

Virginia Department of Medical Assistance Services Applied Behavior Analysis



Rate-Setting Methodology

Commonwealth of Virginia
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Brad Diaz, FSA, MAAA
Brenda Jackson

1. Introductions
2. Discussion on Fee-for-Service (FFS) Rate Development
3. Review the Centers for Medicare & Medicaid Services (CMS) Requirements for FFS Rate Development
4. Discussion on the process for developing FFS rates for the following Applied Behavior Analysis (ABA) services:
 - A. Individual Assessment and Treatment
 - B. Group Treatment
 - C. Family Training and Group Family Training
 - D. Team Analysis and Treatment
5. Q&A

Agenda

Introductions



Discussion on FFS Rate Development

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Fee-for-Service

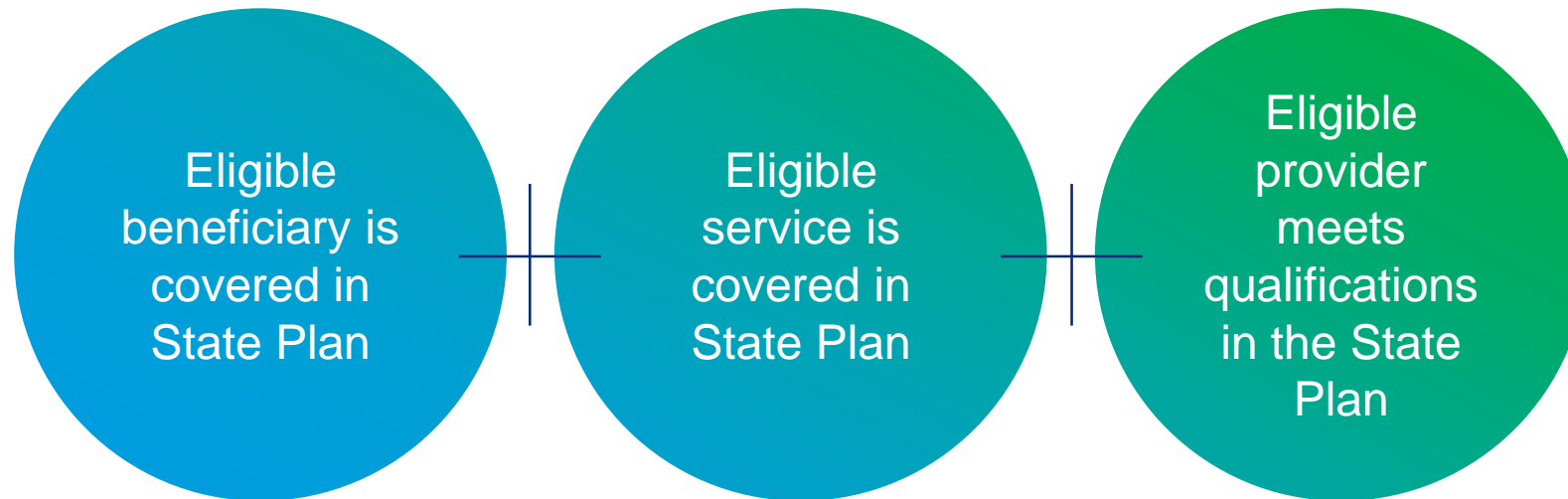
- FFS payments:
 - Outlined in the Commonwealth's approved State Plan for covered services.
 - Typically a set amount for each service procedure code.
 - Paid by the Commonwealth to a provider only if a service was provided.
- Policy and clinical staff develop the service description outlining the service 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 managed care organizations (MCOs) in their rate negotiations for the same services.

CMS Requirements for FFS Rate Setting

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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:





Medicaid Reimbursement

- Medicaid/Medical Assistance 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)

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

Costs associated with service delivery (e.g., Evidence-based practice training and oversight, travel, occupancy, administration)

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-Medical assistance 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.

Process for Developing FFS Rates for the Following Services:

- Individual Assessment and Treatment
- Group Treatment
- Family Training and Group Family Training
- Team Analysis and Treatment



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

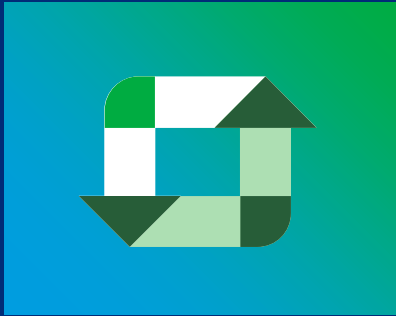
- Ensure service is designed to achieve clinical results, both for the individual service and across the system of care



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

ABA Rate-Setting Information

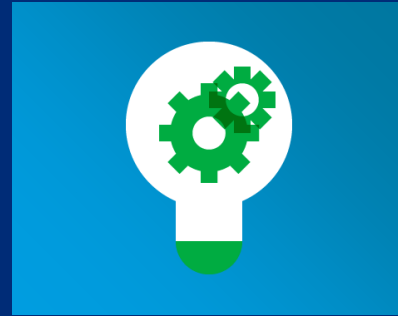


Information was gathered to assist Virginia in ensuring key CMS requirements are addressed in developing a service description and associated payment rate.



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-medical assistance 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

Process for Developing FFS Rates for the Following Services:

- Individual Assessment and Treatment



Individual Assessment and Treatment



Qualified Healthcare Professional (QHP) Level Staff

- Behavior identification assessment, administered by a physician or other QHP, administering assessments and discussing findings and recommendations, face-to-face with one patient, each 15 minute.
- Non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.
- Adaptive behavior treatment with protocol modification, administered by physician or other QHP, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.
- This can be a Licensed Assistant Behavior Analyst (LABA), Licensed Mental Health Professional (LMHP), or Licensed Behavior Analyst (LBA)



Technician Level Staff

- Behavior identification supporting assessment, administered by one technician under the direction of a physician or other QHP, face-to-face with one patient, each 15 minute.
- Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other QHP, face-to-face with one patient, each 15 minutes.
- This can be a Registered or Unregistered Behavior Technician (RBT/UBT) or an LABA, LMHP, or LBA functioning as a technician.

Individual Assessment and Treatment

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

- Separate procedure/bill code for each staff level
 - Practitioners performing ABA services will include the following:
 - RBT/UBT
 - LABA
 - LMHP
 - LBA
- 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.



Individual Assessment and Treatment

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.

Individual Assessment and Treatment

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

- Employee-related expenses (ERE)
- 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- and short-term disability, retirement benefits, etc.

Productivity Assumption

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

Individual Assessment and Treatment

DMAS developed a **15 minute** rate based on the total costs to provide the ABA services incurred in an individual setting for one year and the total number of billable hours the staff is expected to achieve.

For complete rate development please refer to the rate assumptions chart. Please also see the relevant billing guidance on codes that may be billed together.

Individual Assessment and Treatment

DMAS Proposed Rates

- RBT/UBT: \$13.33
- LABA: \$20.87
- LMHP: \$35.02
- LBA: \$41.45

Process for Developing FFS Rates for the Following Services:

- Group Treatment



Group Treatment

- The group treatment rate utilizes the individual rates developed above and applies the appropriate group staffing assumptions.
- The developed rates assume an average of three children in a group.
- The rate billed depends on whether the practitioner is leading the group alone or if there is a technician(s) working 1:1 with a child(ren) in the group.
- The appropriate rate is billed once for each child in the group. The rate is billed once for each child and **not** for each staff present in the group setting.

Group Treatment

- Rate is billed once for each child and **not** for each staff present in the group setting.
- Assumed group size: Three children
- Assumed group size limit: Five children

Group without 1:1 Technicians

- 3:1 ratio
- 1 Group Leader (i.e., 3 children = 1 Group Leader)
- Group led by RBT/UBT and LABA will reflect additional 0.5 FTE LMHP/LBA for close supervision
- Note: any level of practitioner may lead the group including RBT/UBTs.

Group led by QHP with 1:1 Technicians

- 3:4 ratio
- 1 QHP and 3 technicians (i.e., 3 children = 1 QHP + 3 technicians)
- Note: only LABAs, LMHPs, and LBAs may be QHPs. Any practitioner may be a technician.

Group Treatment – Billing

Billing by provider if there is no technician assigned 1:1 to the child.

RBT/UBT

An RBT/UBT leading a group of children will bill 97154 for each child.

LABA

An LABA leading a group will bill 97154 HN if there is no technician (RBT/UBT) assigned 1:1 to the child.

LMHP

An LMHP leading a group will bill 97154 TF if there is no technician (LABA/RBT/UBT) assigned 1:1 to the child.

LBA

An LBA leading a group will bill 97154 HO if there is no technician (any practitioner type) assigned 1:1 to the child.

Billing by provider if there is a technician assigned 1:1 to the child.

LABA

An LABA leading a group will bill 97158 HN if there is a technician (RBT/UBT) assigned 1:1 to the child.

LMHP

An LMHP leading a group will bill 97158 TF if there is a technician (LABA/RBT/UBT) assigned 1:1 to the child.

LBA

An LBA leading a group will bill 97158 HO if there is a technician (any practitioner type) assigned 1:1 to the child.

Group Treatment

DMAS developed a **15 minute** rate based on the total costs to provide the ABA services incurred in a group setting for one year and the total number of billable hours the staff are expected to achieve.

For complete rate development please refer to the rate assumptions chart. Please also see the relevant billing guidance on codes that may be billed together.

Group Treatment

DMAS Proposed Rates

- 97154 RBT/UBT leads: \$11.35
- 97154 HN LABA leads; no RBT/UBT assigned to child: \$13.87
- 97154 TF LMHP leads; no LABA/RBT/UBT assigned to child: \$11.67
- 97154 HO LBA leads; no LMHP/LABA/RBT/UBT assigned to child: \$13.82
- 97158 HN LABA leads; with RBT/UBT assigned to child: \$20.29
- 97158 TF LMHP leads; with LABA/RBT/UBT assigned to child: \$25.00
- 97158 HO LBA leads; with LMHP/LABA/RBT/UBT assigned to child: \$27.15

Process for Developing FFS Rates for the Following Services:

- Family Training and Group Family Training



Family Training

- Family adaptive behavior treatment guidance, administered by physician or other QHP (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.
- The family training service is performed directly with the guardian/caregiver (1:1 staff ratio) and therefore utilizes the individual treatment rate.
- Practitioners to perform family training include LABAs, LMHPs, and LBAs.

Group Family Training

- Multiple-family group adaptive behavior treatment guidance, administered by physician or other QHP (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.
- The group family training rate utilizes the family training rate and applies the appropriate group staffing.
- Rate is billed once for each guardian/caregiver in a group.
- Assumed group size: Three guardians/caregivers
- Assumed group size limit: Five guardians/caregivers
- Practitioners to perform group family training include LABAs, LMHPs, and LBAs.

Group Staffing

- 3:1 ratio
- 3 caregivers = 1 practitioner

Family and Group Family Training

DMAS developed a **15 minute** rate based on the total costs to provide family and group family ABA services for one year and the total number of billable hours the staff is expected to achieve.

For complete rate development please refer to the rate assumptions chart. Please also see the relevant billing guidance on codes that may be billed together. Additional ABA codes may not be billed with family or group family training.

Family and Group Family Training

DMAS Proposed Rates

Family Training

- LABA: \$20.87
- LMHP: \$35.02
- LBA: \$41.45

Group Family Training

- LABA: \$6.96
- LMHP: \$11.67
- LBA: \$13.82

Process for Developing FFS Rates for the Following Services:

- Team Analysis and Treatment



Team Analysis and Treatment

- Team Analysis:
 - Functional analysis of severe maladaptive behaviors in specialized settings.
 - Behavior identification supporting assessment.
- Team Treatment:
 - Direct treatment of severe maladaptive behavior in specialized settings.
 - Adaptive behavior treatment with protocol modification.
- The team services will require the following components:
 - Administered by the physician or other QHP who is onsite,
 - with the assistance of two or more technicians,
 - for a patient who exhibits destructive behavior, and
 - be completed in an environment that is customized, to the patient's behavior.
- Rate is billed once for the child and **not** for each staff present in the team setting.
- Practitioners to lead team services include LABAs, LMHPs, and LBAs with RBTs/UBTs on the team.

Team Analysis and Treatment

The team structure is the same with only the lead practitioner varying.

LABA

- 1:3 ratio
- 1 LABA, additional 2 RBT/UBTs assisting (i.e., 1 child = 1 LABA + 2 RBT/UBTs)

LMHP

- 1:3 ratio
- 1 LMHP, additional 2 RBT/UBTs assisting (i.e., 1 child = 1 LMHP + 2 RBT/UBTs)

LBA

- 1:3 ratio
- 1 LBA, additional 2 RBT/UBTs assisting (i.e., 1 child = 1 LBA + 2 RBT/UBTs)

Team Analysis and Treatment

DMAS developed a **15 minute** rate based on the total costs to provide the ABA services incurred in a team setting for one year and the total number of billable hours the team is expected to achieve.

For complete rate development please refer to the rate assumptions chart. Please also see the relevant billing guidance on codes that may be billed together. Additional ABA codes may not be billed with team analysis and treatment.

Team Analysis and Treatment

DMAS Proposed Rates

QHP level

- LABA; with 2 RBT/UBTs assisting: \$47.53
- LMHP; with 2 RBT/UBTs assisting: \$61.68
- LBA; with 2 RBT/UBTs assisting: \$68.11

Q&A





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