

Financing Options for Co-occurring Services

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Overview of Presentation



- ★ Administrative and Financing Issues re: Co-occurring Services



- ★ Discussion of Funding Streams

- ★ Pricing Co-occurring services

- ★ Opportunities and Examples





Administrative and Financing Issues



* Lack of consensus of what AOD, MH and Medicaid are willing to buy



* Federal and state statutes/requirements don't allow agencies to blend funding



* Suspicion/reluctance to transfer dollars

* No clear agreement/process to track encounters or expenditures



Administrative and Financing Issues



★ Lack of experience with each other's networks—although often they share providers



★ Agreeing upon program design and credentials for staff



★ Deciphering state practice acts that are important to other payers--QBHPs



Administrative and Financing Issues



★ Changing provider reporting/billing practices

- No requirements to report more than one diagnosis for most current services
- Few incentives or tools to do additional (and accurate) program reporting





State General Revenue Constraints



- * If separate AOD and MH state authorities—different contracting, reimbursement, credentialing and monitoring requirements
- * No new money—often seen as a separate initiative needing new dollars
- * Issues with cost centers and ability of co-mingling of services and fund sources
- * Rules/regulations that don't promote IGA that allow money to flow between agencies





State General Revenue Constraints



- ★ Difficult to determine how has primary contracting and reimbursement responsibility (not our clients)
- ★ Create “siloing” effect in providers creating separate programs





State General Revenue Constraints



★ Potential Federal Funding Sources

- SAPTBG
- MHBG
- Medicaid
- TANF
- Others





Using or Leveraging Federal Funds



* SAPT and MH Block Grants

- Clear direction that block grants should be used to finance co-occurring services
- Block grant applications do not reflect directive
- Federal statutory/regulatory requirements have not changed to reflect this direction
- No specific exclusions
- States are very cautious re: mingling funds across block grants and other federal programs



Using or Leveraging Federal Funds

* Medicaid

- Will fund treatment and support services
 - Screening
 - Assessment
 - Outpatient
 - Individual
 - Family (including multi-family)
 - Group
 - Intensive Outpatient Services
 - Crisis Services
 - Methadone
 - ACT





Using or Leveraging Federal Funds



- * May Fund Residential Services—considerations:
 - Specifying the treatment and support components
 - Quantifying the treatment and support component per day, week or month
 - Historic and new Issues with IMD
 - Will not pay for watchful oversight
 - Will not pay for room and board

- * Other limitations:
 - Education
 - Employment

- * Services must be medically necessary and ensure:
 - Statewideness
 - Choice of any willing/qualified provider
 - Comparability of Services



Using or Leveraging Federal Funds



- ★ State match is required for Medicaid – can not use other Federal funds (e.g. block grants).



Factors Influencing Pricing

- * Identifying and understanding program costs for discrete programs—rates not related to costs will impact access
- * Identifying specific enhancements to existing programs and associated state and provider costs:
 - Training/Orientation (state costs)
 - Effects on productivity of trainees (provider costs)
 - Retaining qualified providers/staff—making sure you provide incentives for continuing program fidelity
 - Costs of state certification/credentialing process





Factors Influencing Pricing

- ★ Number and qualification of staff
 - Staffing patterns
 - Expectations re: crisis response
 - Number and level of practitioner to ensure good risk management and payer qualifications
 - Medical oversight needed—how much?
 - Supervision requirements for non-licensed/credentialed staff





Opportunities

- ★ Joint Purchasing Among Agencies
 - Different state agencies purchasing same service:
 - Development of a purchasing cooperative through and MOA
 - Standardized contracting
 - Standardized pricing
 - Expectation that state is payer of last resort





Example: Connecticut SA/MH Day Programs



* Three agencies purchasing services:

- DMHA
- DOC
- Court Supported Services Division



* Goals:

- Common contracting
- Rate setting
- Financial Reporting





Example: Connecticut SA/MH Day Programs

* Results:

- One agency (DMHAS) will contract for co-occurring services for all three agencies
- CSSD, DOC and DMHAS developed contract—Domino's theory
- CSSD and DOC transfer funds quarterly to DMHAS
- DMHAS pays providers
- IGA specifies frequency/format for reporting





Example: Connecticut SA/MH Day Programs



★ Critical foundation:

- Clear about the services that were going to be purchased
- Good cooperation and trust among participating agencies
- Clear protocol for identifying client payment responsibility



Opportunities

* Third Party Intermediary

- Implements multi agency intents and policies
- Makes decisions about the fund source that is used
- Provides accountability to all payers
- Addresses state issues that state agencies have regarding co-mingling of funds





Example: Michigan

- * State has been focused on co-occurring issue for over 10 years
- * AOD authority issued a policy to respond to barriers identified relative to provision of services for co-occurring disorders:
 - Eligibility for services
 - Funding
 - Diagnosis
 - Encounter reporting





Example: Michigan

- * **Eligibility** – Standards for eligibility did not change. When a client meets MH or AOD eligibility criteria, services to address co-occurring disorder are covered.
- * **Funding** – State general MH funds, state AOD funds and Medicaid can be used to pay for services
- * **Diagnosis** – Presence or sequence of diagnosis not a factor in reimbursement
- * **Encounter Reporting** – Demographic information from encounter reports assists state with outcomes measurement





Example: Iowa

- * Goal – Not to add a third services tier (i.e., AOD, MH and co-occurring)
- * No new services or new rates
- * Strategies for co-occurring services are aimed at the treatment level
- * Encourage dually-accredited providers who will be deemed eligible to participate across systems
- * Managed care plan regularly interface with providers at roundtables and association meetings to discuss case-specific issues





Opportunities

- ★ Single state agency identified as lead:
 - Statutory/Regulatory authority for co-occurring
 - Has identified budget authority for co-occurring





Decisions

★ Need a framework before you discuss financing:

- Agreement on what you are buying:
 - Services
 - Competencies
 - Positions
- Agreement on service requirements
 - Service activities
 - Agency requirements
 - Staff credentials
 - Staffing patterns
 - Hours of operation





Decisions

- * Agreement on rate or rate methodologies
 - Fee for Service
 - Grant
 - Case Rate
- * Affordability
 - What will it cost (include start up)
 - What will be the projected utilization (18-24 months)





Decisions



- ★ Identify funding sources do we have available



- ★ Identify how services will be purchased

- ★ How will services be monitored and changed over time

