Behavioral Health Programs

Overview of Payment Processes and Standard Procedure Codes

Agenda

10:00 – 10:05	Welcome and Introductions
10:05 – 10:15	DHCS Overview of CalAIM Goals and Workgroup Charter
10:15 – 11:00	Overview of Current Payment Methodologies and Goals of Payment Reform
11:00 – 12:00	Workgroup Discussion: Benefits and Challenges of Current Payment Methodologies and Processes
12:00 – 1:00	Break for Lunch
1:00 – 1:45	Overview of Healthcare Common Procedure Coding System (HCPCS) and Requirements
1:45 – 2:30	Workgroup Discussion: Challenges and Opportunities of transition to HCPCS Level I coding
2:30 – 2:40	Discuss Future Meeting Approach And Workgroup Suggestions
2:40 – 2:55	Public Comment
2:55 – 3:00	Closing and Next Steps

Welcome and Introductions

CalAIM Overview

DHCS has developed a comprehensive and ambitious framework for the upcoming waiver renewals that encompasses a broader delivery system, and program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal.

Includes initiatives and reforms for:

- Medi-Cal Managed Care
- Behavioral Health
- Dental
- Other County Programs and Services

CalAIM Goals

CalAIM has three primary goals:

- Identify and manage member risk and need through Whole Person Care approaches and addressing social determinants of health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

CalAIM Overview

Advances several key priorities of the Newsom Administration by leveraging Medi-Cal as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as:

- homelessness,
- increasing behavioral health care access,
- children with complex medical conditions,
- growing number of justice-involved populations who have significant clinical needs, and
- growing aging population.

Workgroup Objectives

- The objective of the behavioral health payment reform workgroup is to:
- Discuss opportunities and challenges around reforming behavioral health payment methodologies
- Provide feedback on proposed transition to HCPCS Level I coding and implementation timeline
- Provide recommendations on payment structure for each behavioral health delivery system

Overview of Current Payment Processes

- Interim Claim
- Interim Payment
- Cost Report
- Interim Cost Report Settlement
- Audit
- Audit Appeals

Interim Claim

- Counties submit interim claims (837 transactions) to the Short-Doyle/Medi-Cal (SD/MC) Claiming system for SMHS, DMC State Plan and DMC ODS services.
- Counties also submit signed certifications for each interim claim (i.e., Certified Public Expenditure).
- SD/MC adjudicates the claim and either approves or denies the claim.
- SD/MC issues the county an 835 transaction with information regarding the result of its claim adjudication.

Interim Payment

- DHCS issues an interim payment to the county for approved claims.
- The interim payment includes the federal share and state share, if any, of the approved amount.
- The interim payment is limited to a county interim rate for SMHS and DMC-ODS counties, and to the SMA for DMC State Plan counties.

Cost Report Submission

- All network providers, including the county, must prepare a cost report for SMHS, DMC, and DMC ODS, except for NTP providers.
- Counties compile the cost report and submit to DHCS by November 1 (DMC and DMC ODS) or December 31st (SMHS) following the close of the fiscal year.
- The cost report determines how much it cost each provider to render the services DHCS reimbursed over the course of the fiscal year.

Interim Cost Settlement

- DHCS compares interim payments to actual costs as determined in the cost report.
- DHCS recoups from the county if interim payments exceed actual cost.
- DHCS makes an additional payment for actual costs that exceed interim payments.

Audit

- DHCS audits each county's cost report.
- The audit results in adjustments and/or reclassification of costs.
- Adjustments and reclassifications result in either recoupments from or additional payments to the county.

Audit Appeal

- Counties may appeal the result of the final audit.
- The appeal decision may result in another calculation of the final audit settlement.

Committee Discussion

HIPAA STANDARD CODE SETS

- CMS requires HIPAA covered transactions to use standard code sets.
- The Current Procedural Terminology (CPT) code set is the standard for physician services.
- The Healthcare Common Procedure Coding System (HCPCS) code set is the standard for other health care services.

Standard Code Sets In SD/MC

- DHCS currently requires counties to use HCPCS codes for all SMH and DMC services, including physician services.
- To comply with the HIPAA standards, DHCS must require counties to use CPT codes for SMH and DMC services provided by physicians.
- DHCS will continue to use HCPCS codes for other health care services.

Physician Services - Example (CPT Codes)

- Assessments
- Plan Development
- Therapy
- Collateral
- Prescribing medication
- Administering medication

Other Health Care Services – Example (HCPCS Codes)

- Rehabilitation
- Targeted Case Management
- Crisis Intervention
- Day Services
- Residential services

Committee Discussion

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Workgroup Expected Deliverables

- Policy recommendations based on workgroup focus questions
- Vet timelines for transition to HCPCS Level I Coding
- Vet proposed payment timelines under new methodologies
- Provide recommendations for how to group counties for Peer Groupings

Workgroup Focus Questions

- What are the barriers for providers to transition from HCPCS Level II to HCPCS Level I coding?
- What are the largest barriers of transitioning county contributed non-federal share from certified public expenditures (CPE) to intergovernmental transfers (IGT)?
- How often should rates be updated under new methodologies?
- How often should counties claim reimbursement and provide IGT?
- Should DHCS transition all three delivery systems on the same schedule or should the systems be transitioned via a phase-in schedule?
- Counties and providers are in different states of readiness for transition to HCPCS Level I Coding submission to DHCS, what steps should DHCS take to ensure counties are prepared for transition?

Future Meeting Planning

- **Future Workgroup Meeting Dates:**
- Friday, January 10th
- Tuesday, February 4th

- **Other Important Dates**
- Monday, January 6th – Behavioral Health Stakeholder Advisory Committee – CalAIM focus

- **Workgroup Feedback**
- Hear from workgroup members what they would like to discuss at future meetings
- What additional information is needed to inform policy recommendations?

Public Comment

Please limit comments to 2 minutes

Closing and Next Steps

- REMINDER: DHCS is seeking input, edits, comments, or questions by Monday, December 23, 2019.

- Next Meeting: Friday, January 10th