Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

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House File 2463 Report – December 2014
Substance-Related Disorder Reimbursement Provisions

Introduction

In House File 2463, the 2014 Iowa General Assembly directed the Iowa Department of Public Health (IDPH) to work with stakeholders to review reimbursement provisions for substance-related disorder providers as follows:

> *"The department of public health shall engage stakeholders to review reimbursement provisions applicable to substance-related disorder providers. The issues considered shall include but not be limited to the adequacy of the reimbursement provisions, whether it is appropriate to rebase reimbursement, equity of the reimbursement provisions as compared to the reimbursement methodologies used for providers of similar behavioral health services, and the effect of health coverage expansion through the Iowa health and wellness plan on such providers. The department shall report its findings and recommendations to the general assembly on or before December 15, 2014."*

IDPH discussed historical and current reimbursement provisions with specific stakeholders and convened stakeholder representative meetings on November 21 and December 12, 2014.

Stakeholder Representatives

Ron Berg, Executive Director	MECCA Services, Iowa City
Kermit Dahlen, Executive Director	Jackson Recovery Center, Sioux City
Marv Fangman, Executive Director	Clearview Recovery Inc., Prairie City
Jason Haglund, Treatment Services Director	Youth and Shelter Services, Ames
Jay Hansen, Executive Director	Prairie Ridge Addiction Treatment Services, Mason City
Liz Matney, Managed Care Director	Department of Human Services / Iowa Medicaid Enterprise, Des Moines
Maria Montanaro, Chief Executive Officer	Magellan of Iowa, West Des Moines
Dennis Petersen, Chief Operating Officer	Magellan of Iowa, West Des Moines
Deanna Triplett, Chief Executive Officer	Iowa Behavioral Health Association, Des Moines
Kathy Stone, Division Director	Iowa Department of Public Health / Division of Behavioral Health, Des Moines

Background

Providers of comprehensive substance-related disorder services have historically been one-third of what's been described as Iowa's "three-legged**" *collaborative, community-based safety-net health services infrastructure for low income Iowans***. In general, this three-legged arrangement has been comprised of the following:

(1) Community Health Centers/Federally Qualified Health Centers (CHC/FQHCs), providing primary medical care in this safety-net health services system;

(2) Community Mental Health Centers (CMHCs), providing most outpatient mental health services; and

(3) a core group of substance-related disorder providers, primarily those programs competitively procured as the IDPH-funded provider network, providing the majority of outpatient and residential substance abuse treatment.

This three-part safety-net infrastructure, comprised of ***one primary care provider type* – CHCs/FQHCs** – and ***two specialty behavioral health provider types* – CMHCs and substance-related disorder programs** – has generally operated differently and separately from the predominately private sector healthcare provider network of hospitals and private practices. ***Of the three safety-net provider types, only substance-related disorder providers do not receive reimbursement from Medicaid that is related to their costs.***

To understand the reimbursement methodologies used for providers of similar behavioral health services, the stakeholder representatives began their work by reviewing the reimbursement language in HF 2463 for CMHCs, which states:

> *"… For the fiscal year beginning July 1, 2014, community mental health centers may choose to be reimbursed for the services provided to recipients of medical assistance through either of the following options: (1) For 100 percent of the reasonable costs of the services. (2) In accordance with the alternative reimbursement rate methodology established by the medical assistance program's managed care contractor for mental health services and approved by the department of human services."*

The Iowa Plan for Behavioral Health is Iowa's managed care plan for mental health and substance-related disorder services funded by Medicaid under the authority of the Iowa Department of Human Services Iowa Medicaid Enterprise (DHS IME), and for substance-related disorder treatment funded by federal block grant and General Fund appropriation under the authority of the Iowa Department of Public Health Division of Behavioral Health (IDPH).

Dennis Petersen, representing Magellan of Iowa (Magellan), the state's managed care contractor for the Iowa Plan for Behavioral Health, outlined the ***history of CMHC Medicaid funding methodologies since 1995 under the Iowa Plan for Behavioral Health***:

a. Historically, CMHCs were paid on a *fee-for-service* basis for the mental health services they provided.
    - CMHCs sought rate increases from Magellan as the CMHCs determined necessary.
    - Magellan increased rates as Magellan determined appropriate and feasible.

b. CMHCs were also eligible to receive *Iowa Plan Medicaid Community Reinvestment funding* for priority projects to improve services to enrollees.
    - The majority of Iowa Plan Community Reinvestment projects have focused on mental health services and supports.

c. Over time, CMHCs determined that the fee-for-service rates were not adequate to cover their costs.

d. Around 2005, the General Assembly passed legislation that added a *100% cost-based reimbursement methodology* to CMHC fee-for-service payments, with defined cost parameters and processes.
    - CMHCs continued to submit claims to Magellan and were reimbursed on a fee-for-service basis for the mental health services they provided.
    - In addition, every year, each CMHC generated an annual cost report for the mental health services they provided and submitted that cost report to DHS IME.
        - The cost report reconciliation process was complex. It could take up to two years for CMHCs to receive their additional reimbursement.
        - CMHCs sometimes covered their costs in the interim by borrowing money from counties and repaying the counties after receiving their additional reimbursement from the cost report reconciliation.
    - Following implementation of the cost-based reimbursement methodology, the overall total cost of CMHC reimbursement rose approximately 15% a year for six years.

e. In 2011, Magellan, on behalf of DHS IME, launched an *Integrated Health Home pilot program* with five CMHCs in partnership with local FQHCs in four Iowa counties.
    - In July 2013, Magellan began an expanded program in accordance with the Affordable Care Act's Integrated Health Home provision Section 2703 focused on Medicaid enrollees with severe mental illness and concurrent chronic health conditions.

f. Certain CMHCs approached Magellan requesting an alternative to the cost-based reimbursement methodology and cost report reconciliation process.

g. With the approval of DHS IME, Magellan met with a CMHC group to understand the actual total dollars paid to CMHCs through both fee-for-service reimbursement and the cost-based methodology and to determine how to get those total dollars to the CMHCs in a more timely fashion,
    - DHS IME developed an *alternative reimbursement rate schedule* for CMHCs based on the actual total dollars paid for common services across all CMHCs.
        - The alternative rate schedule was intended to be cost neutral overall.
        - The alternative rates for specific services were not designed to be "reasonable" and may appear to be considerably higher than comparable standard fee-for-service reimbursement rates when viewed outside the perspective of overall cost neutrality.

h. In 2014, the General Assembly, through HF 2463, made it optional for each CMHC to choose its reimbursement methodology: (a) fee-for-service reimbursement plus cost-based reconciliation or (b) fee-for-service reimbursement at the alternative reimbursement rate level.
    - As of the time of this report, approximately 17 of 28 CMHCs have moved to the alternative reimbursement rates.

Mr. Petersen and provider representatives then reviewed the ***history of Medicaid reimbursement to substance-related disorder providers under the Iowa Plan for Behavioral Health since 1995:***

a. Substance-related disorder providers are paid on a *fee-for-service* basis for the substance-related disorder treatment they provide.
    - Substance-related disorder providers have sought rate increases from Magellan.
    - Magellan increased rates as Magellan determined appropriate and feasible.

b. Substance-related disorder providers were eligible to receive *Iowa Plan Medicaid Community Reinvestment funding* for a limited subset of projects focused on substance-related disorder services.

c. Historically, fee-for-service reimbursement rates for services provided by substance-related disorder providers have been lower than rates for similar services provided by CMHCs.

d. Around 2004, when Magellan moved to standardized coding and a standard rate sheet, the difference in reimbursement rates between CMHCs and substance-related disorder providers became clear.
    - Magellan then generally aligned rates for similar services, regardless of whether the services were provided in a CMHC or a substance-related disorder setting.
        - By 2005, the aligned rates were no longer comparable to the actual total reimbursement received by CMHCs through the combination of fee-for-service reimbursement and the cost-based reconciliation methodology.

e. In 2011, Magellan increased reimbursement rates for certain outpatient substance-related disorder services.

f. In 2011, Magellan launched its Integrated Health Home pilot program with five CMHCs and local FQHCs.
    - In July 2013, Magellan expanded the Integrated Health Home program for Medicaid enrollees with severe mental illness and concurrent chronic health conditions.
        - Certain CMHCs participating in the Integrated Health Home program are also licensed substance-related disorder providers.
        - Most of the Integrated Health Home providers are not licensed substance-related disorder programs.
            - Such providers may consider outpatient substance-related disorder services within the scope of practice for their staff who are professionally licensed at the independent level. They generally do not refer Integrated Health Home members with substance-related disorders to the substance-related disorder provider network for specialty care.

g. Substance-related disorder providers requested the opportunity to consider alternative reimbursement methodologies under the Iowa Plan for Behavioral Health, with the goal of assuring equitable fee-for service rates as well as overall reimbursement.
    - A concern for the providers was their understanding that under the fee-for-service plus cost-based reimbursement methodology as well as under the proposed alternative reimbursement methodology, CMHCs were being paid much higher rates for services similar to those provided by substance-related disorder providers.
        - Further, those CMHCs that were also substance-related disorder providers were being paid the higher rates for the same services provided by non-CMHC substance-related disorder providers.

h. In 2014, the General Assembly, through HF 2463, directed that there be a review and recommendations on reimbursement provisions for substance-related disorder providers.

Findings

A. Adequacy of reimbursement provisions? → *No, current reimbursement provisions are not adequate.*

Historical and current reimbursement provisions have put substance-related disorder providers at a *competitive disadvantage* in hiring and retaining qualified staff when compared to CMHCs as providers of similar behavioral health services. Provider representatives gave multiple examples of how the low reimbursement they receive means they must hire staff at below market salary and benefit levels. These providers consistently hire entry level licensed professionals, train them for a year, and then lose these same professionals to CMHCs or to other providers or organizations that are able to offer higher salaries and benefits. One provider reported a 45% staff turnover rate in the past year.

In describing themselves as *specialty providers in the safety-net healthcare infrastructure*, the substance-related disorder provider representatives explained how they have expanded their capacity over the past several years to meet the complex needs of their patients, including integrating delivery of medical and mental health services into their program operations. Substance-related disorder providers often act as their patients' initial entry into the larger medical and mental health services system. In a survey conducted two years ago, 89% of the patients served by a specific core group of substance-related disorder providers, when asked where they would prefer to receive medical and mental health services, responded that they'd like to receive such services on-site in the substance-related disorder treatment setting in which they already felt welcomed and comfortable. While many substance-related disorder providers have added medical and mental health professionals to their staff, either directly or by contractual arrangement or co-location, they are hampered again by low salaries and benefits. This has most recently slowed efforts to address emerging trends like prescription abuse and to implement promising models like medication-assisted treatment. As one provider representative stated when asked about training and evidence-based practices, "You have to have revenue to conduct training [and] you can't have different care if you don't pay for it!"

The substance-related disorder providers have stated they *cannot survive on the current reimbursement rates*. Approximately 15% of Iowa Plan for Behavioral Health Medicaid enrollees participate in substance-related disorder services each year. A core group of the substance-related disorder providers has historically provided up to 80% of the substance abuse treatment received by Iowa Plan for Behavioral Health Medicaid enrollees. Losing this safety-net specialty provider network would decrease capacity for all substance-related disorder services statewide – for all patients and all payors.

B. Rebase reimbursement? → *Yes, rebasing reimbursement is needed.*

The current fee-for service reimbursement rates paid to substance-related disorder providers are not sufficient to support continued delivery of appropriate and effective substance-related disorder services. The current rates do not cover provider costs and do not allow financial flexibility in training for improved practices and vital quality initiatives.

Provider representatives have not requested cost-based reimbursement and do not believe a simple analysis of current substance-related disorder provider costs would accurately reflect their funding needs, primarily because their current costs, particularly for staff salaries and benefits, are not representative of current market levels across the state for similar staff and services.

C. Equity of reimbursement provisions compared to reimbursement methodologies for providers of similar behavioral health services? → *No, current reimbursement provisions are not equitable.*

Substance-related disorder providers are similar to CMHCs in the provision of behavioral health services to Iowa Plan for Behavioral Health Medicaid enrollees in terms of their accreditation processes and the types of staff they hire. The provider representatives specifically stipulated that the core group of substance-related disorder providers, primarily those that provide services that are prioritized by IDPH, provide comprehensive treatment services covering the full continuum of care from assessment through individual and group counseling to 24-hour residential treatment, making them different from private practice providers who generally offer outpatient counseling only. Substance-related disorder providers employ a mix of certified and licensed professionals to provide evidence-based practices and nationally-accepted models of care. Many of the core group of substance-related providers are accredited at the national level, e.g. under the CARF Integrated Behavioral Health Standards, in addition to IDPH licensure.

CMHCs, including those CMHCs that are also substance-related disorder providers, currently receive overall reimbursement that is much higher than that received by non-CMHC substance-related disorder providers for the same or similar services. The current reimbursement structure also pushes substance-related disorder providers to assign caseloads to their staff that exceed normal practice standards in an attempt to maximize revenue. The providers believe that the quality and effectiveness of substance-related disorder treatment suffer when high volume becomes the driving force.

D. Effect of health coverage expansion through the Iowa Health and Wellness Plan? → *Yes, health coverage expansion through the Iowa Health and Wellness Plan will affect providers but the full extent and implications are not yet known.*

In 2014, IDPH commissioned an initial analysis of the potential impact of implementation of the Iowa Health and Wellness Plan on the demand for substance-related disorder services. That analysis, conducted by the Milliman actuarial firm, suggests an increase in overall demand for services, with a *critical transition period for substance-related disorder providers between 2014 and 2017.*

The analysis considered but did not quantify the need or costs for what have been described as wraparound or gap-filling services such as transportation, that support the effectiveness of behavioral health services provided to the Medicaid population.

Recommendations

From the November 21, 2014 Stakeholder Meeting:

Establish a Plan to Address Findings:
In December 2014, provider representatives, DHS IME, IDPH and Magellan will meet to jointly establish a plan to improve Iowa Plan for Behavioral Health Medicaid reimbursement for substance-related disorder providers that addresses both adequacy and equity of reimbursement provisions.

From the December 12, 2014 Stakeholder Meeting:

1. **Iowa Plan for Behavioral Health Medicaid Reimbursement Rate Increases:**

    a. By January 30, 2015, Magellan will analyze fee-for-service reimbursement rates for substance-related disorder providers.

    b. By March 1, 2015, Magellan will implement an initial "stabilizing" increase in fee-for-service reimbursement rates for substance-related disorder providers.

    c. By July 1, 2015, Magellan will increase fee-for-service reimbursement rates for substance-related disorder providers based on analysis of costs; targeted priority services, enrollee groups, and providers; and available funding.

2. **Alternative Reimbursement Methodologies:**

    a. In January 2015, DHS IME and IDPH will convene substance-related disorder providers to identify options for their participation in existing alternative funding methodologies, such as the Chronic Condition Health Home and Integrated Health Home models, or in new models or demonstration projects.

    b. In March 2015, pending approval by DHS IME and by the Centers for Medicare and Medicaid Services (CMS), Magellan will release an Iowa Plan for Behavioral Health Medicaid Community Reinvestment funding opportunity announcement for implementation of evidence-based practices that includes $1.5M (25% of the total funding opportunity) for substance-related disorder providers.

    c. By March 2015, provider representatives will work with IDPH, Magellan, and others to understand potential reimbursement methodology options available outside of the Iowa Plan for Behavioral Health, such as expanded FQHC linkage to increase medical care capacity and professional loan repayment.

3. Analysis of Iowa Plan for Behavioral Health Substance-Related Disorder Provider Costs and Reimbursement Adequacy:

a. By February 2015, providers, with DHS IME, IDPH, and Magellan support, will conduct a cost-based rate study to quantify:

(1) The current total costs for substance-related disorder providers, acknowledging that current and historical costs are artificially low;

(2) The projected total costs for substance-related disorder providers if current costs are rebased at appropriate market levels, e.g. at salary and benefit levels that are consistent with CMHC and other community norms for like professionals;

(3) The disparity between current/projected total substance-related disorder provider costs and current reimbursement rates;

(4) The projected cost of the loss of the substance-related disorder specialty health services safety-net provider network that currently provides the bulk of Iowa Plan for Behavioral Health Medicaid-funded substance abuse treatment and related priority services; and

(5) The funding needed to support an effective statewide substance-related disorder provider network in State Fiscal Year 2016 and subsequent years.

b. By July 2015, IDPH will update the substance abuse treatment section of its Milliman ACA Impact Study Report to reflect the analysis contained in the provider cost-based rate study referenced above and data available on 2014 actual service utilization and related expenditures. IDPH will also include, as feasible, related DHS IME data and information as well as data from associated IDPH federal grant programs and the annual treatment outcomes study.

Both reports will be made available to the General Assembly.

Questions about this report may be directed to Kathy Stone/IDPH at
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