behavioral health system focused on documentation standards & audit risk, rather than client care

California leaving federal dollars on the table

Behavioral health plans out of sync with reimbursement, reporting, and documentation in other health systems

Driving workforce out of the system

Little opportunity for value-based payments or system reinvestment

Value Proposition

Administrative
Simplification

Steppingstone to capitation
and options for value-based
payments to BH plans and
providers

Payment Reform: The Basics

PRESENT: Cost-based reimbursement tied to CPE

- FFS claims for federal funds (FFP)
- FFP paid to BH plans at interim rates and settled to cost
- Use one minute or fifteen-minute increments or per diem
- Non-federal share = Certified Public Expenditure (CPE)
- Cost report, audit & settlement process

FUTURE: Fee-for-service tied to IGT

- FFS claims for federal funds (FFP)
- BH plans paid at fixed rate ***with no cost settlement***
- Units of service reimbursed consistent with HCPCS Level 1/CPT codes; retain some HCPCS Level 2 codes at current billing increments
- Non-federal share = Intergovernmental Transfer (IGT)
 - ***No change to dedicated BH funding sources (Realignment/MHSA) or allowable sources of non-federal share***
- New approach to reporting cost data
 - ***Plus new approach to audits/reviews***

Changing In July 2023

Coding

Implement CPT coding transition for applicable services/providers

- Guidance: <https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx>

Financing Mechanism

Change county mechanism for providing non-federal share: CPE to IGT

- IGT funded with local, non-federal funds
- Eliminate current requirements for county and provider cost reporting and settlement

BH Plan Rates

Adopt fee-for-service rates and reimbursement for county BH plans

NOT Changing in July 2023

Does not add new funds to public behavioral health system

- No change to available county sources of non-federal share

Fee-for-service rates established by DHCS are for BH plans

- Provider payments still negotiated with plans
- **BH Plan rates are primarily funded with federal funds and local funds (IGT)**

Behavioral Health Payment Reform Objectives

- Transition from HCPCS II coding to CPT coding where codes exist.
- Eliminate cost-based reimbursement for Behavioral Health (BH) Plans using CPEs by transitioning to a BH Plan fee schedule using Intergovernmental Transfers (IGTs).
- Go live with both coding and fee schedule July 1st, 2023.



DHCS
Rate Methodology

BH Plan Fee Schedule: Development Strategy

RATE SETTING SEPARATED INTO DISTINCT METHODOLOGIES:

- Utilization Review & Quality Assurance
- BHP Administration
- Inpatient services
- Narcotic Treatment Programs
- Outpatient services
- 24-hour services

- Day Services
- Partnership Regional Model (DMC-ODS)
- Therapeutic Foster Care
- Inpatient Withdrawal Management
- Mobile Crisis Intervention

BH Plan Fee Schedule Rates

- **Goal:** Appropriate reimbursement in aggregate that reflects current market conditions, and enables BH plans to sustain an adequate network of fairly compensated providers
- **Limitation:** County BH plans not considered full risk-bearing plans so not entitled to retain underwriting gains to help manage risk from year to year, despite holding significant risk due to global budget

BH Plan Fee Schedule: Development Strategy

- Rates are primarily based on costs associated with the specific activity.
 - Filed cost reports and service-specific cost surveys.
- DHCS along with counties have developed and deployed cost surveys for both county operated and contracted providers.
 - Not all activities required a cost survey such as NTPs and DMC-ODS regional model.
- DHCS aggregated this cost data and compared to other market factors and data sources to determine any additional factors to include in rate setting.
- DHCS will determine a rate adjustment process for routine increases where applicable.

BH Plan Fee Schedule: Key Points

- BH Plan outpatient rates developed using time spent providing direct patient care
 - Uses fully-loaded, total cost per FTE divided by direct patient care hours to compute rate
 - Time spent on travel and documentation is not a billable activity, but the costs associated with travel and documentation are included in the outpatient rates
- SUD residential treatment rates do not include the costs of care coordination, MAT or recovery services.
 - Care coordination, MAT, and recovery services should be claimed separately
- Encourage providers to work with counties as we work through payment reform changes
 - We all have much to learn in year 1 of payment reform!

Outpatient Rates: Data Inputs

- Bureau of Labor Statistics (BLS) mean wage data for California and by region.
 - Use of BLS data for consistency and applicability to the market overall.
- Cost survey developed by DHCS with input from counties.
 - Cost survey distributed to both county operated and contracted providers.
 - Cost survey used to establish statewide average direct patient care levels as well as county-specific support staff, operating and indirect cost percentages.
- Home Health Market Basket Index
- Elasticity of labor supply meta-analysis used to develop a rate adjustment for vacancies and labor shortages
 - Input attempts to improve vacancy rates for counties due to competing payer demand for the same labor force by increasing payments

Outpatient Base and Final Rate Equation

$$\text{Base Rate} = \frac{(\text{BLS mean wage}) \times (1.6225) \times (\text{county cost of labor index}) + (\% \text{ increase for support staff}) + (\% \text{ increase for indirect and operating costs})}{\text{Statewide standard \% time spent on direct patient care}}$$

$$\text{Final Rate} = ((\text{Base Rate}) \times (\text{Home Health Market Basket Index})) \times \text{Price Elasticity of Labor}$$

Outpatient Rate: Additional Qualifications

- Calculation of a Cost of Labor Index from BLS mean wage regional data
- Trending using the Home Health Market Basket Index using an average of four quarters from the base year
- Selecting the higher of two practitioner rates for SMHS and SUD delivery systems
- AOD Peers Support Specialists and Other Qualified Providers
- Percent of time spent on direct patient care data adjusted to remove outliers and weighted statewide
 - Mental health average direct patient care hours per FTE=**775** hours per year
 - Substance Use Disorder average direct patient care hours per FTE=**1,060** hours per year

CaIMHSA

FAQ: Why was the data used from a Covid year?

Our modeling showed use of this data was the most advantageous year to develop a rate. Every year had data issues, the state selected this year and added adjustments like a vacancy adjustment to account for the challenges associated with this year.

2021 data was trended forward based on home health market basket index data to account for increased costs.

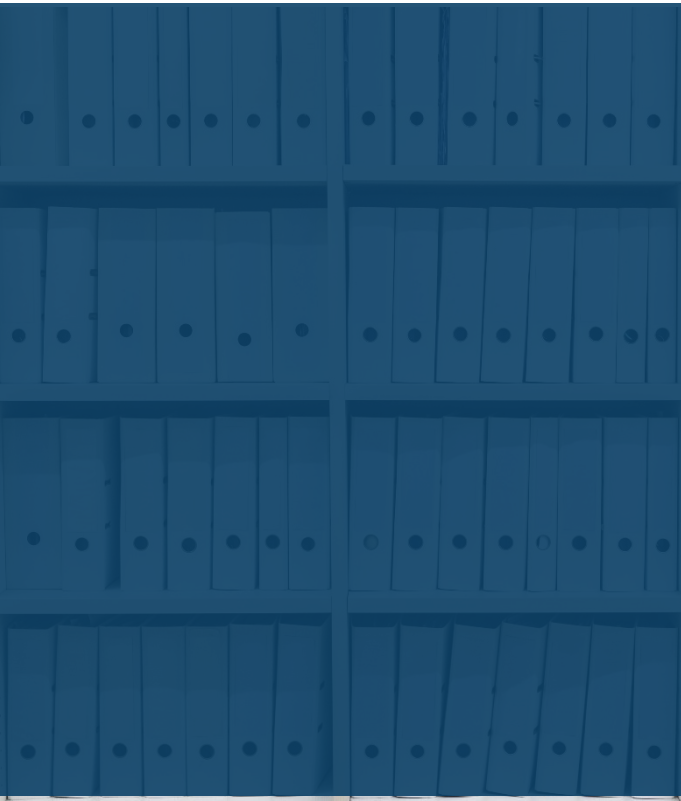
Rates will continue to change based on the home health market basket index which reflects inflation.

FAQ: The way travel time works, the state is trying to eliminate home-based services




The development of practitioner-based rates involves an analysis of average travel and documentation time that is included into a fully loaded rate per minute which is then translated into a CPT code.

FAQ: The current workforce challenges are not part of the rates



A 14% vacancy rate inflator was added into the rates to account for the current workforce challenges. This is an “elasticity of labor” calculation.

Suggested Business Practices



Make sure you capture travel and documentation time in your EHR, this data will be essential to measure adequacy of rates



**CalAIM Payment
Reform is a
Way Station on the
Road to Our Final
Destination ...**



Capitated payments to
BH plans to maximize
delivery system
flexibility



Explore options for
alternative
payment models
for BH providers



Expand value-based
payment
arrangements to
incentivize desired
outcomes



Increased services and
improved quality of
care

Long-Term Vision

**Additional Training
Opportunity Coming Soon**



Questions & Answers
