California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Payment Reform

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MEDI-CAL
BEHAVIORAL HEALTH PLAN RESPONSIBILITIES

DHCS

Medi-Cal Managed Care

- Mild-to-Moderate Mental Health
- Dyadic, ECM, Community Supports

County Specialty Mental Health

- 56 Specialty Mental Health Plans (MHPs)

County Substance Use Disorder Services

- 37 Drug Medi-Cal Organized Delivery System Plans
- 21 Drug Medi-Cal State Plan Counties

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MEDI-CAL
PLAN FINANCING BY DELIVERY SYSTEM

Medi-Cal Managed Care Plans

- ***State*** pays for non-federal share
- Guaranteed payment per member per month (capitated) and risk-based
- Rates must be actuarily sound (tied to analysis of services rendered)
- Plans may retain a profit increment
- Providers are contracted with plans and paid negotiated rates

County Behavioral Health Plans

- ***County*** pays for non-federal share
- Availability of funding is not tied to number of beneficiaries or need
- Rates based on and limited to cost
- Plans may retain no profit increment
- Providers are contracted with plans and paid negotiated rates

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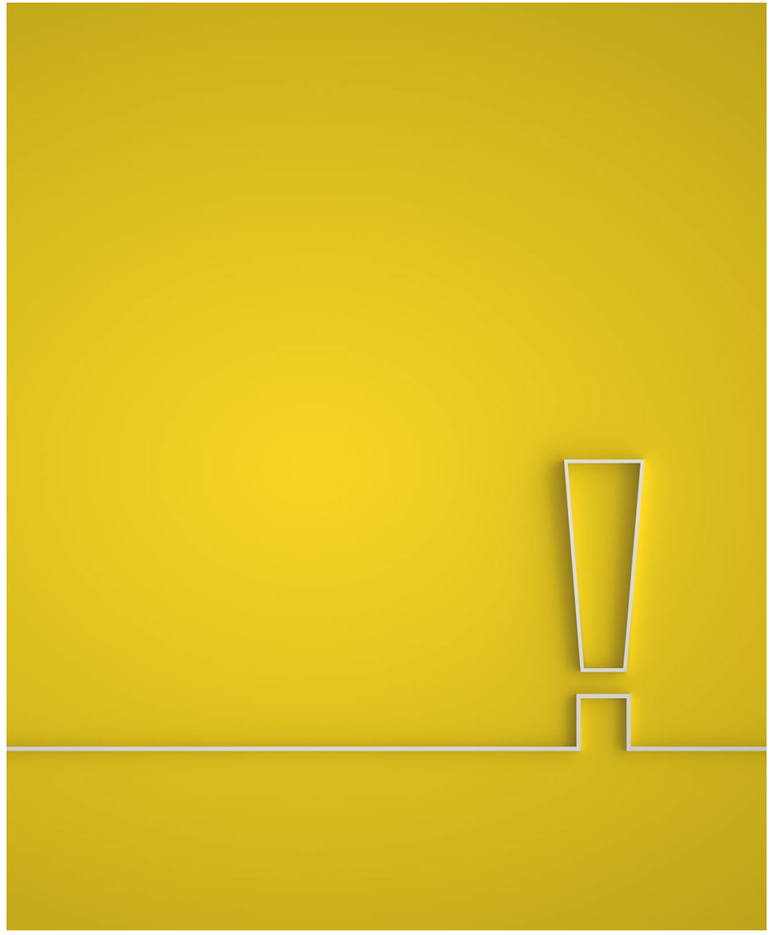
THE PROBLEM WITH COUNTY BEHAVIORAL HEALTH PLAN FINANCING



- County behavioral health plans used Certified Public Expenditures (CPE) to claim and pay for Medi-Cal
- CPE requires extensive documentation of allowable costs
- Complexity increases state and federal audit liability
  - State is still reconciling claims from 9 years ago
  - Counties carry hundreds of millions in risk year-to-year
- California out of compliance with health care coding requirements

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THE CASE FOR REFORM

Counties *and providers* at high risk for recoupment and self-disallowance

Public behavioral health system focused on documentation standards & audit risk, ***rather than beneficiary 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

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PAST: Cost Reimbursement	CURRENT: Payment Reform	FUTURE: Value Based Payment
• Through June 30, 2023 • Cost based • Provisional payments made to contracted providers during the FY, with Cost Reporting and settlements based on services and allowable/approved costs • DBH recoup overpayments from DBH/contracted providers • DHCS audit annual Cost Report to finalize reimbursements to DBH (inclusive of contracted providers); currently nine (9) years in arrear (FY 2015-16)	• Effective July 1, 2023 • Volume based • Provisional payments being made to contracted providers • Reconciliation of services and costs to establish contracted providers rate & reimbursement methodology • Outcome-based incentives are possible if reimbursement from DHCS to DBH is sufficient • DHCS reimburses DBH (inclusive of contracted providers) based on Fee-For-Service rates with no audit	• Effective date TBD • Outcome based • DHCS reimburses DBH based on Capitated rates (like the Managed Care Plans) • Contracted provider payment methodology TBD • Availability of incentives TBD

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DHCS
RATE 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 increases where applicable.

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DHCS
RATE CALCULATION EXAMPLE

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

Final Rate = ((Base Rate) X (Home Health Market Basket Index)) X Price Elasticity of Labor

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RATE CALCULATION EXAMPLE DEFINITION

- 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

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DHCS
DISTINCT RATE SETTING 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

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DHCS SMHS & DMC-ODS FEES

- *By Provider Type*
  - Including but not limited to AOD Counselor, Community Health Worker, Licensed Clinical Social Worker/ Marriage & Family Therapist, Licensed Physician, Nurse Practitioner, etc.
- *By Service Type*
  - Including but not limited to Assessment, Crisis, Medication Support, Referral & Linkage, Rehabilitation, Therapeutic Behavioral Health Services, Treatment Planning, etc.
- *Over 840 combinations*

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PAYMENT REFORM IMPERATIVES

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 rates negotiated with BH plans are distinct

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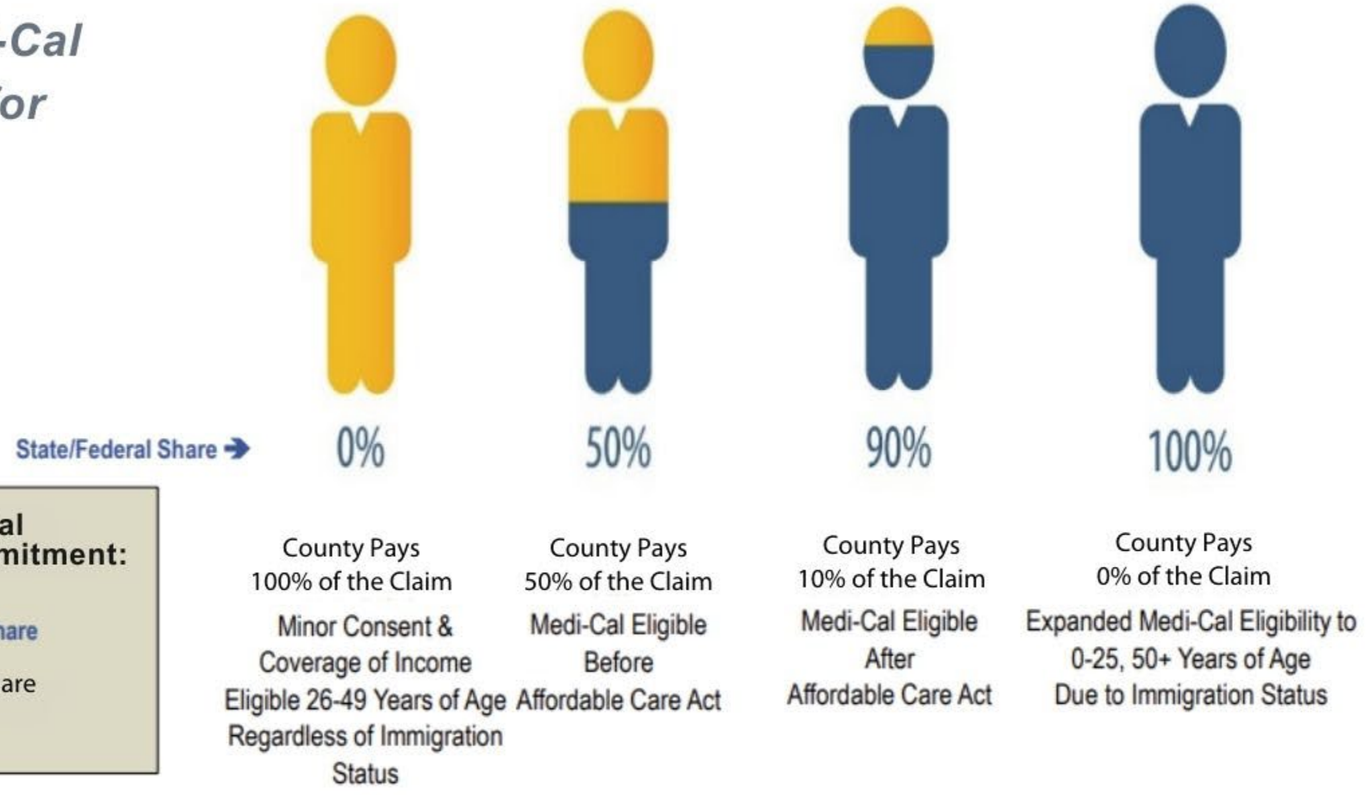
Why do the rates paid to providers matter to the County/DBH?

For most services and levels of care, Counties are responsible for paying a share of each reimbursed service with non-federal funds.

This means Counties need to set rates at a level that move the system forward but are affordable given available matching funds.

Basic Medi-Cal Financing for Treatment Services



Medi-Cal Funding Commitment:

- Federal/State Share
- Local (DBH) Share

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CalAIM BH Payment Reform: Sample Rate & Reimbursement Methodology

Provider X:		**Provider X:**
• Contracted to provide outpatient services • Units of service based • Likely reimbursement methodology: *Fee-For-Service*		• Also contracted to provide 24/7/365 services • Availability based • Likely reimbursement methodology: *Cost Reimbursement*

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CalAIM Incentive Overview

What could this look like if DHCS sets rates sufficiently higher than current rates?

DHCS Approved Rate for San Bernardino County (DBH)

DBH Retains a Share to Cover County Costs or Services

DBH Can Retain a Share for Other Needs such as Incentives

DBH shares rates with providers for all levels of care.

All providers receive reimbursement based on the volume of approved services delivered

Only providers who meet goals receive supplemental incentive payments

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Discussion & Questions

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