

READY FOR NEXT

Together...We Are Ready For What Comes Next

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES BEHAVIORAL HEALTH REDESIGN

RATE SETTING METHODOLOGY

DECEMBER 3, 2019

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DEVELOPING FFS RATES FOR THE
FOLLOWING SERVICES:

- ACT
- MST/FFT
- CRISIS
- PHP/IOP

FEE FOR SERVICE

Fee for Services (FFS) payments:

- Outlined in the Commonwealth's approved State Plan for covered services
- Typically a set amount for each service procedure code
- Paid by the Commonwealth to a provider only if a service was provided

Policy and clinical staff develop the service description outlining the service interventions and practitioner qualifications for delivering those interventions.

Financial staff set rates for the expected average provider costs for those interventions by qualified providers.

The Commonwealth must strategically consider how to incent cost-effective treatments for specified populations including Evidence-Based Practices.

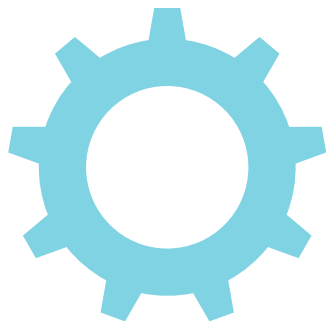
FFS rates are typically considered by MCOs in their rate negotiations for the same services.

CMS REQUIREMENTS FOR FFS RATE SETTING

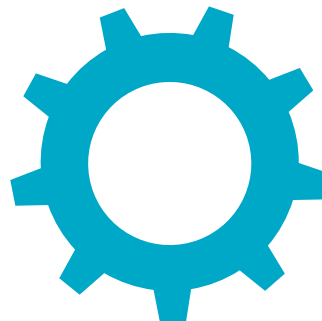


MEDICAID REIMBURSEMENT

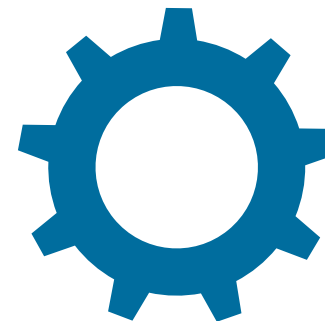
- Medicaid is a complex federal/state program where the federal government partially funds state medical services meeting certain federal requirements.
- CMS enters into a contract (a “State Plan”) with the state defining the exact beneficiaries receiving services from providers meeting specified qualifications.
- Medicaid reimbursement hinges on these three components:



Eligible beneficiary
is covered in State
Plan



Eligible service is
covered in State
Plan



Eligible provider
meets qualifications
in the State Plan

MEDICAID REIMBURSEMENT

Medicaid/Medical Assistance (MA) reimbursement compensates for services meeting federal definitions and requirements.

In addition, state-set reimbursement should include consideration for:

- Overall system goals and strategies to promote cost-effective care
- Intended delivery and desired outcomes of the service
- Ensuring payment rates are sufficient to enlist enough providers and are not excessive to incentivize over- or under-utilization of other services

MEDICAID REIMBURSEMENT



- Federal regulations at 42 CFR Part 447 provide regulatory guidance for service payments made by the states using Medicaid funds. The regulations are broad-based to allow states to establish different payment options in their Medicaid services and programs.



- Reimbursement for Medicaid FFS services are based on each services' provider qualifications that are required to deliver the services as defined in the State Plan.

MEDICAID REIMBURSEMENT

Broad rate-setting requirements:

Payments must be sufficient to attract enough providers such that services are readily available to beneficiaries (42 CFR 447.204)

Payments must be consistent with efficiency, economy and quality of care (42 CFR 447.200)

Each service must be sufficient in amount, duration and scope to achieve its purpose (42 CFR 440.230)

Public notice is required for any significant change in FFS methodology or standards for setting payment rates for services (42 CFR 447.205). CMS interprets this as any change in FFS rates

MEDICAID REIMBURSEMENT

What influences reimbursement?

Provider qualifications are the primary determinant of FFS provider rates

Service definitions and medical necessity criteria influence the provider qualifications, indirect costs and non-productive time (e.g., caseload, supervisor to staff ratios, etc.)

Costs associated with service delivery (e.g., EBP training and oversight, travel, occupancy, administration, etc.)

CMS REIMBURSEMENT PRINCIPLES

Fee schedule or cost-based rates need to consider:

- Direct costs of services to be utilized
- Indirect costs associated with service delivery
- General administration
- Non-MA activities
- How billed time does not exceed available productive time
- Single rates exclude differently licensed practitioners

Contents of this slide will be discussed in more detail in the next section.

CMS REIMBURSEMENT PRINCIPLES

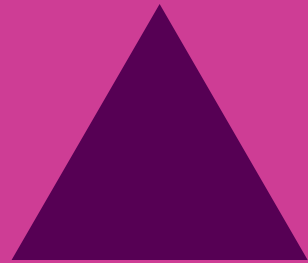
State Plans

- State plans are written for discrete services reimbursed using FFS methodologies. States may implement managed care arrangements to apply alternative reimbursement methodologies.

FFS

- The FFS payment methodology must be based on the unit of service to be paid.

FFS RATE DEVELOPMENT PROCESS



PROCESS FOR DEVELOPING FFS RATES

- Key steps in the process include:
 - Gathering State-specific information
 - Reviewing the service description
 - Discussing rate components and assumptions:
 - Determining unit of service
 - Developing direct, indirect, productivity and administration assumptions
 - Modeling rates based on Virginia expectations of service delivery
 - Reviewing any available provider financial data
 - Comparing rates to other states, where applicable
 - Finalizing recommendations for service descriptions, rates and billing guidance to ensure consistency

PROCESS FOR DEVELOPING FFS RATES

A critical component of the rate development process is clarifying the service definitions:

- What are the expected service outcomes?
- What are the national models and service standards, and how have they been implemented (or how will they be implemented) in Virginia?
- What constitutes a billable service?
- Which costs are included in each service?

PROCESS FOR DEVELOPING FFS RATES



Policy perspective

- Ensure CMS participation in funding via compliance with federal requirements
- Ensure compliance with state regulations and requirements



Clinical perspective

- Ensure service is designed to achieve clinical results, both for the individual service and across the system of care



Financial perspective

- Ensure assumptions incent behaviors that meet clinical objectives and meet CMS requirements:
 - Payment/rates priced too low will hinder provider recruitment and service utilization
 - Payment/rates priced too high may attract provider base, but may not achieve clinical results

BEHAVIORAL HEALTH RATE-SETTING INFORMATION

- Information was gathered to assist Virginia in ensuring key CMS requirements are addressed in developing a service description and associated payment rate.
- The information required a combination of:
 - Policy decisions
 - Clinical best practices of program models and service delivery
 - Discussion of allowable costs and activities associated with service delivery
- The information included four key parts:
 - Eligible populations
 - Eligible providers
 - Rate-setting methodology/general questions
 - Fee schedule methodologies

RATE ASSUMPTIONS AND DEVELOPMENT

CMS REIMBURSEMENT PRINCIPLES

Fee schedule rates considered

- Direct costs of services to be utilized (e.g., wages of practitioners delivering the service)
- Indirect costs (e.g., wages of supervisors)
- General administration
- Costs for non-MA activities were excluded
- How billed time does not exceed available productive time
- Single rates exclude differently licensed practitioners

Reimbursement

- Relevant federal reimbursement principles that are applicable in determining rates paid to providers, when those rates are established under a FFS program

ASSERTIVE COMMUNITY TREATMENT (ACT)



ACT

- Because a service description for ACT had been previously developed, the information was gathered based on the existing service description and the fidelity monitoring now required.
- For ACT, there are national standards related to service delivery, staffing, training and certification.
- *DMAS recognized where the service design and delivery envisioned for the Commonwealth was different than the national model and discussed whether or not that was appropriate given overall system goals.*

ACT

- Staffing requirements matching the national fidelity model of Tool for Measurement of Assertive Community Treatment (TMACT) was utilized.
- Financial decisions to be made as a result of this process:
 - Wages to pay practitioners
 - Benefits to allow for in the rate
 - Rate structure/number of rates
 - Training expenses to include
 - Components of service delivery that reduce productivity
 - General and administrative allowances
- *DMAS developed a base fidelity rate for existing ACT teams and a high fidelity rate to incentivize team growth to the desired fidelity based on the TMACT fidelity model.*

ACT

Significant component of the rate is the cost of the direct care worker providing the service.

Compensation data was taken from the Bureau of Labor Statistics, which is representative of wages paid in the Washington-Arlington-Alexandria metropolitan area:

- Mercer performed reasonability checks of average wages and wage ranges by comparing to compensation studies on similar positions in other regions of the Commonwealth

ACT

Costs associated with the direct service, but not directly billable, include items such as:

.....

- Employee-related expenses (ERE)
- Cost of materials or equipment required to deliver the service
- Cost of travel, training and other expenses incurred specifically to carry out the service
- Cost of required supervision of direct care practitioners

ERE may include the following:

.....

- Health insurance
- Federal and state unemployment taxes annual cost
- Workers' compensation
- Federal Insurance Contributions Act
- Other benefits, such as long-term and short-term disability, retirement benefits, etc.

ACT

For ACT, the following costs are included to ensure fidelity to the model:

.....

- Training expenses related to the initial and ongoing training costs for each team
- Costs for fidelity review and report writing
- Costs associated with consultation/technical assistance, including travel for the consultant

Costs associated with the general administrative expenses include items, such as:

.....

- Salaries of staff supporting the provision of service/other staff support
- Facility costs
- Buildings and equipment maintenance and depreciation
- Insurance expenses

ACT

DMAS developed a per diem rate for ACT based on the total costs incurred by one team for one year and the total number of clients expected to be served in that time period.

For complete listing of the assumptions utilized in the rate development process, please refer to rate assumptions chart.

DMAS Proposed Rates

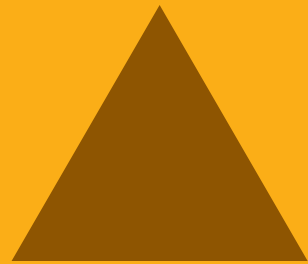
Base Fidelity

- Small Team: \$195.20
- Medium Team: \$169.33
- Large Team: \$158.90

High Fidelity

- Small Team: \$245.29
- Medium Team: \$206.64
- Large Team: \$190.08

**MULTI-SYSTEMIC
THERAPY/FUNCTIONAL
FAMILY THERAPY
(MST/FFT)**



MST/FFT



Established separate rates for practitioners with similar licensure/educational requirements:

.....

- Separate procedure/bill code for bachelor-level staff and master-level staff
- Providers required to bill appropriately for services rendered by each licensed practitioner. In the event providers are not properly billing for appropriate staff, the provider will be held accountable in the event of a disallowance

MST/FFT

Significant component of the rate is the cost of the direct care worker providing the service.

Compensation data was taken from the Bureau of Labor Statistics, which is representative of wages paid in the Washington-Arlington-Alexandria metropolitan area :

- Mercer performed reasonability checks of average wages and wage ranges by comparing to compensation studies on similar positions in other regions of the Commonwealth

MST/FFT

Costs associated with the direct service, but not directly billable, include items such as:

.....

- ERE
- Cost of materials or equipment required to deliver the service
- Cost of travel, training and other expenses incurred specifically to carry out the service
- Cost of required supervision of direct care practitioners

ERE may include the following:

.....

- Health insurance
- Federal and state unemployment taxes annual cost
- Workers' compensation
- Federal Insurance Contributions Act
- Other benefits, such as long-term and short-term disability, retirement benefits, etc.

MST/FFT

The number of days the provider will be able to bill in any given year was determined omitting:

- Non-billable days, such as vacation, holiday, sick leave and training

The amount of productive time in each billable day was also determined omitting:

- Non-billable hours, such as travel to/from a client visit, documentation, employer contact, other required meetings, etc.

MST direct care workers are assumed to bill 3.5 hours in an 8 hour day

FFT direct care workers are assumed to bill 3.75 hours in an 8 hour day

MST/FFT

DMAS developed a 15 minute rate based on the total costs incurred by one team for one year and the total number of billable hours the team is expected to achieve.

For complete rate development please refer to rate assumptions chart.

MST/FFT

DMAS Proposed Rates

MST – Established Teams

- Bachelor's Level: \$46.03
- Master's Level: \$49.96

MST – New Teams

- Bachelor's Level: \$51.00
- Master's Level: \$55.03

MST/FFT

DMAS Proposed Rates

FFT – Established Teams

- Bachelor's Level: \$34.11
- Master's Level: \$37.28

FFT – New Teams

- Bachelor's Level: \$40.73
- Master's Level: \$44.17

CRISIS SERVICES



CRISIS SERVICES

Established separate rates for the following crisis services:

.....

- Crisis services delivered by a mobile crisis intervention team
- Community-based crisis stabilization services provided for up to 30 days
- 23-hour observation stays in non-hospital community-based facilities
- Crisis Stabilization Unit (CSU) stays in non-hospital community based residential facilities

For mobile crisis intervention and community-based crisis stabilization, Mercer established separate rates for practitioners with similar licensure/educational requirements:

.....

- Separate procedure/bill code for bachelor-level staff and master-level staff
- Providers required to bill appropriately for services rendered by each licensed practitioner. In the event providers are not properly billing for appropriate staff, the provider will be held accountable in the event of a disallowance

CRISIS SERVICES

Significant component of the rate is the cost of the direct care worker providing the service.

Compensation data was taken from the Bureau of Labor Statistics, which is representative of wages paid in the Washington-Arlington-Alexandria metropolitan area:

- Mercer performed reasonability checks of average wages and wage ranges by comparing to compensation studies on similar positions in other regions of the Commonwealth

CRISIS SERVICES

Costs associated with the direct service, but not directly billable, include items such as:

.....

- ERE
- Cost of materials or equipment required to deliver the service
- Cost of travel, training and other expenses incurred specifically to carry out the service
- Cost of required supervision of direct care practitioners
- Call center expenses

ERE may include the following:

.....

- Health insurance
- Federal and state unemployment taxes annual cost
- Workers' compensation
- Federal Insurance Contributions Act
- Other benefits, such as long-term and short-term disability, retirement benefits, etc.

CRISIS SERVICES

The number of days the provider will be able to bill in any given year was determined omitting:

- Non-billable days, such as vacation, holiday, sick leave and training

The amount of productive time in each billable day was also determined omitting:

- Non-billable hours, such as travel to/from a client visit, documentation, employer contact, other required meetings, etc.

Mobile crisis intervention and community-based crisis stabilization direct care workers are assumed to bill 4.5 hours in an 8 hour day

CRISIS SERVICES

DMAS developed a 15 minute rate for mobile crisis intervention and community-based crisis stabilization based on the total costs incurred by one team for one year and the total number of billable hours the team is expected to achieve.

DMAS developed a per diem rate for 23-hour observation and CSU based on the total costs incurred by one team for one year and the total number of clients expected to be served in that time period.

For complete rate development please refer to rate assumptions chart.

CRISIS SERVICES

DMAS Proposed Rates

Mobile Crisis Intervention

- 2:1 (Licensed/Peer): \$108.01
- 2:1 (Licensed/MA): \$117.27
- 2:1 (MA/MA): \$110.46
- 2:1 (MA/Peer): \$101.20
- 1:1 (Licensed): \$63.18

CRISIS SERVICES

DMAS Proposed Rates

Community-Based Crisis Stabilization

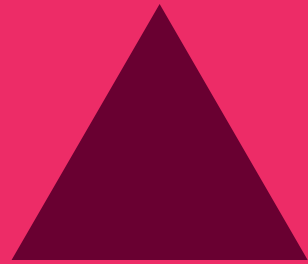
- 2:1 (Licensed/Peer): \$66.54
- 2:1 (Licensed/MA): \$76.29
- 1:1 (MA): \$35.76
- 1:1 (Licensed): \$42.93

CRISIS SERVICES

DMAS Proposed Rates

- 23-Hour Observation: \$817.83
- Crisis Stabilization Unit: \$684.48

**PARTIAL
HOSPITALIZATION
PROGRAMS/ INTENSIVE
OUTPATIENT
PROGRAMS (PHP/IOP)**



PHP/IOP



Mercer established two rates in this area:

.....

- An intensive outpatient rate (IOP)
 - An intensive outpatient specialty rate including occupational and recreational therapists. IOP with OT rate includes 0.10 FTE (2 days a month) for occupational and recreational therapists
-
- It is assumed that the Commonwealth will utilize the Medicare partial hospitalization rate for qualified PHP programs.

Significant component of the rate is the cost of the direct care worker providing the service.

Compensation data was taken from the Bureau of Labor Statistics, which is representative of wages paid in the Washington-Arlington-Alexandria metropolitan area:

- Mercer performed reasonability checks of average wages and wage ranges by comparing to compensation studies on similar positions in other regions of the Commonwealth

PHP/IOP

Costs associated with the direct service, but not directly billable, include items such as:

.....

- ERE
- Cost of materials or equipment required to deliver the service
- Cost of travel, training and other expenses incurred specifically to carry out the service
- Cost of required supervision of direct care practitioners

ERE may include the following:

.....

- Health insurance
- Federal and state unemployment taxes annual cost
- Workers' compensation
- Federal Insurance Contributions Act
- Other benefits, such as long-term and short-term disability, retirement benefits, etc.

The number of days the provider will be able to bill in any given year was determined omitting:

- Non-billable days, such as vacation, holiday, sick leave and training

The amount of productive time in each billable day was also determined omitting:

- Non-billable hours, such as travel to/from a client visit, documentation, employer contact, other required meetings, etc.

PHP/IOP

DMAS developed a per diem rate for IOP and for IOP with OT based on the total costs incurred by one team for one year and the total number of clients expected to be served in that time period.

For complete rate development please refer to rate assumptions chart.

DMAS Proposed Rates

- IOP Per Diem: \$141.51
- Specialty Rate with Occupational/Recreational Therapy: \$142.96

MERCER GOVERNMENT

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