Drug/Medi-Cal

Organized Delivery System Waiver

CIBHS Fiscal Leadership
June 6, 2017

Marin County DHCS Approvals:
Implementation Plan: August 1, 2016
Fiscal Plan: October 3, 2016

Go Live !!! April 1,2017

DMS-ODS Fiscal Plan
Establish an Interim Rate

Considerations on the Rate-Setting Process

- Interim rates are based on weighted averages and are for cash flow purposes– they will not be the rates reflected in provider contracts
- BHRS will negotiate provider-specific service rates
- BHRS will submit an annual fiscal plan, so will have the opportunity to re-negotiate rates with DHCS and providers
- Cost settlement: Reimburse on a Fee for Service basis and cost settlement will be subject to the lower of cost or charge, up to the contract maximum
- If your actual costs to deliver the service **exceed the FFS advances**, then the County will reimburse the provider at the lower of cost or charge up to the contract maximum
- If your actual costs to deliver the service are **less than the FFS advances**, then the provider will be required to reimburse the County for the overpayment
- Similar to current requirements, cost reports will need to reflect actual costs for DMC, Non-DMC and Other/Private for each modality of service. HHS Fiscal will provide technical assistance to ensure DMC-ODS providers have sufficient systems and clear methodologies to track expenditures and revenues prior to commencing services.

Methodology for Developing D/MC-ODS Contract Services & Budgets

***Existing* ASAM LOC and *Existing* Provider**

Utilized FY 2015/16 FFS rates, rather than DMC rates, to serve as the foundation
* Projected FY 2016/17 units of service to determine a weighted average UOS rate
* Factored in a 15% percentage increase, which was based on a review of projected increases from provider budgets related to DMC-ODS requirements, adding:
  - > Medical Director for new/additional DMC services
  - > Additional LPHA staff to perform assessments and medical necessity determinations
  - > Additional staff time for utilization review, quality improvement and compliance activities
  - > Providing access to oral interpreter services and translation of materials

* Factored in a 2.4% inflation index (DHCS approved inflation factor for DMC-ODS)

Existing ASAM LOC and New Provider

* Establish a FFS rate to serve as the foundation
* Case Management (CBO Providers) – Use rates use to calculate the weighted averages for ASAM Level 1.0 (General Outpatient)
* ASAM Level 3.1 (Adolescent) – Actual cost budget that reflects a 75% utilization rate
* Follow the above steps (bullets 2 – 4)

Methodology for Developing D/MC-ODS Contract Services and Budgets

Findings:

Marin has previously subsidized D/MC Rates; Validates these rates at Cost Report
BHRS developed worksheets with formulas – happy to share worksheet
CBO's with previous D/MC did not have as significant of increases

Methodology – Room & Board *(Residential and Withdrawal Management)*

* Reviewed proposed FY 2016/17 budgets and removed select R & B items per CMS guidance, such as food.
* Reviewed line item budgets supporting R & B and treatment, removed a percentage based on square footage of facility
* Reviewed facility maps to compare % allocated to budget line items.

Findings:
Varied between 60-80% allocated to treatment between facilities
Demand for residential has been higher than projected however actual billings to D/MC less likely due to extensive URC before uploading

Negotiating Provider Contract Rates

- **BHRS provided Capacity targets based on CBO prior history of service deliver**
- **BHRS provided Capacity / Fiscal targets of Medi-Cal and Low Cost Uninsured. Differentiated between Mandatory and Newly Eligible Projections.**
- **BHRS provided a Financial Modeling Tool where CBO's input the projected types and units of service for the number of projected clients.**

  Modeling Tool generated the amount of direct service FTE's needed to implement the services. Formula based on a 60% direct service delivery rate (@ 24 hours per 40 hour week)
- **This resulted in a generated unit rate.**
- **CBO's submitted budgets for review by BHRS**
- **BHRS reviewed: Does FTE's align with modeling:**

  Do the amount of services align with the amounts of units we expect to be delivered?; Are the services reasonable and appropriate?; Reviewed for Audit Compliance
- **CBO Contracts include funding for both D/MC and Uninsured. The percentages vary by Agency. For residential and IOT treatment services we anticipated 80-85% D/MC eligible clients/services. For new Waiver services projections for D/MC reimbursements were projected lower.**

Terms & Conditions of Payments
Provider Contract: Exhibit B

Cost Reimbursement

Any Drug/Medi-Cal denials shall be resubmitted, as appropriate, by the Contractor to the County, by the 20th of the month following notification of the denial (CBO's are now paid actual costs – less incentive to for resubmissions so included in contract**.**

As claims for Physician consultation can be billed by the eligible DMC provider receiving Physician Consultation services, Contractor is responsible for submitting claims for any Physician Consultation services provided by the County to the Contractor. The County will retain all reimbursements for Physician Consultation services provided by the County to the Contractor. The County can provide receipts to Contractor for the purposes of documentation. (Included in Provider Scope of Work that County retains the revenue.)

On a quarterly basis, BHRS and Contractor will review actual costs, services delivered and compliance with the terms and conditions of the contract to determine if any contracts adjustments are necessary. (If thre are increases or decreases needed ---we created Master Agreements for Residential and Outpatient services to enable the Director of Health & Human Services to sign amendments to the various contracts within the MA.

Unless otherwise noted in the contract, services provided and reimbursed under this contract are only for Marin County Medi-Cal beneficiaries and low-income (<138% FPL) uninsured Marin residents.

Lessons Learned

- One month in, we are planning contract revisions for July 1, 2017:
  - * More residential than projected;
  - * Billing less to Case Management and Recovery Services
  - * Changing population projections to absorb non-DMC Costs & Revenues
  - * Extensive chart reviews and pulling out claims we are uncertain of
  - * Considering going back to fee-for-service and settle actual costs during cost report.