

Medi-Cal MH/SUD Payment Transition

In order to assist in successfully navigating the transition from Medi-Cal cost-based reimbursement to fee-for-service (FFS)-based reimbursement, this paper will outline the most notable threats and opportunities which come with that transition. A more detailed transition playbook will later be produced that will explore each of the threats and opportunities in greater detail and provide key steps and strategies for counties to maximize success and mitigate risks in the transition ahead.

The biggest threat counties face in the transition is the unplanned shift or drop in Medi-Cal reimbursement/revenue. If this happens, additional county funding may be required to maintain operations and remain in compliance with the Medi-Cal contract with the State. There are a variety of reasons revenue from Medi-Cal may drop from current revenue levels under cost-based reimbursement. However, the key for successfully navigating the transition will be to ensure no revenue is lost due to issues within the counties' control. For example, errors in billing for services or insufficient tracking and claiming for administration or utilization management, quality assurance, and care management (UM/QA/CM) activities will lead to lost revenue. It will be critical to code services to allow for maximum reimbursement from the State. Additionally, to limit expenses against revenues, counties will need to manage care and resources efficiently.

Likewise, misalignment of contracting arrangements with overall FFS rate reimbursement practices and levels will lead to expenditures that may not be able to be fully recouped from billings to the State. Contracting arrangements that continue to be cost reimbursed with no connection to actual Medi-Cal billings puts the county at risk for low Medi-Cal reimbursement. In order to secure the necessary network, it may be necessary to contract for some services/providers at rates marginally above the counties' new fee schedule rates. However, as long as the mix of services and contracting arrangements cover the costs in total, the counties will be able to achieve fiscal solvency on the Medi-Cal line of business.

With this transition, it is recommended for counties to carefully catalogue all sources and uses of funds. As part of this, counties should identify all populations being served as well as the services provided. How does this compare to covered populations and sources of funds? To the extent that non-mandated populations are accessing care, or non-covered services are being provided, counties should know the detailed differences in case tough financial and operational decisions have to be made in the future. Counties should also use this catalogue to inform county management of opportunities to increase local behavioral health spending authority. This would allow counties to provide enhanced incentive-based funding to contractors and potentially county staff.

Finally, counties will want to implement appropriate monitoring protocols to track their revenues and expenditures against budgets. This monthly tracking will provide early warning of any issues developing in terms of revenue short falls as well as mix of services. Measuring monthly and quarterly results against benchmarks and budgeted figures also becomes one of the best ways to improve the accuracy

of budgeting and forecasting going forward. This monitoring can provide valuable information as to what provider capacity exists compared to member utilization and where additional resources are needed.

The transition also presents various opportunities for counties. Moving to a FFS-based reimbursement model from a cost-based model, that involves multiple reconciliation settlements, will provide more complete funding in a timely manner. Therefore, accounting for Medi-Cal revenues should be simplified and counties will not have to undergo multiple reconciliation processes. Counties should incorporate this administrative simplification into their contracting arrangements by moving away from cost reconciliation with contractors unless it is absolutely necessary in order to maintain a specific contractor.

In addition, as travel and documentation time are no longer separately billable in the all-inclusive fee schedule environment, counties will want to ensure they are maximizing the efficiency of their staff and contractors. This can be done a few different ways. The COVID-19 pandemic necessitated and the State has allowed greater expansion of telemedicine as a mode of service delivery. To the extent available and appropriate, services delivered via telemedicine clearly lower the time and cost of travel. In addition, establishing best practices for standardized documentation processes will ensure maximum efficiency of providers' time. These documentation processes will also be critical for accurate and appropriate billing to ensure timely and maximum reimbursement from the State. Lastly, counties should consider a more regionalized service delivery approach in order to minimize travel time. Counties should assign staff to regional communities as well as develop contracts specific to an area of the county to reduce travel time and increase direct patient care time.

Now is the right time to assess the current mix of services being provided by all types of providers (employed and contracted). With the shortage of staffing and contracted provider resources in today's environment, counties will want to best align service provision by having staff and contracted providers operating at the top of their competencies. This will also lead to maximized reimbursement under the new FFS reimbursement model and will ensure scarce resources are utilized most efficiently and effectively. Establishing benchmarks for expected levels of services to be provided by staff and contracted providers will help in network planning and monitoring.

In some cases, there may be opportunities to incorporate other payment models such as value-based payments or alternative payment arrangements. Such payment models can be effective to attract and retain network providers.

In the longer term, successfully navigating this transition through the considerations outlined above, will put counties on the path to operating as managed care entities. Medi-Cal reimbursement during the first three to four years under the FFS approach will most likely be used to develop capitation rates. Since the FFS rates are set by the State, the only way for the county to maximize Medi-Cal reimbursement is by claiming for the highest number of units possible. This will help to pave the way to safely enable the journey towards a full-risk capitation payment arrangement in the future.