March 6, 2020

Via Email: Jacey.cooper@dhcs.ca.gov
Attention: Jacey Cooper, State Medicaid Director and Chief Deputy Director of Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899

RE: Behavioral Health Payment Reform: Rate Setting, Peer Groupings, and Intergovernmental Transfers

Dear Ms. Cooper,

The California Children's Trust (CCT) and the California Alliance of Child and Family Services (Alliance) are pleased to submit comments in response to the California Advancing and Innovating Medi-Cal (CalAIM) initiative led by the Department of Health Care Services (DHCS). The CCT represents a broad statewide coalition of stakeholders committed to addressing the children's behavioral health crisis in California. The Alliance is a statewide association of more than 145 nationally accredited, private nonprofit agencies dedicated to achieving progressively better outcomes for vulnerable children, youth and families in public human services systems.

We want to reiterate our support of CalAIM's proposed move from Certified Public Expenditure (CPE)-based funding to Intergovernmental Transfer (IGT)-based funding. This evolution creates invaluable opportunities to increase access for Medi-Cal beneficiaries. We believe that with this proposal, counties and providers will be able to maximize local funding sources as a means of increasing federal match. In addition, we believe this proposal will fundamentally transform the state's overly burdensome documentation demands with an efficient reimbursement process based exclusively on the federal CMS requirements.

We are concerned that to narrow the interpretation of the IGT mechanism runs the risk of having only marginal impact. This methodological change must account for all costs (direct and indirect) and it must serve as strategy to incentivize collaboration across child serving systems.

Our comments in this letter focus on items discussed at the Behavioral Health Payment Reform Workgroups on February 4th and February 27th including rate setting, peer groupings, and intergovernmental transfers.

Reimbursement rates not based solely on previous cost reports

We strongly recommend that, in addition to previous cost reports, DHCS incorporate additional factors when developing behavioral health reimbursement rates. These factors, which we discuss below, will help ensure that rates: 1) ameliorate existing inequities in access to care and 2) reflect the true costs of delivering services in that region.

We have two key concerns with DHCS's proposal to base new reimbursement rates solely on counties' previous cost reports. First, rates based on historical county Medi-Cal spending patterns will perpetuate the profound inequities in access to care that currently exist between California MHPs. Specialty Mental Health System (SMHS) rates often correlate directly with access to care for eligible youth. Based on comparisons of the Performance Outcomes Systems data[1] and DHCS reports on County Interim rates[2], there are likely impacts on penetration rates that correlate with a county's reimbursement rate. As DHCS and its system partners work to increase access to care throughout California, use of this type of data will be helpful to reference as it set benchmarks for penetration rates.

Second, it is not fully clear how administrative costs are distributed under the current reimbursement system. The county interim rates vary significantly from one county to the next, and some of these differences appear to be explained by differences in administrative costs claimed by each county. CCT and the Alliance are concerned that as DHCS redesigns the Medi-Cal system that we do not perpetuate past practices that lead to some counties and CBOs receiving inadequate reimbursement that does not support the real administrative costs associated with high quality care. There may be additional information regarding this large variance in rates, but it is not obvious in reviewing the statewide information that is available. These significant differences in county rates highlight the need for more transparent accounting of county expenditures for administrative and direct service activities. Without this information,

[1] https://www.dhcs.ca.gov/provgovpart/pos/Pages/September-2018-County-Level-Aggregate-Reports.aspx
[2] https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx

it is difficult to know whether county cost reports represent the best measure of the true costs of delivering care.

In light of these concerns, we urge DHCS to incorporate additional factors when setting peer group reimbursement rates. These factors could include:

1) **Counties with lower penetration rates**

As DHCS has emphasized, a primary goal of CalAIM is to expand access to care. As noted above, lower county reimbursement rates often correlate with lower county penetration rates. Higher reimbursement rates in these areas would enable counties to devote more resources to outreach and enrollment efforts.

2) **Counties with greater network adequacy challenges**

Counties that have particularly severe network adequacy challenges should also receive higher reimbursement rates. The ten counties who received financial penalties due to their inability to meet network adequacy requirements, for example, must be able to offer rates high enough to attract more critically needed mental health professionals. Mental Health Provider Shortage Areas provide a similar mechanism for identifying regions that most need rate increases.

3) **Criteria similar to those used to distribute Mental Health Service Act funds**

We encourage DHCS to draw from the criteria already developed by state policymakers to distribute MHSA funds. These criteria could include the percentage of the population living below the poverty level, the prevalence of mental illness in the region, cost of living measures such as the cost of being self-sufficient in the region, and resources available in the region. This would assist in "leveling the playing field" and the rates would assist counties to build the infrastructure and network needed to improve access to services.

<u>Reimbursement for County Administrative Costs</u>

We support the option of paying counties an administrative fee based upon a percentage of the service provided (Option 2 proposed at the Payment Reform Workgroup on February 27). Compared to the option of paying a per utilizer per month fee, a fee based on a percentage of the service costs will incentivize counties to provide all necessary services to each utilizer. In addition, we support the option to pay counties a Utilization Review/Quality Assurance fee that

is separate from the administrative services fee. As DHCS implements this new transitional payment structure on its way to payment reform, we provide the following recommendations:

- **DHCS should issue guidance to plans regarding administrative costs and their contractual relationships with providers**

The wide variation across the state of county and provider rates noted above suggests that guidance from DHCS could be helpful in gaining more consistency for provider organization rates for services. Structuring contracts so that providers also have access to administrative supports, quality improvement and other critical infrastructure needs in addition to service delivery will lead to a stronger and higher quality system throughout the state.

- **Maximize federal matching funds for mental health services**

We urge DHCS to take full advantage of the opportunities created by CalAIM to maximize Federal Financial Participation (FFP) for mental health services. We applaud DHCS's strong advocacy on this issue in its January 28, 2020 letter opposing CMS efforts to restrict the available sources of local matching funds, and we encourage DHCS to draft the 1915(b) waiver with language that preserves all potential sources for non-federal matching funds.

To date, some counties have been much more successful than others in leveraging Realignment funds to earn increased FFP. A comparison of FFP generated by each county in FY 2017-2018 indicates that while some counties earned only about 50 cents in FFP for every dollar they received from the Department of Finance, other counties earned more than $1.30 for every dollar they received.[3] These data illustrate the tremendous potential for strengthening our mental health service system by implementing strategies to more effectively leverage FFP.

- **Support for counties to generate additional sources of local matching funds**

Increased technical assistance from DHCS will be critical to help counties identify additional sources of local matching funds for Medi-Cal services. One Bay Area county, for example, has drawn from multiple sources of non-federal matching funds, including the Tobacco Settlement and the California Children and Families Act (Proposition 10). In the longer term, the state can

[3] Source: County Cost Settlement Summaries (MH1992 Sum) and State Controller's Office Apportionment and Allocation reports for 2010-2011 through 2017-2018. Data compiled and presented by Patrick Gardner, JD, Young Minds Advocacy: Realignment's Impact on Medi-Cal's Specialty Mental Health Program for Youth.

play an essential role in encouraging counties to build partnerships with other child-serving systems, such as school districts and juvenile justice programs, in order to create new sources of local matching funds.

- **Provide technical assistance to counties on strategies to claim MAA program funds**

As mentioned above, only a small portion of California counties -- about 14 -- have made the investments necessary to claim MAA program funds. Yet this strategy can bring profound increases in federal matching funds. Alameda County, for example, was able to increase its MAA funding between 2004 and 2014 from $3 million to $17 million.[4] By dramatically increasing its access to MAA funds, Alameda was able to invest in more outreach, enrollment and program planning activities and achieve a relatively high penetration rate of 5.7%.

Translation services must be fully funded

To minimize barriers to care, DHCS should ensure that translation services are reimbursable, regardless of whether they are provided by clinical or non-clinical staff. Currently, however, translation services provided by non-clinical staff are limited. As some CBOs that serve historically underrepresented and underserved communities have shared, billing Medicaid for reimbursement for translation services is successful and largely tied to how skilled a provider is in writing a note. Yet, translation services are critical parts of providing quality culturally responsive care. Medi-Cal providers are required to provide translation services to beneficiaries who need them,[5] and the federal government has confirmed that all translation services may be billed as an administrative expense, or, for oral translation services, in 15 minute increments with the CPT code T1013.[6]

Service providers (county and CBOs) must be fully compensated for actual travel time

In order to ensure access to the full array of EPSDT benefits, providers must have the capacity to meet with children and families in their homes and communities. Community-based services will only remain viable if **staff travel is reimbursed at the same rate as the underlying service** provided, as it is currently. To ensure DCHS can gather data regarding service delivery time that is separate from travel time, providers could bill travel time with an "add-on" HCPCS billing code that is linked to the underlying service.

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[4] Millions Unclaimed: Behind California's Troubled Mental Health Care Funding System, Chronicle of Social Change

[5] Language Access Services for Limited-English Proficient and Non-English Proficient Individuals, All County Letter, No. 10-3.

[6] Translation and Interpretation Services,Medicaid.gov.

In order to provide care that is truly accessible, providers must be able to cover the staff costs associated with traveling to work with clients where they live, attend school, and play. Any reimbursement system that offers a set rate for travel -- regardless of the actual time spent in transit -- will jeopardize the feasibility of community-based care.

In addition, by enabling providers to bill for the full time spent travelling with a separate billing code, DHCS will be able to gather data regarding the actual travel times required for each type of mental health service. These data will be essential to the development of capitated rates for Full Integration Plans that accurately reflect the costs of delivering accessible, community-based care.

Providers should receive at a minimum 75% of what the county claims for provider services

We recommend that DHCS require MHPs to pay providers at a minimum 75% of the rate for each service that the plan receives from the state. The Affordable Care Act (ACA) imposes a Medical Loss Ratio (MLR) of 85% for large group plans, limiting costs for administration, profit and marketing to 15%.[7] In Washington state, plans are required to limit their "administrative load" for WISE (Wrap around) services to just 6%.[8]

These requirements are critical to ensure provider participation in CalAIM. While we support the allocation in the governor's budget to help counties cover the additional costs associated with CalAIM, we urge DHCS to keep in mind that providers also will incur significant administrative costs associated with these new policies. Without rates that cover these additional administrative costs, many community-based providers will not be able to participate.

Payment Methodology (IGT Transfers)

We do not have a recommendation on the two options presented, but we want to reiterate points made earlier in this letter that whatever option is selected, **providers will still be paid timely and the lag from the IGT does not impact service providers.**

We do have concerns that the two choices being considered do not serve to maximize potential federal revenues due to local revenues being provided from MHPs without a larger statewide effort to develop a plan to utilize a broad range of state funding as match for FFP. While realignment may limit the state's ability to require that counties use certain local funds as

[7] Kaiser Family Foundation, Explaining Health Care Reform: Medical Loss Ratio (MLR)
[8] Washington BHO Rate Methodology FY 17/18, p. 15

match in the IGT formula, it does seem that a more detailed discussion regarding how to best leverage every state dollar as match should take place going forward.

Thank you for your consideration of these recommendations and comments, and for your work to improve our state's most important safety net for children and families. We look forward to next steps.

With appreciation,

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