

## Paying for Integrated Services: FQHC, Medi-Cal and other Funding Strategies

Presented by  
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## Assumptions about the Attendees

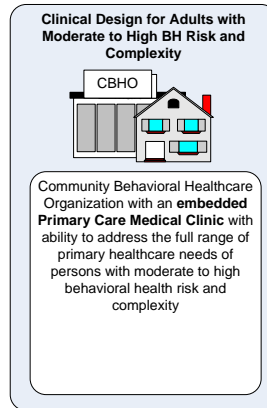
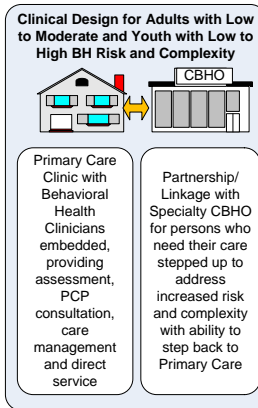
- You are ***somewhere in the process*** of integrating Primary Care (PC)/Mental Health (MH)/Substance Use (SU) services (planning or doing)
- You want to ***get paid*** for this work
- You are probably not a ***triple expert*** in how California financing is designed for FQHCs, Mental Health AND Alcohol & Drug Services
- You may or may not have run into the various ***financing barriers***
- You'd like to expand you knowledge in these areas in order to ***increase the likelihood of success*** for your integration project



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## Assumptions about the Attendees

- You are working on one or both parts of the **bi-directional model** of Integrated Care; but I'm going to assume both:
- You are attempting to provide Medical Services in MH/SU
- And MH/SU Services in Primary Care
- Using the 4 quadrant integration model and researched-based clinical designs such as the IMPACT model

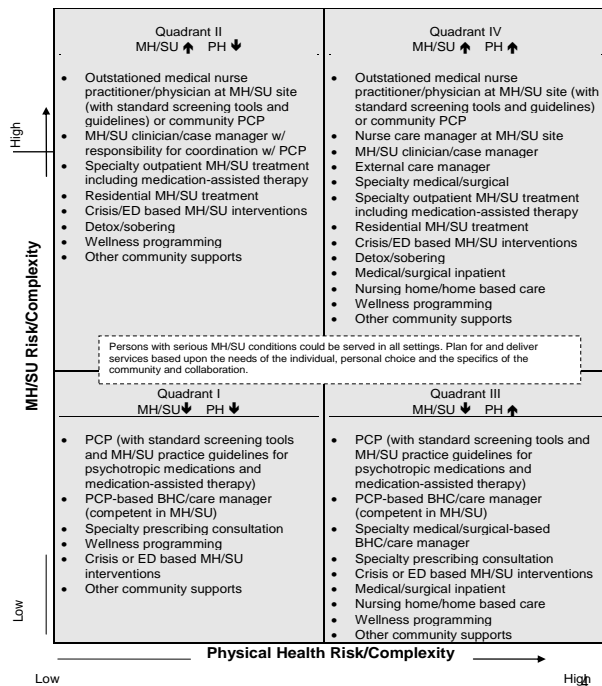


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## The 4 Quadrant Clinical Integration Model

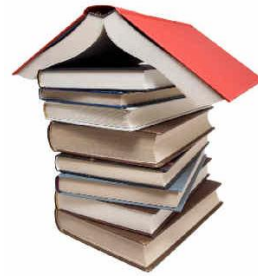
**Q I and III: MH/SU services in a Primary Care Clinic**

**Q II and IV: Primary Care services in a MH/SU Clinic**



## Three Chapters

- Basics of Current California Primary Care, Mental Health and Substance Use Financing
- How can we get Paid Today?
- How are we going to get Paid Tomorrow?
- Q&A

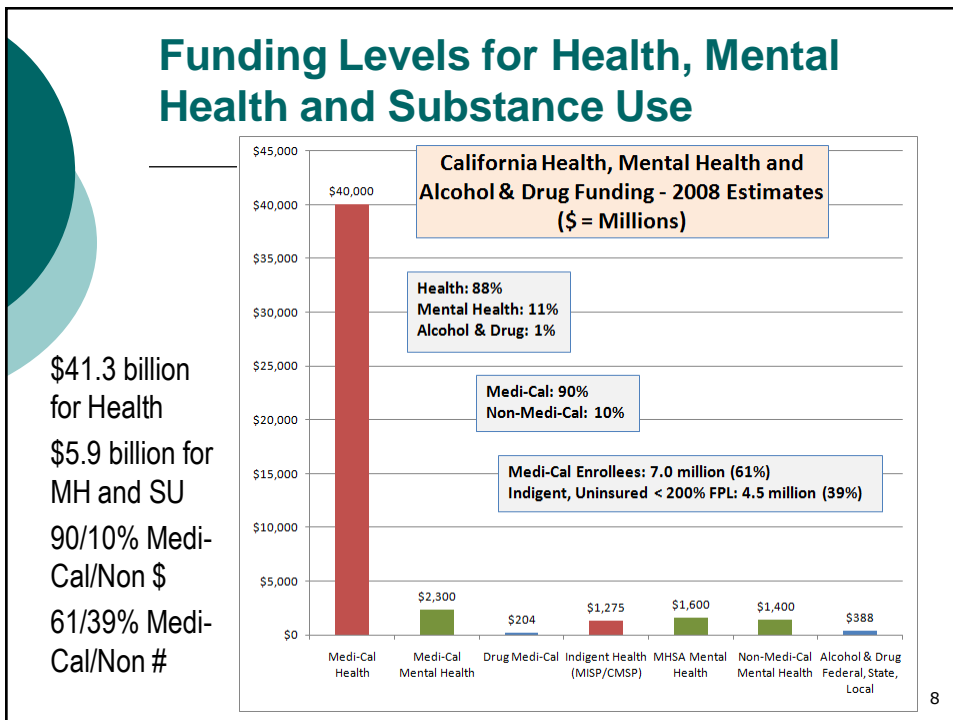
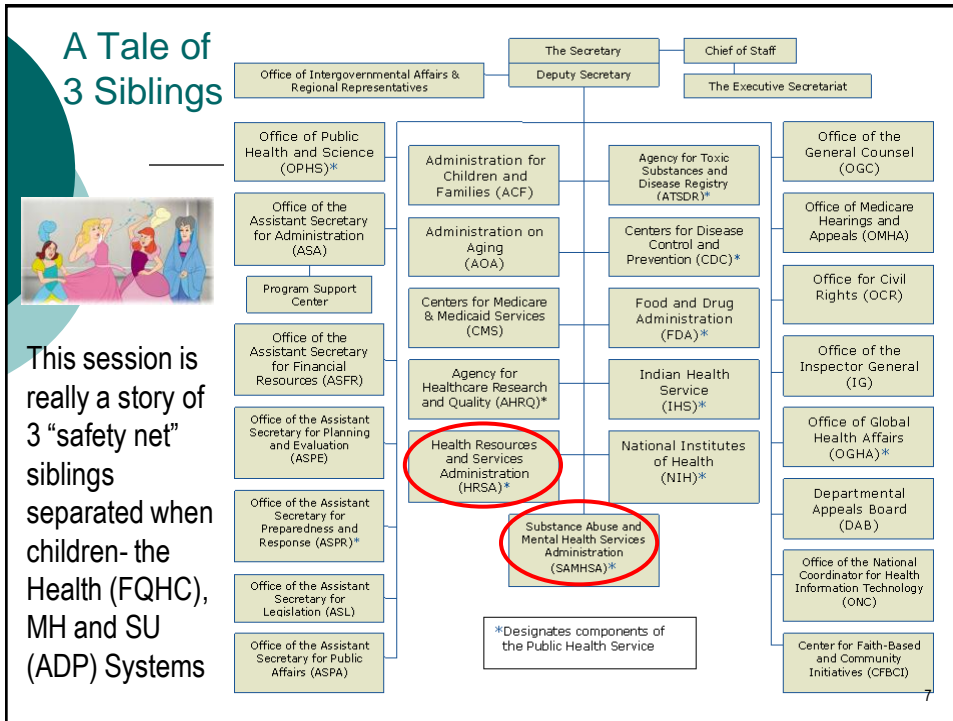


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## Basics of Current California Primary Care, Mental Health and Substance Use Financing



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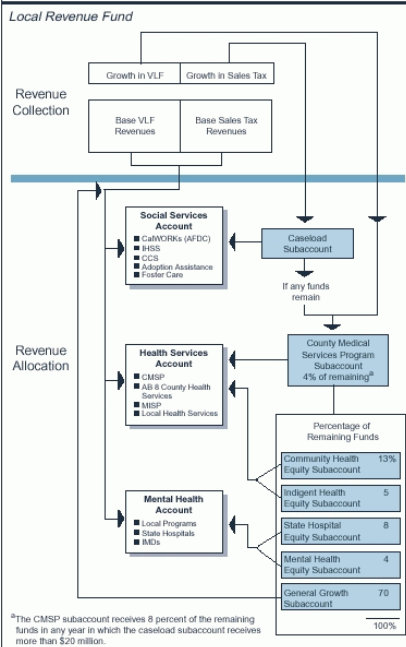
## Funding Flows for Health, Mental Health and Substance Use

	Priority Populations				Non-Priority Populations		
	ABD	Duals	SMI	CCS Youth	TANF	Hlthy Fam	Other
<b>Medi-Cal Funding</b>	Medi-Cal Health Services (\$40 Billion)				Mostly Managed Care	Mostly FFS	Mostly FFS
	<----- Mostly Fee For Service ----->						
	Medi-Cal Mental Health Services (\$2.3 Billion)						
	Co. MH Plans ("Pseudo-Capitated" due to Limits on Realignment to Cover Match)						
	Drug Medi-Cal (\$204 Million)						
	County Managed Fee for Service: State makes the Match						
<b>Non-Medi-Cal Funding</b>	Non-Medi-Cal MISP, CMSP Health Services						
	Locally or Regionally Managed (CMSP \$255 Million; MISP \$?)						
	MHSA Mental Health Services						
	Locally Managed (\$1.6 Billion)						
	Non-Medi-Cal Mental Health Services						
	Locally Managed and Long Term Care (\$1.4 Billion)						
	Non-Medi-Cal ADP Federal, State, Local						
	State and Locally Managed (\$388 Million)						

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Figure 2

### Allocation of Realignment Revenues



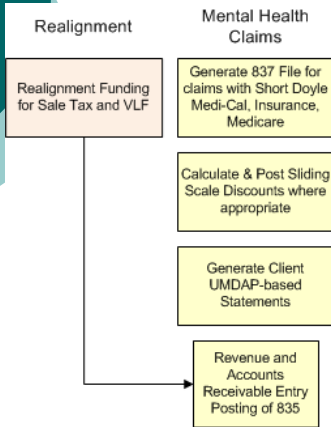
\* The CMSP subaccount receives 8 percent of the remaining funds in any year in which the case-load subaccount receives more than \$20 million.

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## Mental Health Cliff Notes: Funding

- California has 57 Medi-Cal Mental Health Plans that operate under contract with the California Department of Mental Health (Sutter-Yuba combined)
- Realignment funded through sales tax and vehicle license fees is combined with Federal Financial Participation (FFP or FMAP) to fund Medi-Cal Mental Health Services
- Realignment is also used, along with Mental Health Services Act (MHSA) monies to fund non-Medi-Cal services and non-Medi-Cal enrollees

## Mental Health Cliff Notes: Funding



- California’s Medi-Cal Mental Health funding is primarily Fee for Service with a Back End Cost Report Settlement Process
- Fees are capped by a Schedule of Maximum Allowable (SMA)
- Plus Funding for Administrative and Quality Assurance Activities
- Realignment and some MHSA serve as the state/local match; if you use them all up, you can’t draw down any more federal Medi-Cal dollars
- The majority of public mental health services in California are provided by County Employees, supplemented by Other Community Providers

## Mental Health Cliff Notes: MHSA

Mental Health Service Act passed in November 2004 via Proposition 63, increasing funding to support county mental health programs

- The MHSA imposes a 1% income tax on personal income in excess of \$1 million generating over \$1 billion per year
- Targeted Funding to six categories
- Non-Supplantation: “The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services.”
- With this funding, California only has roughly half the funding needed to meet demand

	Fiscal Year		
	Actual Receipts	Estimated Receipts	Projected Receipts
	2007/08	2008/09	2009/10
Community Services and Supports (Excluding Innovation)	\$784.8	\$960.3	\$1,006.0
Workforce Education & Training	\$150.2	\$0.0	\$0.0
Capital Facilities and Technological Needs	\$150.2	\$0.0	\$0.0
Prevention & Early Intervention (Excluding Innovation)	\$285.4	\$240.1	\$251.4
Innovation	\$56.3	\$63.3	\$66.2
State Administration	\$75.1	\$66.5	\$69.8
<b>Total Estimated Revenue Receipts</b>	<b>\$1,502.0</b>	<b>\$1,330.2</b>	<b>\$1,393.4</b>

State	Total State Mental Health Revenue	Target # of Persons to Serve/Year	Revenue per Target Client	Rank	\$ Over (Under) Top 10 Average	% Over (Under) Top 10 Average
Pennsylvania	\$3,332,904,698	544,949	\$6,116	1	\$1,644	37%
Maine	\$464,300,000	76,362	\$6,080	2	\$1,608	36%
District of Columbia	\$229,400,000	38,093	\$6,022	3	\$1,550	35%
Alaska	\$183,200,000	33,512	\$5,467	4	\$995	22%
New Hampshire	\$166,100,000	38,394	\$4,326	5	-\$146	-3%
Maryland	\$810,000,000	233,097	\$3,475	6	-\$997	-22%
New Jersey	\$1,241,600,000	365,082	\$3,401	7	-\$1,071	-24%
Minnesota	\$721,100,000	213,635	\$3,375	8	-\$1,096	-25%
Vermont	\$122,500,000	36,426	\$3,363	9	-\$1,109	-25%
New York	\$3,982,300,000	1,287,434	\$3,093	10	-\$1,379	-31%
<b>Top 10 Average</b>			<b>\$4,472</b>			
Montana	\$137,500,000	51,778	\$2,656	11	-\$1,816	-41%
Wisconsin	\$600,400,000	230,727	\$2,602	12	-\$1,870	-42%
Wyoming	\$52,600,000	22,248	\$2,364	13	-\$2,108	-47%
Iowa	\$299,300,000	133,468	\$2,242	14	-\$2,229	-50%
Arizona	<del>\$977,900,000</del>	<del>447,063</del>	<del>\$2,187</del>	<del>15</del>	<del>-\$2,284</del>	<del>-51%</del>
California	\$5,300,000,000	2,474,848	\$2,142	16	-\$2,330	-52%
Oregon	\$432,300,000	202,819	\$2,131	17	-\$2,340	-52%
North Carolina	\$1,105,400,000	530,609	\$2,083	18	-\$2,389	-53%
Michigan	\$1,010,000,000	485,839	\$2,079	19	-\$2,393	-54%
Washington	\$624,500,000	304,553	\$2,051	20	-\$2,421	-54%
Missouri	\$597,500,000	294,546	\$2,029	21	-\$2,443	-55%

## Alcohol & Drug Cliff Notes: Funding Overview



- A combination of many funding sources managed at the state or county level
- Each with their own set of restrictions and target populations
- Paid in a variety of ways and also includes a Cost Reporting Settlement Process
- Medi-Cal = 1/3, Federal Grants = 1/2, Other State = 1/6
- Funding levels are even further from approaching need than Mental Health
- And will be found to be significantly out of compliance with the new Parity Law, like many other states

## Alcohol & Drug Cliff Notes: Program Budget

California DADP Budget, FY2010-11						
	General Fund	Other State	Federal Grants & Reimburse-ments	Medi-Cal SGF	Medi-Cal FMAP	Total
Non-DMC Regular Services	\$5,189,000					\$5,189,000
Non-DMC Perinatal Services	\$20,448,000					\$20,448,000
Drug Court Partnership	\$7,106,000					\$7,106,000
Comprehensive Drug Court Implementation Act Prgm	\$16,217,000					\$16,217,000
Dependency Drug Court Program	\$4,548,000					\$4,548,000
Parolee Services	\$33,900,000		\$11,184,000			\$45,084,000
Drug Medi-Cal Regular				\$87,847,000	\$108,106,000	\$195,953,000
Drug Medi-Cal Perinatal				\$2,750,000	\$3,822,000	\$6,572,000
HIPAA				\$785,000	\$785,000	\$1,570,000
Residential & OP Program (ROPLF)	\$4,479,000		\$661,000			\$5,140,000
DUI Program	\$1,687,000					\$1,687,000
Narcotic Tx Program	\$1,418,000					\$1,418,000
Indian Gaming Special Distribution Fund	\$8,484,000					\$8,484,000
Audit Repayment Trust Fund	\$71,000					\$71,000
MHSA Prop 63	\$272,000					\$272,000
Gambling Addiction Program	\$166,000		\$125,000			\$291,000
SA Block Grant			\$256,797,000			\$256,797,000
SDFSC Grant			\$7,026,000			\$7,026,000
UDS			\$327,000			\$327,000
Access to Recovery Grant			\$4,839,000			\$4,839,000
SBIRT Grant			\$2,889,000			\$2,889,000
SEOW			\$157,000			\$157,000
Other			\$319,000			\$319,000
<b>Totals</b>	<b>\$87,408,000</b>	<b>\$16,577,000</b>	<b>\$284,324,000</b>	<b>\$91,382,000</b>	<b>\$112,713,000</b>	<b>\$592,404,000</b>
	15%	3%	48%	15%	19%	

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## Cliff Notes: Drug Medi-Cal Rates, FY2009

Program Code: 20 (Alcohol and Drug Services)

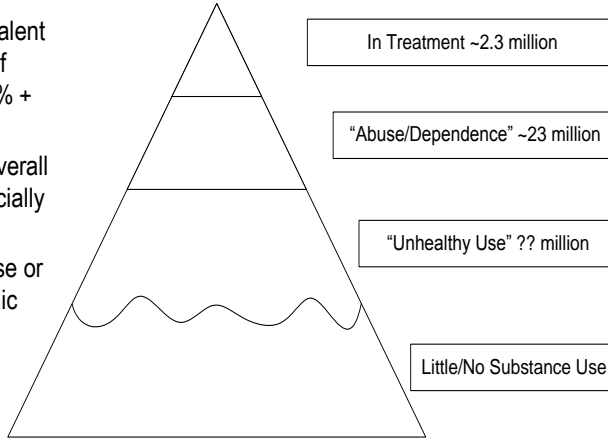
Description	Service Function Code	Unit of Service (UOS)	FY 2008-09 UOS Rate
Narcotic Treatment Program (NTP) - Methadone	20, 21	Daily	\$12.44
NTP - Methadone - SACPA Clients	22		1.14 (*)
NTP - Individual Counseling (**)	26	One 10-minute	\$15.00
NTP - Individual Counseling - SACPA Clients (**)	27	Increment	1.37 (*)
NTP - Group Counseling (**)	28	One 10-minute	\$3.49
NTP - Group Counseling - SACPA Clients (**)	29	Increment	0.32 (*)
Day Care Rehabilitative (DCR)	30 - 38	Face-to-Face	\$67.96
DCR - SACPA Clients	39	Visit	
Naltrexone (NAL) (***)	50 - 58	Face-to-Face	\$21.19
NAL - SACPA Clients (***)	59	Visit	
Outpatient Drug Free (ODF) Individual Counseling	80 - 83	Face-to-Face Visit	\$74.99
ODF Individual Counseling - SACPA Clients	84	(Per Person)	
ODF Group Counseling	85 - 88	Face-to-Face Visit	\$31.45
ODF Group Counseling - SACPA Clients	89	(Per Person)	

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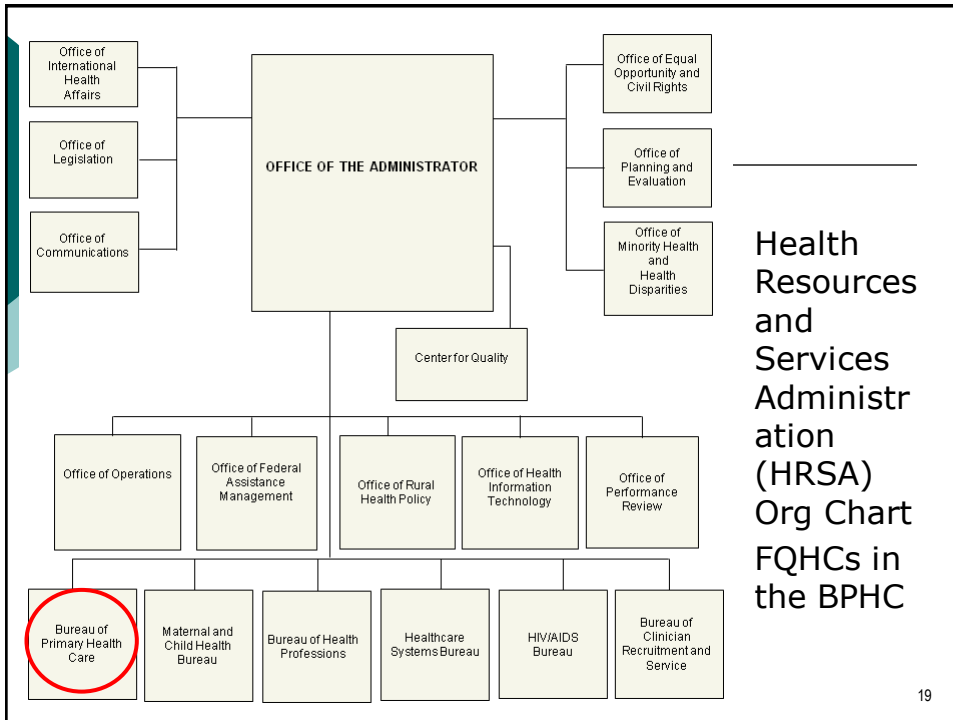
## Alcohol & Drug Cliff Notes: National Estimates & Issues

SU conditions are prevalent in primary care: Tens of millions (McLellan); 21% + (Willenbring)

- SU conditions add to overall healthcare costs, especially for Medicaid
- SU conditions can cause or exacerbate other chronic health conditions
- SU interventions can reduce healthcare utilization and cost



## FQHC Cliff Notes: Federal Program Managed by HRSA



## FQHC Cliff Notes: Definition of a Federally Qualified Health Center

An FQHC is an entity that receives a grant under Section 330 of the Public Health Service Act

- (1) **In general.** For purposes of this section, the term "health center" means an entity that **serves a population** that is:
  - medically underserved, or
  - a special medically underserved population comprised of:
    - migratory and seasonal agricultural workers,
    - the homeless, and
    - residents of public housing,
- by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements, **required primary health services**



## FQHC Cliff Notes: Five Types of FQHCs in Two Categories

An FQHC is:

- An entity that receives a grant under Section 330 of the Public Health Service Act – Health Center Program including:
  - Community Health Center Program – Section 330(e) note that school-based health centers must also meet these requirements, per PIN #2001-13
  - Migrant Health Center Program – Section 330(g)
  - Health Care for the Homeless Program – Section 330(h)
  - Public Housing Primary Care Program – Section 330(i)
- An entity that is determined by DHHS to meet requirements to receive funding without actually receiving a grant (i.e., FQHC “Look-Alike”)



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## FQHC Cliff Notes – Five Decades of Unfolding

<b>1960s</b>	<b>Migrant Health Act of 1962 for farm workers/families Economic Opportunity Act of 1964 funds CHCs</b>
<b>1970s</b>	<b>Section 330 of the Public Health Services Act - Community Health Center Program – Section 330(e) - Migrant Health Center Program – Section 330(g) National Health Service Corps begins</b>
<b>1980s</b>	<b>Health Care for the Homeless Program – Section 330(h) The 3 Types of CHCs become known as FQHCs FQHC Cost-Based Payments for Medicare &amp; Medicaid</b>
<b>1990s</b>	<b>Free Federal Tort Protection (Malpractice Insurance) Public Housing Primary Care Program – Section 330(i)</b>
<b>2000s</b>	<b>Prospective Payment System States Required to Cover Difference between Rates &amp; PPS Expansion of Funding and Capacity, adding BH Services</b>

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## FQHC Cliff Notes: California

- **California Primary Care Association** is designated by the **Federal Bureau of Primary Health Care** as the state primary care association and receives federal program support to develop and enhance services for 800+ member clinics; not all are FQHCs and County FQHCs are not members
- **California Department of Public Health**, Center for Health Care Quality licenses FQHCs
- **California Department of Health Care Services (DHCS)** interprets federal policy regarding FQHCs, with the bulk of the rule setting being done by Federal BPHC through PINs (Policy Information Notices) and PALs (Program Assistance Letters)



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## FQHC Cliff Notes: Payments

- **FQHC Medi-Cal Reimbursement: All Inclusive Rate Per Visit**
- **Visit = Face to Face Encounter** with an approved provider, providing an approved service, at an approved site
- FQHC Per Visit Payment = a **Prospective Payment (PPS)** that is adjusted annually based on Federal law
- California has a **wraparound process** for the PPS system—this is a reconciliation process for backfilling the difference between the PPS rate and what ended up being paid during the year through Managed Care, the Child Health and Disability Prevention program, and Medi-Medi Crossover visits
- Unlike some other states, California **does not** require the submission of annual Cost Reports



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## FQHC Cliff Notes: Benefits

### 1. Operating Grants

- Federal Grants to support the costs of uncompensated primary health care and enabling services delivered to uninsured and underinsured populations at sites within the approved scope of project

### 2. Medicaid Reimbursement

- Enhanced reimbursement under Prospective Payment System (PPS) or other state-approved alternative payment methodology; every service provided is a mandatory Medicaid service (i.e. can't get cut)

### 3. Medicaid Enrollment Workers

- The right to have Medicaid eligibility workers on site, or receive reimbursement for outstationed intake and enrollment conducted by Center personnel

### 4. Medicare Reimbursement

- PPS-type reimbursement by Medicare for the "first dollar" of services rendered to Medicare beneficiaries (deductible is waived)

### 5. Capital Improvements

- Access to Federal loan guarantees for developing and operating managed care and practice management networks or plans and capital improvements (including IT)

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## FQHC Cliff Notes: Benefits

### 6. Drug Pricing

- Access to favorable drug pricing under Section 340B of the PHS Act; centers that provide, or contract for the provision of, pharmaceuticals are entitled to favorable pricing from the drug manufacturers

### 7. Safe Harbor

- Safe harbor under the Federal anti-kickback statute for waiver of co-payments patients below 200% FPL; certain arrangements with other providers or suppliers of goods, services, donations, loans, etc.

### 8. FTCA Coverage

- Access to Federal Tort Claims Act (FTCA) coverage for the Center and its health care professionals, including certain contracted professionals in lieu of purchasing malpractice insurance

### 9. Recruitment

- Access to providers through the National Health Service Corps if the Center's service area is designated as a health professional shortage area

### 10. Quality Improvement

- The opportunity to participate in BPHC disease management learning models and the Health Disparities Collaboratives

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## FQHC Cliff Notes: Requirements

### 1. Eligible Entities

- Private, charitable, tax-exempt nonprofit organization or public entity; Note: FQBHC could add: plus Licensed or certified by the State in which it is located as a CMHC or SU Provider

### 2. Service Area

- In order for a primary care clinic to qualify for FQHC status, it must be located in a high need designated area (designated as a Medically Underserved Areas or Medically Underserved Population)

### 3. Target Population

- Each FQHC must identify the medically underserved population to be served; Note: FQBHCs will focus on residents with MH/SU disorders

### 4. Clinical Operations

- Must employ a core staff of clinical staff that is multi-disciplinary, and culturally and linguistically competent; must provide an agreed-upon set of clinical services directly or through contract

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## FQHC Cliff Notes: Requirements

### 5. Service Providers

- Providers are individual healthcare professionals who exercise independent judgment and document services in the patient's record; Note: FQBHC add language - peers and non-licensed providers to work under the oversight of a licensed provider

### 6. IT System

- Must have an IT system that is able to collect, organize and analyze data for reporting and to support management decision-making and submit the Uniform Data System (UDS)

### 7. Quality Improvement Activities

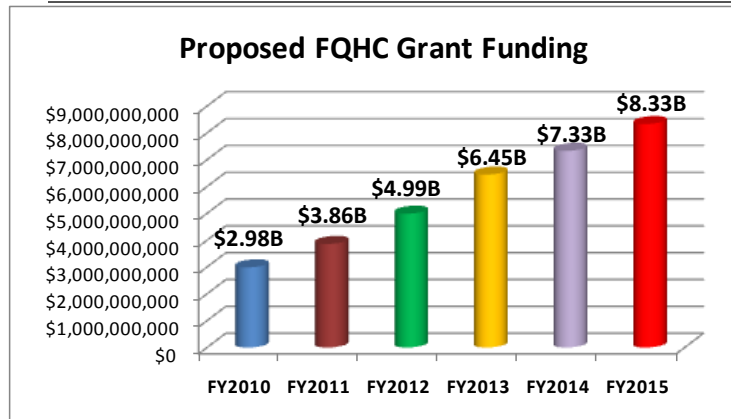
- FQHCs must participate in Health Disparities Collaboratives and other structured quality improvement activities

### 8. Productivity Expectations

- Physicians are expected to provide 4,200 encounters and midlevel clinicians 2,100 encounters per FTE per year

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## Where FQHC Funding is Headed



### Healthcare Reform Law – March 2010

- FQHCs are acknowledged as a critical component of healthcare reform
- Grant Funding will nearly triple over five years

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## On the Horizon? FQBHCs

- Language from the PPACA that didn't make it into the final bill but will likely resurface
- Possibly in the SAMHSA reauthorization process

“(c) CRITERIA FOR FEDERALLY QUALIFIED BEHAVIORAL HEALTH CENTERS.—

“(1) IN GENERAL.—The Administrator shall certify, and recertify at least every 5 years, federally qualified behavioral health centers as meeting the criteria specified in this subsection.

“(2) REGULATIONS.—Not later than 18 months after the date of the enactment of the Affordable Health Care for America Act, the Administrator shall issue final regulations for certifying centers under paragraph (1).

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## How can we get Paid Today?

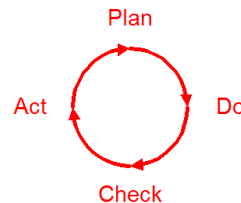


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## 6-Step Integration Game Plan

The emerging Best Practice involves developing a workgroup of local PC/MH/SU integration partners to:

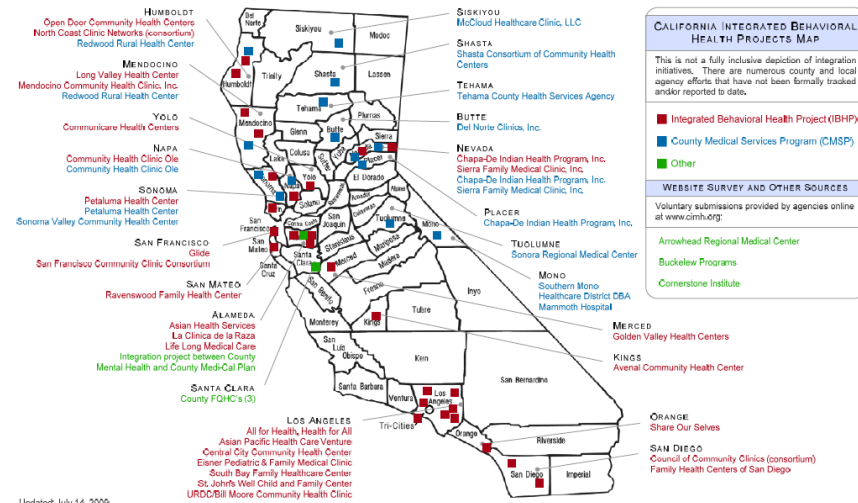
1. Design the **Clinical Model** you will implement (what works best for the patient/consumer)
  2. Identify and address the **Funding Barriers**
    - Draw on the Integration Policy Initiative Report (see next slide) and **local resources** to address barriers within your expertise
    - Get **additional help** to address the barriers you think may be solvable but can't figure out on your own
  3. Craft an **Integration Budget** based on this work, sorting what will be funded by PC/MH/SU
  4. Revise your **Business Processes** and **Obtain Necessary Approvals** to support the Clinical Design and achieve financial stability
  5. Design your **Implementation Plan** that covers all the necessary tasks
  6. Go for it, **monitoring and adjusting** your plan as you move forward
- Note: the IBHP toolkit has more details ([www.ibhp.org](http://www.ibhp.org))



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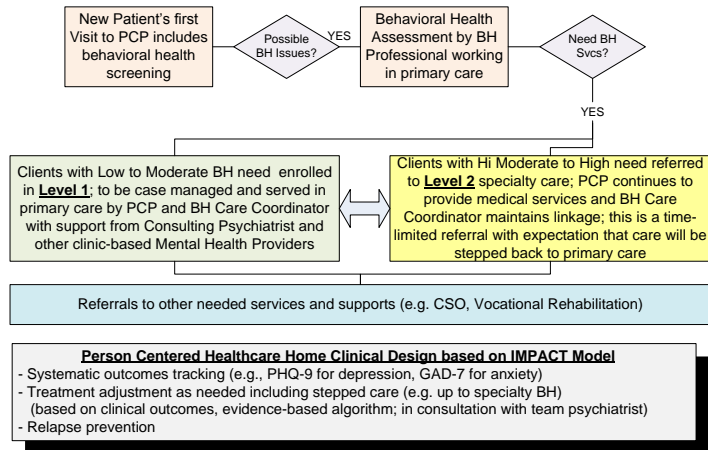
# California is Leading the Way with Numerous Integration Projects

Map of Selected California Integration Initiatives



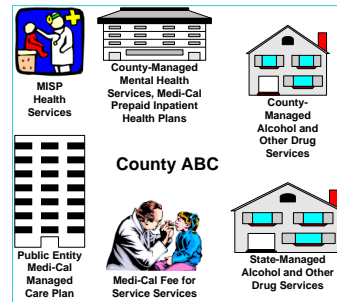
## Design the Clinical Model

- Example of IMPACT-Based MH/SU in PC for Quadrants I & III



## Identify & Address Funding Barriers

- Because **All Healthcare is Local**, a Primary Care, Mental Health, Substance Use Ecosystem has evolved in each community in California that has assembled the PC/MH/SU pieces differently, working within the state and federal funding frameworks
- Six sets of issues were identified by the Integration Policy Initiative, (Volume II) as a result of studying these “ecosystems”
- Some things currently can’t be funded by PC, some can’t be funded by MH, some can’t be funded by SU



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## Caveat about Addressing Barriers

- Many of the financing barriers that have been identified are the result of federal or state law/regulation that would need to be changed before they stop being a barrier
- This creates a “Serenity Prayer” moment: grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference
- And pushes a number of issues over into the “how do I get paid tomorrow” category



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Alignment of Current Financing			
Service Codes/Allowable Costs	Site of Service	Who Can Provide/Bill	
<p><u>Lack of Clarity on What Can/Cannot be Included for FQHC Billing or Cost Settlement</u></p> <ul style="list-style-type: none"> <li>• Services</li> <li>• Staff</li> </ul> <p><u>Same Day Billing Restriction</u></p> <p><u>Lack of Codes for Psychiatric Consultation on Care Management</u></p> <p><u>Lack of SBIRT Codes</u></p> <p><u>Lack of Health &amp; Behavior Codes for Non-FQHC PC</u></p> <p><u>Rules for Off Site/Outstationed Staff/Outreach</u></p>	<p><u>No Psychiatric Consultation to PCP or Care Manager</u></p> <p><u>Face to Face vs. Email or Telephone</u></p> <p><u>Limited Telemedicine/Telepsychiatry</u></p> <ul style="list-style-type: none"> <li>• Logistics of who writes prescription</li> </ul> <p><u>Site Certification Processes</u></p> <ul style="list-style-type: none"> <li>• MH done by counties</li> <li>• SU done by state with detailed requirements</li> <li>• Programs licensed as MH cannot receive drug Medi-Cal reimbursement, vice versa</li> </ul>	<p><u>No MFT/LPC in FQHCs</u></p> <p><u>No MSWs/PhDs Working Toward License</u></p> <p><u>No Peers/Health Coaches</u></p> <ul style="list-style-type: none"> <li>• Promotors are included in FQHC costs and in some MHSA projects</li> </ul> <p><u>No Recognition of Team Based Care</u></p>	<p>Lack of alignment between MH/SU/CHC financing with the model for integrated care</p>
<p><u>Service/Provider Type Limitations</u></p> <ul style="list-style-type: none"> <li>• Psychologist Encounters/Month</li> <li>• Group visits, FQHCs can only bill for one attendee</li> </ul> <p><u>Specialty MH/SU Enrollment and Ongoing Documentation Requirements</u></p> <ul style="list-style-type: none"> <li>• Service authorization processes and eligibility for MH/SU services</li> <li>• Benefit design</li> <li>• Different/extensive documentation requirements and paperwork</li> </ul> <p><u>County SU Services</u></p> <ul style="list-style-type: none"> <li>• Certification limits</li> <li>• availability/capacity of providers</li> </ul> <p><u>Licensing Barriers</u></p> <ul style="list-style-type: none"> <li>• Who can hire physicians</li> </ul>	<p><u>MH Selected Diagnoses combined with Impairment Level</u></p> <p><u>Federal SU Grants</u></p> <ul style="list-style-type: none"> <li>• Each grant has limits on target populations, frequently on county of service, and services to be provided—hard to see how to braid/blend</li> </ul>	<p><u>Managed Care vs. Fee for Service Variation</u></p> <ul style="list-style-type: none"> <li>• Medi-Cal</li> <li>• Medicare</li> <li>• Medi-Medi</li> <li>• Medically Indigent</li> <li>• CMSP no MH/SU benefit (but current pilots)</li> <li>• Access to cost of medications</li> </ul> <p><u>Lack of 17000 Coverage for MH Services</u></p> <ul style="list-style-type: none"> <li>• Varies by county</li> <li>• Lawsuits</li> </ul>	
Service Limits	Target Populations	Consumer Coverage	

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## Service Codes/Allowable Costs

- **FQHC Billing:** The Feds have very clear rules governing this issue. Generally, an FQHC can modify it's "Scope of Project" to expand the Services, Sites, and/or Providers covered by the FQHC. Look to PIN 2008-01 and PIN 2009-02 for guidance, making sure to obtain Prior Approval from the BPHC.
- **Same Day Billing Restriction:** NOT a Federal issue. In California, AB 1445 was introduced in 2009 to allow Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) to bill up to two visits per day and receive federal matching funds in order to address this problem. This would require a Medicaid State Plan Amendment by the State and necessitate a Change in Scope by the FQHC/RHC in order to obtain an adjustment in the per visit rate. This bill, which has not yet been passed into law, should be supported in order to address the identified barrier.

### Service Codes/Allowable Costs

Lack of Clarity on What Can/Cannot be Included for FQHC Billing or Cost Settlement

- Services
- Staff

Same Day Billing Restriction

Lack of Codes for Psychiatric Consultation on Care Management

Lack of SBIRT Codes

Lack of Health & Behavior Codes for Non-FQHC PC

Rules for Off Site/Outstationed Staff/Outreach

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## Site of Service

- **Psychiatric Consultation to PCP or Care Mgr:** This is an example of where we need to say the Serenity Prayer and acknowledge that the Feds won't pay for a consultation where the person has not been directly seen by the Psychiatrist. This is an issue that needs to be address through Healthcare Payment Reform through the adoption of new payment models that cover the costs of evidence-based care and care management.
- **Email, Telephone, Telemedicine:** As above, not billable. As above, another example of Federal regulation not catching up with current practice.
- **Site Certification Processes:** Yes, we have to say the Serenity Prayer again. This time, California needs to address these barriers. **Important:** California will have to "radically alter" it's Drug Medi-Cal benefit because it is vastly out of compliance with the Parity and Health Reform Laws; this will be an opportunity to address numerous, outdated regulations and practices.

### Site of Service

#### No Psychiatric Consultation to PCP or Care Manager

#### Face to Face vs. Email or Telephone

#### Limited Telemedicine/Telepsychiatry

- Logistics of who writes prescription

#### Site Certification Processes

- MH done by counties
- SU done by state with detailed requirements
- Programs licensed as MH cannot receive drug Medi-Cal reimbursement, vice versa

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## Who Can Provide/Bill

- **No MFT/LPC in FQHCs:** The Healthcare Reform Law has new definitions for Mental Health Service Professionals that includes: *"an individual with a graduate or post-graduate degree.. in.. substance use disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling."* I'm assuming that the FQHC regulations will need to be updates accordingly. Clarification needs to be pursued.
- **No Recognition of Team-Based Care:** Another issue that needs to be address through Healthcare Payment Reform through the adoption of new payment models that cover the costs of evidence-based care and care management.

### Who Can Provide/Bill

#### No MFT/LPC in FQHCs

#### No MSWs/PhDs Working Toward License

#### No Peers/Health Coaches

- Promotores are included in FQHC costs and in some MHSA projects

#### No Recognition of Team Based Care

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## Service Limits

- There are a number of service limits that are imposed through California regulations
- This includes the California Code of Regulations that make it difficult to provide mental health services to persons with mild/moderate need in mental health (1830.205)
- And lists as “excluded services” for County Mental Health Programs, specialty mental health services provided by FQHC, IHCs and RHCs
- Changes to support integrated care should be addressed when the 1915(b) Medicaid mental health waiver is renewed

### Service/Provider Type Limitations

- Psychologist Encounters/Month
- Group visits, FQHCs can only bill for one attendee

### Specialty MH/SU Enrollment and Ongoing Documentation Requirements

- Service authorization processes and eligibility for MH/SU services
- Benefit design
- Different/extensive documentation requirements and paperwork

### County SU Services

- Certification limits availability/capacity of providers

### Licensing Barriers

- Who can hire physicians

Service Limits

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## Target Populations and Consumer Coverage

- When an FQHC expands its Scope of Practice to add MH/SU Services, Sites, and/or Providers, the FQHC has to make those services available to **all** patients; i.e. they cannot say, “Oh, we’re just adding MH/SU for Medi-Cal enrollees because we’d go broke if we also provided these services to the uninsured
- The California 1115 Waiver Renewal with expansion of the Coverage Initiatives and Medicaid Expansion will radically alter this equation

### MH Selected Diagnoses combined with Impairment Level

#### Federal SU Grants

- Each grant has limits on target populations, frequently on county of service, and services to be provided—hard to see how to braid/blend

Target Populations

### Managed Care vs. Fee for Service Variation

- Medi-Cal
- Medicare
- Medi-Medi
- Medically Indigent
- CMSP no MH/SU benefit (but current pilots)
- Access to/cost of medications
- Lack of 17000 Coverage for MH Services
- Varies by county
- Lawsuits

Consumer Coverage

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## Identify & Address Funding Barriers

- There is a great deal of local expertise that have figured out what can and can't be done in this environment
- Study Volume III of the IPI Report ([www.ibhp.org](http://www.ibhp.org))
- CIMH is attempting to obtain funding to develop a *Toolkit of Promising Practices for Financing Integrated Care in the California Safety Net*, which could be available by Fall 2010
- Examples Include:
  - San Mateo County Behavioral Health Services hired and placed clinicians, all supervised and with one exception paid for by them, in each of six primary clinic sites. The clinicians provide treatment and arrange access to more intensive mental health services should clients need it.
  - Stanislaus County Behavioral Health outstationed four LCSW's at four County-run primary care clinics funded with MHSA PEI funds.
  - A nurse practitioner from Tom Waddell Health Center in San Francisco comes to South of Market County Mental Health Services twice a week to conduct assessments, triage, preliminary treatment and referrals.

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## Budget Who will Fund What

- Budget the clinical design, identifying the Clinician, Service, Site and Funding Sources
- Remember to take into account the possibility of higher no show rates for consumers with serious MH/SU disorders

Clinician	Service	Site	Funding Source	Notes
<b>IMPACT Model Team</b>				
Primary Care Physician	Prescriber	FQHC	FQHC PPS	
Behavioral Health Professional	Care Coord, Tx	FQHC	Short Doyle Medi-Cal, Realignment	For Medi-Cal, Non-Medi-Cal
Consulting Psychiatrist	Consultation	FQHC	MHSA PEI	
Clinician	Service	Site	Funding Source	Notes
<b>Primary Care Team in MH Center</b>				
Nurse Practitioner	Primary Care	MH Center	FQHC PPS	Expand Scope of Practice
Nurse Care Manager	Medical Care Coord	MH Center	FQHC PPS	"
Primary Care Supervising MD	Supervision	MH Center	FQHC PPS	"

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## Revise Business Processes & Obtain Approvals

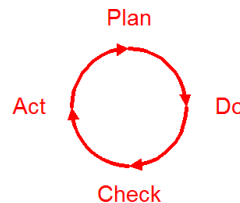
- There are numerous details that may tease out additional startup and ongoing expenditures that will need to be wrapped back into the budget
  - Does the FQHC need a change in Scope of Project?
  - Who will own Charts and how will documentation be shared?
  - Will a shared Patient Registry be implemented?
  - What Outcome Tools and Measures be used?
  - Will existing Productivity Standards work in the new model?

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## 6-Step Integration Game Plan

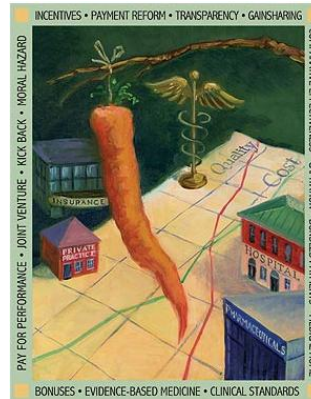
The emerging Best Practice involves developing a workgroup of local PC/MH/SU integration partners to:

1. Design the **Clinical Model** you will implement (what works best for the patient/consumer)
  2. Identify and address the **Funding Barriers**
    - Draw on the Integration Policy Initiative Report (see next slide) and **local resources** to address barriers within your expertise
    - Get **additional help** to address the barriers you think may be solvable but can't figure out on your own
  3. Craft an **Integration Budget** based on this work, sorting what will be funded by PC/MH/SU
  4. Revise your **Business Processes** and **Obtain Necessary Approvals** to support the Clinical Design and achieve financial stability
  5. Design your **Implementation Plan** that covers all the necessary tasks
  6. Go for it, **monitoring and adjusting** your plan as you move forward
- Note: the IBHP toolkit has more details ([www.ibhp.org](http://www.ibhp.org))



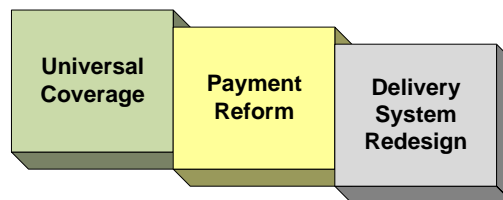
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## How are we going to get Paid Tomorrow?



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## Healthcare Reform

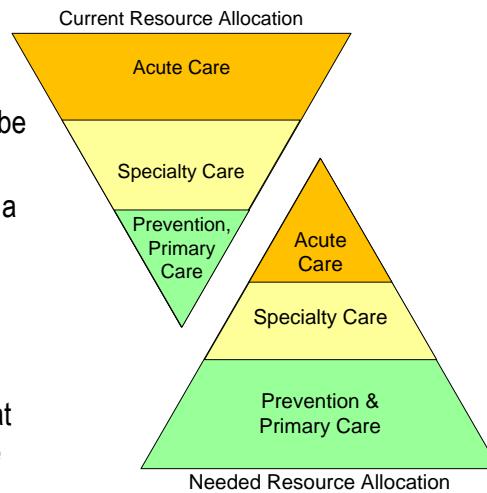


- Three components
  - Universal coverage (with parity)
  - Delivery system design (medical homes and accountable care organizations)
  - Payment reform (case rates, global payments)
- Integrating MH/SU services with healthcare more important than ever before—can't achieve quality and cost reduction goals without it
  - Especially in systems that historically have served the safety-net population

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## The “Big Fix”

- Need to invert the Resource Allocation Triangle
- **Prevention Activities** must be funded and widely deployed
- **Primary Care** must become a desirable occupation and
- **Decrease Demand** in the **Specialty** and **Acute Care** Systems
- These are dramatic shifts that will not *magically* take place



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## Coverage Expansion

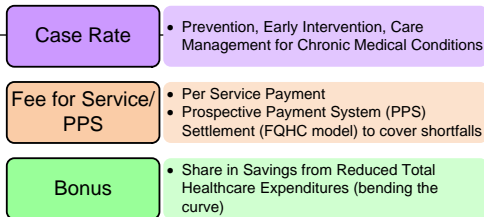
- Medicaid non-elderly enrollment will be 46% higher in 2019 than it would have been without the new law (this will vary by state)
- Large reduction in uninsured; it is likely that most uninsured with moderate to high MH/SU disorders will obtain coverage in Medicaid expansion (up to 133% of FPL), some will be in subsidized plans through the state Health Insurance Exchange (up to 400% of poverty)

	Current Law 2019 (Millions)	Reform Impact (Millions)	Reform Total (Millions)	Reform Impact %
Medicaid/CHIP	35	16	51	46%
Uninsured Persons	54	(32)	22	-59%
Total Safety Net	89	(16)	73	-18%
Private/Other Insured	193	16	209	8%
Total Non-Elderly	282	-	282	

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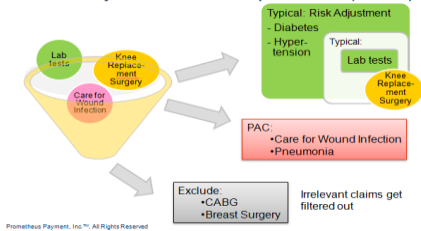
## Future Funding Environments

- New funding mechanisms will be utilized to fund services that manage total healthcare expenditures
- Medical Homes likely funded with a 3-layer model



- Payment for inpatient care will bundle hospital and physician services that only pay for part of Potentially Avoidable Complications (PACs)
- Bundled payments may include all costs in the 30 days post an inpatient stay, including any return to the hospital
- Accountable Care Organizations organize to handle new payment models

### Potentially Avoidable Complications (PACs)



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## Accountable Care Organizations (ACOs)

- ACOs dual purpose:
  - Organization structure for managing bundled payments for inpatient care
  - Vehicle for small to mid-sized primary care practices that want to become Person-Centered Medical Homes

### OPPORTUNITIES FOR HEALTHCARE COST REDUCTION

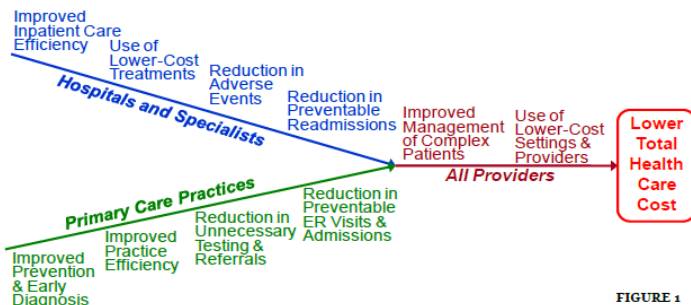


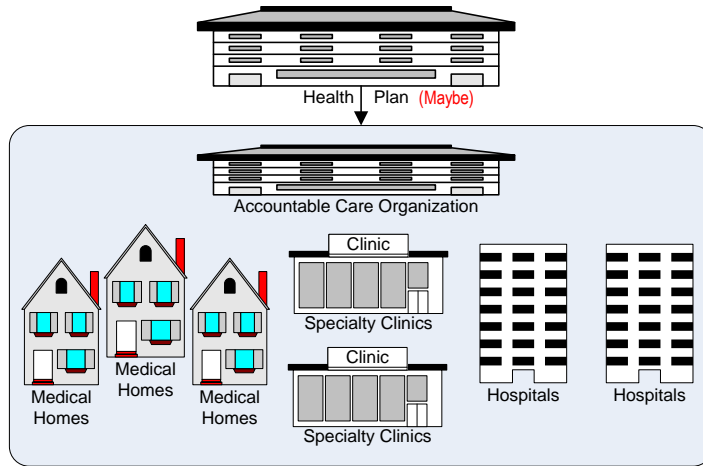
FIGURE 1

Harold Miller, How to Create an Accountable Care Organization, [www.chqpr.org](http://www.chqpr.org), page 4

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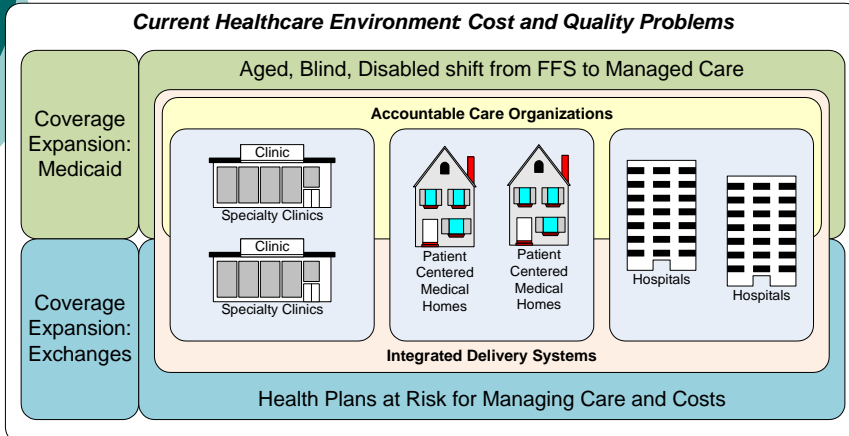
## (ACOs)

- o Accountable Care Organization (ACO)



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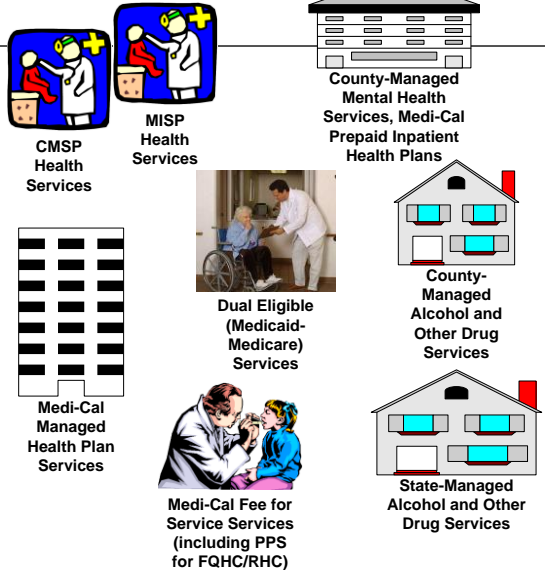
## Summarizing what the Future Holds



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## California's Puzzle

There are eight existing “raw ingredients” that are coming into play as stakeholders in California redesign current waivers and other structures to align with healthcare reform



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## Major Initiatives Coming Soon

- 1115 Waiver initiatives, including Health Care Coverage Initiative expansion to get ready for 2014 Medicaid Expansion
  - Local Dollars converted to Medi-Cal
- Expand Medi-Cal Health Plan benefit package to include SU services
  - Leveraging Cost Savings on the Health Side to pay for part of the costs
- Implement Medical Homes and Accountable Care Organizations
  - With new payment mechanisms and integration as an expectation

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County ABC	Current Medi-Cal Enrollees	Current MISP/ Uninsured	Current Totals	Moderate Scenario Changes	Comments
<b>Enrollees</b>	44,000	21,000	65,000	0	Shift uninsured to HCCI
<b>Revenue</b>	\$110,770,000	\$74,550,000	\$185,320,000	\$22,365,000	Added FMAP; reduce local
<b>Health Care Utilization and Expense</b>					
<b>Inpatient/ED</b>					
Admits	2,200	1,700	3,900	-390	Reduced inpatient
Costs	\$44,000,000	\$42,500,000	\$86,500,000	-\$9,750,000	"
<b>Ambulatory</b>					
Served	41,800	20,000	61,800	3,200	All Served
Costs	\$25,080,000	\$12,000,000	\$37,080,000	\$8,157,600	Increase in Primary Care
<b>Pharmacy</b>					
Costs	\$12,540,000	\$6,000,000	\$18,540,000	\$927,000	All served
<b>Total Health Care</b>	<b>\$81,620,000</b>	<b>\$60,500,000</b>	<b>\$142,120,000</b>	<b>-\$665,400</b>	Calculation
<b>Mental Health Utilization and Expense</b>					
<b>Inpatient</b>					
Admits	1,000	500	1,500	0	Assume no change
Costs	\$8,500,000	\$4,250,000	\$12,750,000	\$0	"
<b>Outpatient</b>					
Served	7,500	3,500	11,000	5,250	Increase to cover demand
Costs	\$15,000,000	\$7,000,000	\$22,000,000	\$10,500,000	"
<b>Residential</b>					
Served	700	350	1,050	0	Assume no increase
Costs	\$5,600,000	\$2,800,000	\$8,400,000	\$0	"
<b>Total Mental Health</b>	<b>\$29,100,000</b>	<b>\$14,050,000</b>	<b>\$43,150,000</b>	<b>\$10,500,000</b>	Calculation
<b>Substance Use Utilization and Expense</b>					
<b>Outpatient/Residential</b>					
Served	100	0	100	6,500	Increase to cover demand
Costs	\$50,000	\$0	\$50,000	\$12,090,000	"
<b>Total Substance Use</b>	<b>\$50,000</b>	<b>\$0</b>	<b>\$50,000</b>	<b>\$12,090,000</b>	Calculation
<b>Total Expense</b>	<b>\$110,770,000</b>	<b>\$74,550,000</b>	<b>\$185,320,000</b>	<b>\$21,924,600</b>	
<b>Excess (Deficit)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$440,400</b>	

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## The Situation in Public Behavioral Healthcare

### California Fee for Service Medi-Cal Analysis - 2007

	Medi-Cal FFS	Medi-Cal FFS	Metric
	Total	SMI	
Medi-Cal FFS Enrollees	1,580,440	166,786	11% SMI % of Total
Medi-Cal FFS Costs	\$6,186,331,620	\$2,395,938,298	39% SMI % of Total
Medi-Cal FFS Cost/Enrollee	\$3,914	\$14,365	3.7 SMI/Non-Ratio
Diabetes	4%	11%	2.8 SMI/Non-Ratio
Ischemic Heart Disease	2%	6%	3.0 SMI/Non-Ratio
Cerebrovascular Disease	1%	3%	3.0 SMI/Non-Ratio
Chronic Respiratory Disease	5%	13%	2.6 SMI/Non-Ratio
Arthritis	2%	7%	3.5 SMI/Non-Ratio
Health Failure	1%	3%	3.0 SMI/Non-Ratio
Inpatient Episodes	100	293	2.9 SMI/Non-Ratio
ER Visits	337	1,167	3.5 SMI/Non-Ratio
Inpatient Acute Days	609	2,094	3.4 SMI/Non-Ratio
Primary Care Visits	128	492	3.8 SMI/Non-Ratio
Specialist Visits	1,211	6,058	5.0 SMI/Non-Ratio

Prepared by JEN Associates, Cambridge, MA

**And are costing the healthcare system a great deal of money**

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## Healthcare Reform and Parity Changes Everything...

- Federal Healthcare reform will trigger dramatic changes in how health and MH/SU services are **organized**
- These changes will create a tipping point in how the **healthcare needs of persons with serious mental illness** and the **MH/SU healthcare needs of all Americans** are addressed
- Which will change the way MH/SU services are **funded and fit into the new healthcare ecosystem**

