DHCS Stakeholder Meeting

November 18, 2014

Summary of major areas of public comments that were received:

- Eligibility: Elimination of CDE, initiate BHT prior to DX, include maintenance as a treatment goal
- Provider participation criteria: Use 3 tier model 1374.73; regional center rates are unsustainable
- Utilization controls: PA for treatment not less than 180 days

Revisions that will be made to State Plan Amendment:

- Eligibility Criteria: Will move forward with CDE dx of ASD; must prevent or minimize the adverse effects of ASD and promote beneficiary functioning
- Provider participation requirements: consistent with H&S Code section 1374.73; but will include some education and training of staff from CMS
- Utilization controls: consistent with 1374.73, not less than 180 days

Transition Plan

- The estimated number of clients in regional center who are Medi-Cal eligible is 7700; looking into whether these clients are assigned to a managed care plan or our fee for service model
- Want to develop a "phased" approach

Overview of Medi-Cal Managed Care BHT Service Delivery

- 22 managed care plans in CA

Overview of Rate Development Process

Greg Rose, Professor of Economics

- Introduction
    - Allowance Analogy: old indemnity insurance versus capitation under managed care
    - Heaven's Gate: gatekeeper
- Purpose
    - Size of the program (# programs, #plans, # of beneficiaries, value of experience)
    - Capitation rate ranges for our managed care programs are developed in accordance with rate-setting guidelines established by the Centers for MediCare and Medicaid Services (CMS). FFP requirements and when they are putting up about 50% of the funds, we will do what they require.
        - CMS says if you want us to pay x then these are the steps you must take
        - Must correctly match the payment to the service
- Process for setting capitation
    - Fee for service equivalent cost – old CMS requirement
    - Experience based rates

    - Base data: health plans give government costs, which is a rate development template
    - Rate of Category of Aid Groupings
    - Issues:
        - Fee for service from Regional Centers – costs (a proxy)
        - Need to figure out what utilization will be
        - May add a kick payment (if client # goes above a certain amount)
- Trends – try to smooth the programs year to year
- Program changes – estimate and build in an adjustment
- Risk and efficiency

Comprehensive Diagnostic Evaluations (2002)

Components of a Best Practice Diagnostic Process

- Review of relevant background
- Parent/caregiver interview
- Medical evaluations
- Direct behavior observations
- Cognitive assessment
- Adaptive functioning

Licensed Practitioners/Specialists

- Specialists in ASD (e.g., UCs, Health Plans)
- Regional centers
- Centers for excellence
- School districts

Requirements

- Regional centers have 60 days to 120 days to complete
- Preventative services (BHT) must be recommended by a licensed practitioner
- Diagnosis is required prior to provision of medically necessary BHT services

Other Health Coverage (OHC)

- Providers can bill Medi-Cal for remaining unpaid balances
- If client has primary insurance from a commercial plan and secondary through Medi-Cal
- Beneficiaries are required to seek OHC first and before utilizing Medi-Cal
- Medi-Cal is reviewing waiver to see if they should pay copays

To Do List for SCCBA:

Need to send wording change regarding QAS professional - DONE

Send document describing how more clients will be eligible and more clients may be eligible for more hours per week.

Send information regarding CPT codes we would like to use; consistent; HIPPA compliant; HICFA standardized; oftentimes they use modifiers (one code with modifiers and specifying what they would be paid); concurrent billing can be done