BEHAVIORAL HEALTH Fiscal Academy

CalMHSA
California Mental Health Services Authority

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Behavioral Health Fiscal Academy

BHFA Session 4

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Forecasting SMH & SUD Medi-Cal Patient Care Revenue

Forecasting Methods & Revenue Factors for SMH & SUD

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Learning Objectives

- Learn the principles and key considerations for forecasting Medi-Cal revenues for behavioral health services
- Identify factors affecting reimbursement trends

Session Roadmap

1. Title XIX – The Medicaid Program
2. Then Versus Now, Cost-Based Claiming to a Prospective Fee Schedule
3. Federal Medical Assistance Percentage (FMAP)
4. Client Aid Codes & Modifiers Affecting Reimbursement
5. IGT Process
6. Understanding the County CFA
7. Revenue & Expense Forecasting
8. Projecting the Impacts from Federal and State Policy Changes
9. Forecasting Revenues for Brand New Programs

Title XIX

Refers to the section of the Social Security Act that established the Medicaid program in 1965.

- Title XIX is the federal legal authority for Medicaid (Medi-Cal in California).
- It authorizes federal reimbursement to states to provide medical assistance, including Specialty Mental Health and Substance Use Disorder services, to eligible members enrolled in Medicaid.
- Title XIX sets the rules for federal financial participation (FFP), meaning the federal government shares the cost of covered services provided to eligible beneficiaries.

The SMH & SUD Medi-Cal Landscape

Federal Level: Title XIX of the Social Security Act	State Level: California Department of Health Care Services (DHCS)	County Level: Local Administration & Service Delivery
- Ultimate Authority: The federal government (Centers for Medicare & Medicaid Services, CMS) sets the legal framework for Medicaid under Title XIX. - FFP: Provides matching funds to states for covered services delivered to eligible Medicaid members.	- Program Administration: California administers Medicaid as "Medi-Cal," adapting federal rules to meet state needs and priorities. - State Plan: California's Medicaid State Plan outlines covered services, eligibility, and reimbursement rules - State Plan Amendments, Waivers & Demonstrations: Allows California to modify Medicaid programs to better meet the needs of its populations. - State Fiscal Role: Contributes a portion of the non-federal share for specific Medi-Cal BH services using State General Fund (SGF).	- County Contracts: California's counties contracts with DHCS to administer SMHS and SUD services for Medi-Cal beneficiaries. - Local Responsibility: Counties manage provider networks, authorize services, pay network providers, and submit claims for reimbursement. - Funding Flow: Counties provide the non-federal share through Intergovernmental Transfers (IGTs), then bills the state for eligible services. The state then claims FFP from the federal government and passes funds back to counties.
Sets the rules and provides the foundation.	***Shapes and stewards the program for California.***	***Makes it real—delivering services and driving impact on the ground.***

CalAIM Payment Reform

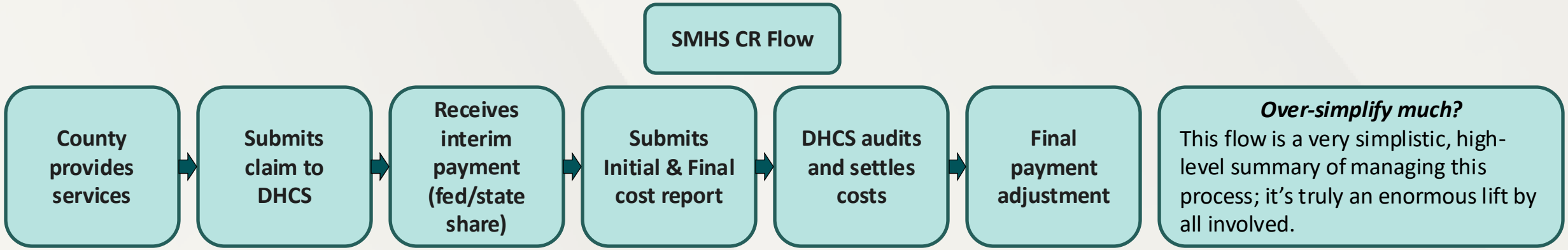
FROM COST-BASED CLAIMING TO A PROSPECTIVE FEE SCHEDULE

County Behavioral Health Financing – The Cost-Based Era

(Pre-7/1/2023)

Complexity, Uncertainty, Administrative Burden: Yes, Yes, and Yes!

- Certified Public Expenditures (CPE): Counties submitted claims based on actual costs incurred for providing SMH and SUD services.
- Interim Payments: DHCS reimbursed counties for the federal and state share, but only on an interim basis.
- County Share: Counties were responsible for funding the non-federal share, often using Realignment, MHSA, or other local sources (this hasn't changed). However, in some programs, the State also contributes a portion of the non-federal share through the State General Fund (SGF).
- Cost Settlement: Counties & their providers submitted two cost reports for each year (an initial & a final) for SMH and a single cost report for SUD. DHCS audited & adjusted payments to reflect actual allowable costs.
- Administrative Burden: Significant effort required for cost reporting, audits, and settlements.



Transition to CalAIM Payment Reform

(Effective 7/1/2023)

- **Prospective Fee Schedule:** DHCS now **reimburses** counties based on a fee schedule for approved services. The fee schedule amount represents the total (gross) payment to counties.
- **Payments are Final**: Payments made to counties are considered final; no more cost settlement or retroactive adjustments.
- **Simplified Administration**: Eliminates annual cost reporting and audit-based settlements.
- **Revenue Certainty**: Counties know the payment amount at the time of **claim approval**.
- **Contract Rate Setting**: Counties negotiate rates with their contracted providers; this is known as the negotiated 'pass through' of the counties DHCS fee schedule amount.
- **Global Budgeting**: Counties must operate within their fee schedule, enhancing the need for strategy around rate setting for SMH & SUD CBOs.

Feature	Cost-Based (Pre-7/1/2023)	Prospective Fee Schedule (Post-7/1/2023)
Payment Timing	Interim, subject to audit years later	Provisionally final at claim approval
Cost Settlement	Required	Eliminated
Administrative Burden	High	Reduced
Revenue Certainty	Low	High
Forecasting Complexity	High	Lower

Why This Transition Matters for the Fiscal Analyst

No More Retroactive Cost Adjustments: Eliminates the risk of future payment recoupments resulting from cost settlements

Forecasting Revenues: Analysts can now use fee schedules and historical utilization to project revenues with confidence.

Forecasting Revenues

No More Retroactive Adjustments

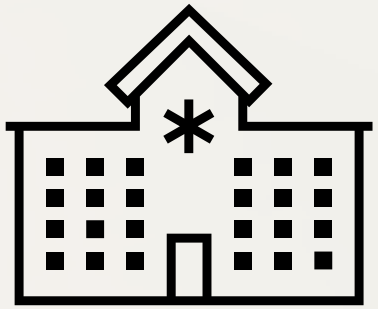
Shifts Focus

Shifts Focus: Away from billing minute by minute and cost tracking, toward strategies that optimize service delivery and improve claim accuracy.

Medi-Cal Service Delivery & Reimbursement

THE BASICS

Short-Doyle Medi-Cal Reimbursement: A High-Level Review of County Behavioral Health Payments



Let's say…

- A County Behavioral Health Plan (BHP) Medi-Cal client receives a one-hour therapy session from a Licensed Practitioner of the Healing Arts (LPHA).
- The county's rate (fee) set by DHCS for an LPHA is $100/hour
  - The county claims the service through SD/MC for $100
- The claim is approved and DHCS issues a ***payment*** to the county of $100 that includes the following ***funding mix****:*
  - $50 FFP
  - $0 State General Funds
  - $50 from the ***County Funds Account*** *(CFA)*
  - This $100 received by the county is now considered ***Medi-Cal Patient Care Revenue***

Wait, what just happened?
There's a lot going on here, so let's slow down and unpack it. We're going to take a closer look at some big concepts that were just introduced: ***Funding mix determinants, County Funds Account, IGT payments, & Medi-Cal Patient Care Revenue***

How is the funding mix determined for Medi-Cal SMH & SUD reimbursement?

We will focus on two key drivers that determine the funding mix for a county's Medi-Cal Patient Care Revenue: Modifiers and Aid Codes.

CPT Procedure Code Modifier

- CPT modifier: 2-digit code that adds billing context (e.g., level of care, provider role, complexity) without changing the procedure.
- Modifiers that affect reimbursement include:
  - HW – Used to identify a service that was required to be provided as a result of a state requirement implemented after 9/30/2012.
  - HV – Used to identify a service that was required to be provided as a result of a federal requirement implemented after 9/30/20212.

Aid Code

- Historically, the most common factor for determining the funding mix for a county's claim reimbursement is the client's aid code and FMAP rate as determined by the Short Doyle Medi-Cal Aid Code Chart
- Each client enrolled in Medi-Cal is assigned an aid code based on eligibility (e.g., income, disability, foster care).

Let's look at "FMAP" a little closer

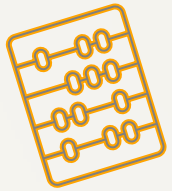
Federal Medical Assistance Percentage (FMAP)

What is FMAP?

- FMAP is the percentage of Medicaid costs paid by the federal government for eligible services and is primarily determined by the client aid code.
- FMAP helps fund specialty mental health and substance use disorder services for Medi-Cal beneficiaries.
- FMAP is a percent, meaning, in most instances the full claim amount isn't reimbursed with 100% FFP; the unfunded portion is called the "non-federal share"

Why Does it Matter?

- FMAP determines how much federal funding counties receive for services they deliver.
- Higher FMAP means more federal support, reducing the financial burden on state and county budgets.
- FMAP rates can change.



Key Concept:

FMAP is the foundation of the federal-state partnership that funds Medi-Cal, but in most instances, it only covers a portion of the total cost.

Funding Mix – Based on Aid Code

Aid codes determine the FMAP rate. Higher FMAP applies to certain aid codes; others default to the 50% standard rate.

Aid codes can determine whether the State contributes State General Funds (SGF).

- Prop 30 requires the State to cover 100% of the non-federal share for services provided as the result of a new state requirement post the 2011 Realignment or 50% of the non-federal share for new federal requirements.

The Short-Doyle Medi-Cal Aid Code Chart in the DHCS MedCCC Library provides the information necessary to determine the link between a client's aid code and the share of federal and state funds.

The table here summarizes FMAP and state cost shares for a few aid code types. Each type, such as 'Regular,' represents a group of two-digit aid codes that fall within this category.

SDMC Aid Codes & Share of Cost			
Aid Code Type	Federal	State	County
Regular	50%	0%	50%
Enhanced	65%	0%	35%
ACA	90%	10%	0%
SB75	0%	100%	0%
Refugee	100%	0%	0%

DHCS SD/MC Aid Code Chart (Revised 4/4/2023)

Prop 30

*There's so much more to learn about California's 2011–2012 Proposition 30. For instance, DMC-ODS counties **do not** draw down SGF through Prop 30 when serving population expansions (i.e. ACA, SB75, etc.).*

Don't miss BHFA Session 5!

Funding Mix – Based on Prop 30 Modifiers

The state's current use of modifiers as a means of signaling its coverage of the non-federal share is:

- HW – Service delivered as the result of a state mandate, post 2011R; 100% of the non-federal share will be covered
- HV – Service delivered as the result of a Federal mandate, post 2011R; 50% of the non-federal share will be covered

Acknowledging differences between these modifier's use across the Drug Medi-Cal Organized Devery System, Drug Medi-Cal, and Specialty Mental Health Services

FY25/26 SMHS Billing Manual Version 3.12	FY25/26 DMC-ODS Billing Manual Version 3.0	FY25/26 DMC Billing Manual Version 3.0
Modifier HW (100%) - Services provided in the scope of Mobile Crisis Intervention, or - The Continuum of Care Reform **Modifier HV (50%)** - Services provided in the scope of the Federal Family First Preventions Services Act (FFPSA)	**Modifier HW (100%)** - Services provided in the scope of Mobile Crisis Intervention **Modifier HV (50%)** - DHCS has not implemented any federally required Proposition 30 services	**Modifier HW (100%)** - Services provided in the scope of Mobile Crisis Intervention **Modifier HV (50%)** - Medication Addiction Treatment (MAT) Services (except for Methadone).

IGT Payments & The County Funds Account

County dollars are the final piece of the "funding mix" in a Medi-Cal IGT payment

What is an IGT?

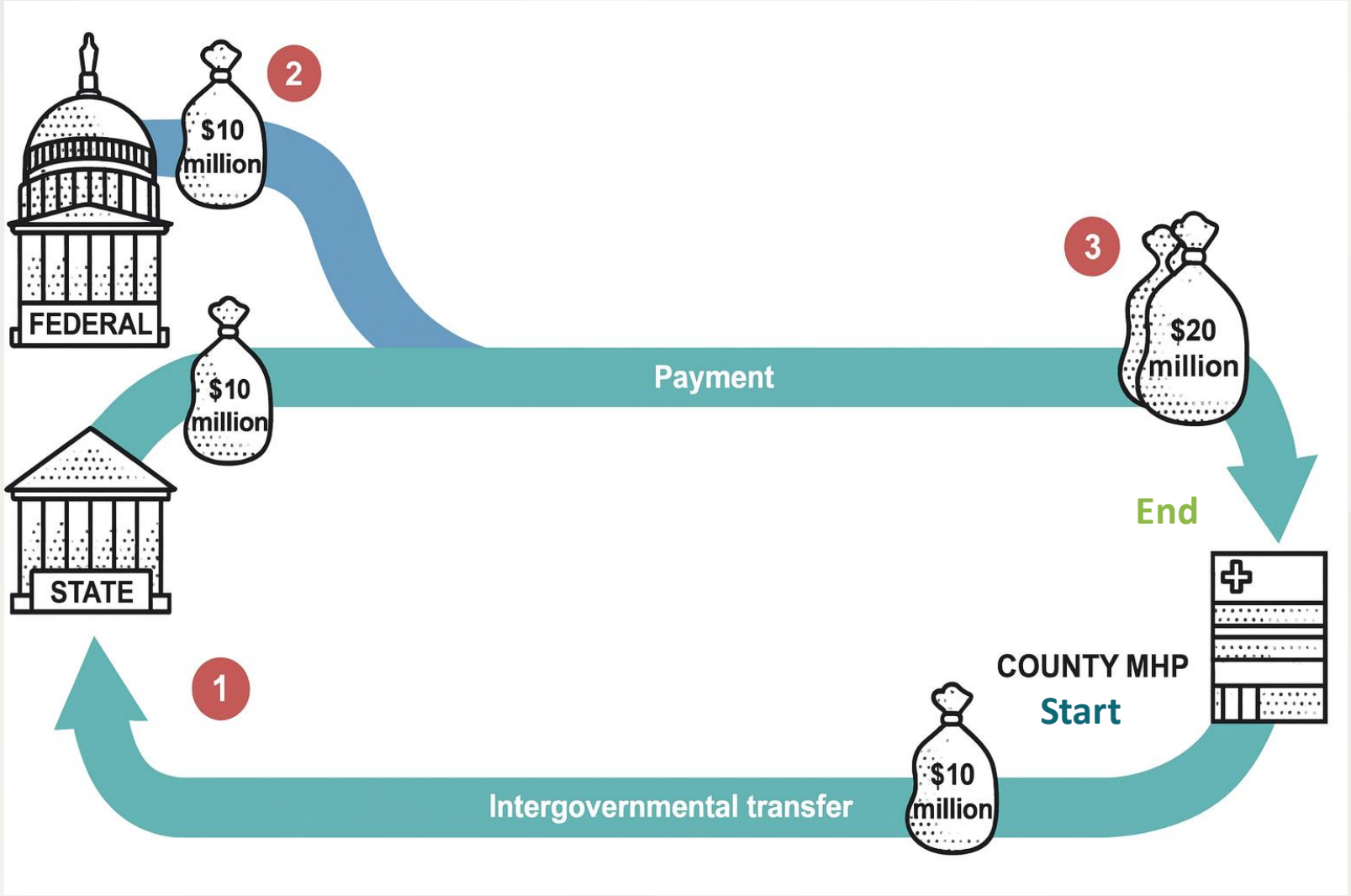
- Intergovernmental Transfer (IGT): A transfer of county funds to DHCS, used as the non-federal share for Medi-Cal claims.

How Does It Work?

- Counties deposit funds, in advance, into a County Fund Account (CFA) at DHCS using three primary funding sources: 1991 Realignment, 2011 Realignment, and MHSA.
- When a claim is approved, DHCS (1) debits the county's CFA for the non-federal share, (2) draws down federal funds and, (3) if applicable, state funds.
- DHCS issues a payment to counties for the Medi-Cal services and the revenue received is called Patient Care Revenue. This payment is equal to the full fee schedule amount, and this payment is a mix of funds consisting of:
    - Funds debited from the county's CFA,
    - FFP from the federal government, and
    - SGF from the state when applicable.

Knowledge Check:
Before we wrap up this section by defining Medi-Cal Patient Care Revenue, let's review a few IGT Payment scenarios.

IGT Payments & The County Funds Account



IGT Reimbursement Scenarios

Regular Aid Code

$100 SMHS claim

FFP: $50
SGF: $0
County (CFA): $50
Funding mix:
50% FFP / 0% State / 50% County

Regular Aid Code + HV Modifier

$100 SMHS claim with HV

FFP: $50
SGF: $25
County (CFA): $25
Funding mix:
50% FFP / 25% State / 25% County

ACA Aid Code

$100 SMHS claim

FFP: $90
SGF: $10
County (CFA): $0
Funding mix:
90% FFP / 10% State / 0% County

Note: These serve as examples based on a point in time reference to the SD/MC Aid Code Master Chart & SMHS Billing Manual. Always confirm current DHCS regulations and policy documents concerning actual claiming & reimbursement determinants.

Medi-Cal Patient Care Revenue

Merging a mix of funds into a single revenue source

Definition:

- Medi-Cal Patient Care Revenue is the total payment received by the county for approved Medi-Cal claims. This payment merges the federal share (FFP), any applicable state share, and the county share (from the CFA) into a single, final payment.

How should it be treated?

- Counties may book the full payment as “Medicaid revenue” or “patient care revenue” in one account—there is no requirement to hold the federal and local shares separately. However, counties should still be able to identify and track the subcomponents (FFP, state-share, and county/local share) for budget forecasting and reporting purposes, since part of the payment is self-financed with local funds.

Medi-Cal Patient Care Revenue

Permissible Uses

- Cover county expenditures for behavioral health services.
- Reimburse contractors and providers.
- Fund behavioral health-related services and activities that benefit Medi-Cal patients.
- Provide IGTs for future Medi-Cal claims (at county discretion, consistent with federal law).

California W&I Code §14184.40(c)

"…The total intergovernmental transfer-funded payment amount, which includes the federal and nonfederal share, paid to a Medi-Cal behavioral health delivery system shall be for the support of behavioral health-related services and activities that benefit patients served by the Medi-Cal behavioral health delivery system, consistent with federal law."

Special Consideration: MHSA

The information contained herein is primarily derived from BHIN 23-026

- MHSA funds sent to the County Funds Account (CFA) are not considered spent at the time of transfer.
- MHSA dollars are only counted as expended when DHCS releases payment to the county for approved Medi-Cal claims that use those funds as the nonfederal share.
- Key Points to Remember:
  - MHSA funds can be used as the nonfederal share for Medi-Cal claims.
  - Revenue generated from these claims can be reinvested anywhere within the behavioral health delivery system. It **does not need** to return to the original MHSA component that funded the claim.
  - However, the MHSA-funded nonfederal share cannot exceed the county's gross payment to the contracted provider (CBO) or the county's own cost to deliver the service – see IGT scenarios 1 & 2
  - Any interest earned on MHSA funds in the CFA, before those funds are spent on approved claims, must be reinvested according to MHSA policy.

MHSA IGT Scenario 1

Gross payment to the provider exceeds the nonfederal share

$70 paid to CBO for SMHS
$100 SMHS claimed
$50 FFP Paid
$50 nonfederal share

Gross Payment: $70
Nonfederal Share: $50
Difference: $20

MHSA IGT Scenario 2

Gross payment to the provider Is less than the nonfederal share

$40 paid to CBO for SMHS
$100 SMHS claimed
$50 FFP Paid
$50 Nonfederal Share

Gross Payment: $40
Nonfederal Share: $50
Difference: ($10)

Recap

- Medi-Cal is California's Medicaid program: Counties deliver SMH & SUD services, bill DHCS, and receive blended payments.
- Claiming has shifted from cost-based to prospective fee schedule, eliminating retroactive cost settlements & related recoupments.
- Funding mix that composes a payment is driven by a variety of factors including aid codes and modifiers.
- Counties receive a single patient care revenue payment that can be booked as one revenue source, but counties should ensure they can tie it back to the component parts.
- Medi-Cal Patient Care Revenue must be used for covering the cost of delivering services, reimbursing contracted providers, investments that support the BH delivery system, or as IGT match.
- MHSA/BHSA funds used for IGT purposes require special considerations.
- Understanding these mechanics is critical for forecasting your county's Medi-Cal revenue.

Finally!

Now that we've laid the foundation, let's dive into some practical knowledge building to help you forecast Medi-Cal revenues

Medi-Cal Revenue Forecasting

A COMPREHENSIVE LOOK AT THE EXPENSES THAT GO IN, THE REVENUE THAT COMES OUT, AND HOW TO PREDICT THE COUNTY'S TOTAL SHARE

Revenue & Expense Forecasting

Down the rabbit hole…
Estimating future changes can be an unending task, but it's worth identifying the major ways that the projected period differs from the historical period.

- Historical Data
- Under-Reporting Adjustment
- Estimate Denials
- Known Changes (e.g., Rate Increase from DHCS)
- Estimate Future Changes
- Final Projection

Aligning assumptions in revenue and expense projections (e.g., volume of clients) improves accuracy

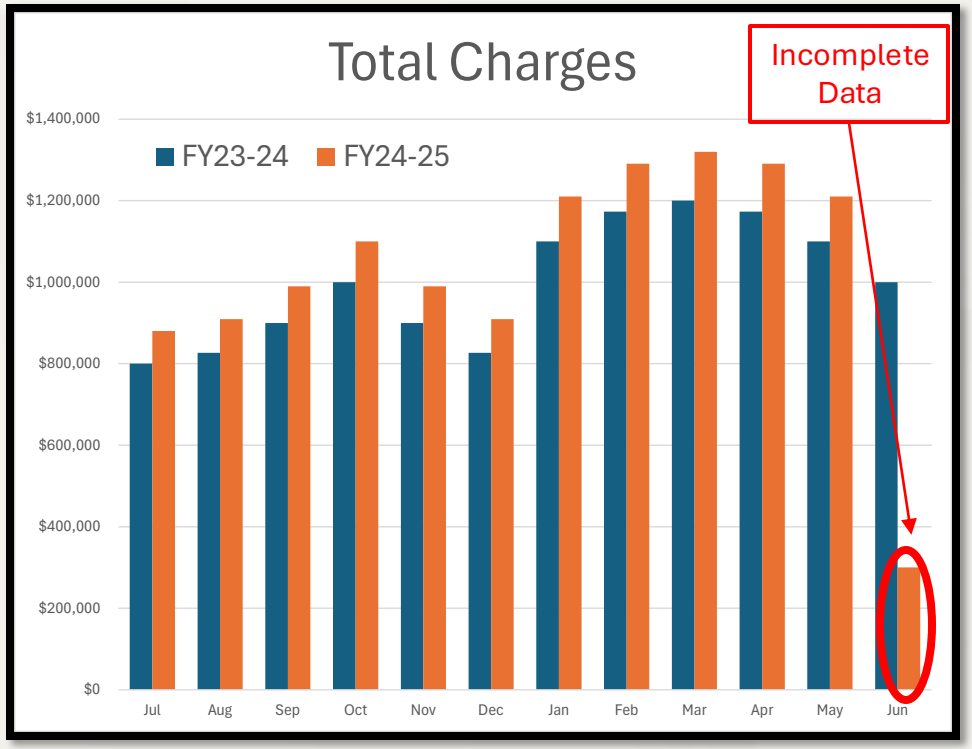
Historical Data, Under-Reporting and Denials

- To predict the future, start with the past
- Use 12 months of data, as utilization can be seasonal, and a partial year could distort results
- Review data by month, in total volume and by status (accepted / denied/ pended), to understand the completeness of your data set.

Historical Data, Under-Reporting and Denials (cont.)

Consider using an older complete year if recent months are incomplete

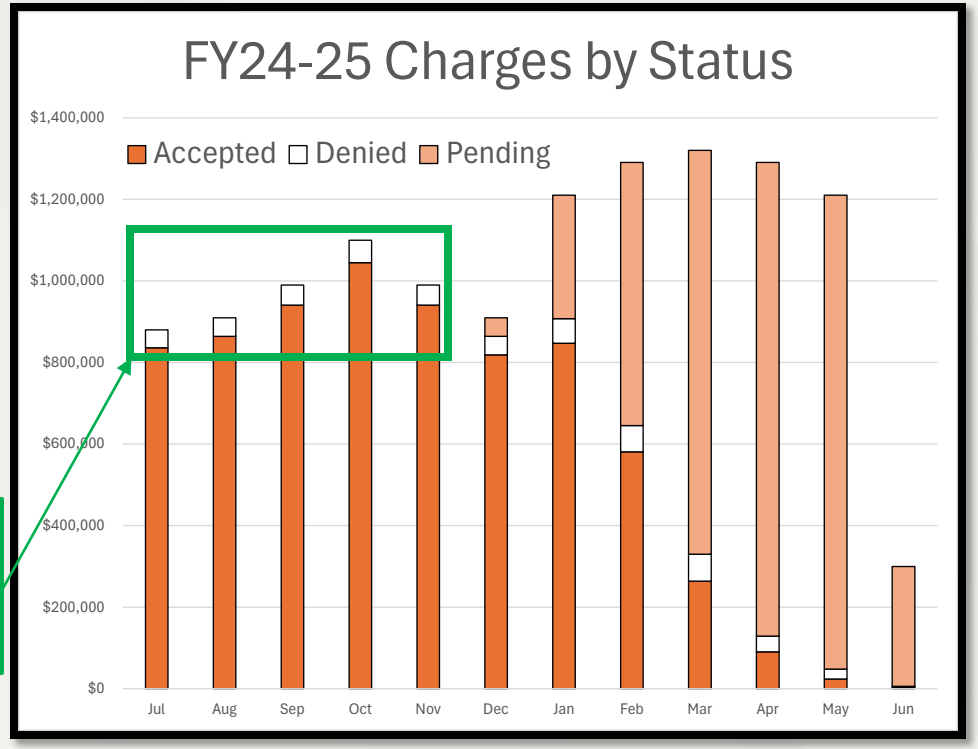
- Calculate an expected denial rate to apply to pending claims.



Historical Data, Under-Reporting and Denials (cont.)

Calculate an expected denial rate to apply to pending claims.

Older data where pending claims are sorted out can give a realistic estimate for a denial rate



Known Changes

Known changes are measurable and do not require estimation to apply.

Examples:

- DHCS rate increases
- Effective July 1, 2024 – DHCS increased rates 3%
- Effective July 1, 2025 – DHCS increased rates 3%

Example of application:

- Your county is using historical claim data from April 1, 2024 through March 31, 2025. This spans two fiscal years and you want to use this to project FY25-26 claiming – how does your analysis reflect future claim totals?

Solution: apply the proper rate increase to the historical period(s) to ensure your analysis accounts for the known changes.

	Charges (Unadjusted)	Factor to Convert Charges to FY25/26 Basis	Charges (Adjusted to FY25/26 Basis)
Apr 24	$930,037	1.06	$985,839
May 24	$1,080,168	1.06	$1,144,978
Jun 24	$924,255	1.06	$979,710
Aug 24	$1,042,528	1.03	$1,073,804
Sep 24	$1,021,278	1.03	$1,051,916
Oct 24	$953,551	1.03	$982,158
Nov 24	$906,988	1.03	$934,198
Dec 24	$1,041,793	1.03	$1,073,047
Jan 25	$1,002,143	1.03	$1,032,207
Feb 25	$953,637	1.03	$982,246
Mar 25	$1,097,779	1.03	$1,130,712

These months need a 6% adjustment:

+3% from 23/24 to 24/25 (Apr – Jun, 2024), and

+3% from 24/25 to 25/26 (Aug – Mar, 2025)

Future Changes

- The future period will differ from the past period. How much of that can you predict?
- Examples of future changes:
  - Policy change of a CBO to increase session length from 50 minutes to 53 minutes.
  - HR 1 (“One Big Beautiful Bill”) enrollment changes due to work requirements.
  - Sunsetting of Medi-Cal for all.
  - Transition from cost reconciliation to fee-for-service.
    - New transition or continued effects from transition two years ago.
  - County policy change that increased CBO financial responsibility for correctly submitting claims.
  - Changes in county’s capacity to deliver services.
  - Changes in demand of services.
- *“All models are wrong, but some models are useful.”* – George Box (statistician)
- You don’t have to predict everything. Focus on (1) major impacts, and (2) easier items for which you have supporting data

CBO Policy Change Example

- Partway through your historical period, one of your CBOs increased their standard session from 45 minutes to an hour. Their charges went up significantly as a result.
- You believe this will be their standard operating procedure going forward.
- Your county has $700,000 in annual charges. How do you determine a good estimate for this policy change?

Step 1: Drill down in your data:

	Charges (Apr 24 – Mar 25)
★ CBO A	$390,000
CBO B	$200,000
CBO C	$110,000
Total	$700,000

Step 2: Adjust your data to reflect the new policy:

Your new total charges for your forecast is **$780,000** ($700,000 - $390,000 + $480,000).

CBO A Charge Data

	Procedure Code		
	90834	90837	Total
Apr 24	$30,000		$30,000
May 24	$30,000		$30,000
Jun 24	$30,000		$30,000
Jul 24	$30,000		$30,000
Aug 24	$30,000		$30,000
Sep 24	$30,000		$30,000
Oct 24	$30,000		$30,000
Nov 24	$30,000		$30,000
Dec 24	$30,000		$30,000
Jan 25		$40,000	$40,000
Feb 25		$40,000	$40,000
Mar 25		$40,000	$40,000
Total	**$270,000**	**$120,000**	**$390,000**

	Procedure Code		
	90834	90837	Total
Apr 24		$40,000	$40,000
May 24		$40,000	$40,000
Jun 24		$40,000	$40,000
Jul 24		$40,000	$40,000
Aug 24		$40,000	$40,000
Sep 24		$40,000	$40,000
Oct 24		$40,000	$40,000
Nov 24		$40,000	$40,000
Dec 24		$40,000	$40,000
Jan 25		$40,000	$40,000
Feb 25		$40,000	$40,000
Mar 25		$40,000	$40,000
Total	**$0**	**$480,000**	**$480,000**

Medi-Cal for All Policy Change Example

- No new enrollees will be accepted to Medi-Cal for All starting on Jan 1, 2026, but existing members will be allowed to maintain enrollment.
- The state fully funds Medi-Cal for All clients (100% SGF); for all other clients, assume the FMAP is 50%.
- How will the county's revenue (i.e., amount of FFP) be affected in FY26-27?

Your revenue forecast (before adjusting for Medi-Cal for All enrollment loss), looks like this:

	Charges	FMAP	Revenue
Medi-Cal for All	$2,000,000	0%	$2,000,000
Other Programs	$8,000,000	50%	$4,000,000
Total	$10,000,000	60%	$6,000,000

Now you realize that your Medi-Cal charges and revenue are overstated because you based your projection on historical data when Medi-Cal for All was unrestricted.

Solution: **Estimate the loss of membership and scale down your charges accordingly.** Using historical unique clients for this population you learn that within one year 40% of members will disenroll. Assuming that happens evenly throughout the year, that's a 20% reduction to apply to Medi-Cal for all. Revised estimate:

	Charges	FMAP	Revenue
Medi-Cal for All	$1,600,000	0%	$1,600,000
Other Programs	$8,000,000	50%	$4,000,000
Total	$9,600,000	↓ 58%	$5,600,000

The average FMAP went from 60% to 58%, meaning the county share increased from 40% to 42%, or 5%!

Crisis Stabilization Unit (CSU) Example

- For the first time ever, your county will have a 12-bed CSU
- You received a rate from DHCS of $300/hour, and you have negotiated to pay the CBO in charge of your CSU $250/hour
- Let's assume you will receive 50% FMAP on these services
- How do you project the charges, revenues and expenses on this entirely new benefit with no historical data?

Solution: Combine the **known** rates (from DHCS and to CBO) with estimates for the **unknown** utilization.

Estimate utilization:

- CSU is expected to have 12 beds
- From researching comparable facilities, you estimate that the facility may run at 70% capacity and the average client will stay for 10 hours
- $Annual\ Service\ Hours = 12 \times 70\% \times 10 \times 365 = 30{,}660$

Apply utilization to cost figures:

- $Total\ Charges = 30{,}660 \times \$300 = \$9{,}198{,}000$
- $Total\ Revenue = \$9{,}198{,}000 \times 50\% = \$4{,}599{,}000$
- $Total\ Expenses = 30{,}660 \times \$250 = \$7{,}665{,}000$
- $Net\ Fiscal\ Impact = \$3{,}066{,}000$

Putting It Into Practice

FROM CONCEPT TO PRACTICE: MEDI-CAL REVENUE FORECASTING

Walkthrough Excel Example

We'll now move over to a set of sample data to walk through the application of Medi-Cal revenue forecasting using a set of similar scenarios.

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Q&A

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Thank You!

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CalMHSA