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MINNESOTA STATE LEGISLATURE REPORT: FINAL STUDY OF MENTAL HEALTH REIMBURSEMENT

July 17, 2018

INTRODUCTION

This summary report for the Minnesota Legislature in response to Minnesota Laws 2015, Chapter 71, Article 2, Section 39, discusses options for Medicaid provider payments to support and sustain community based mental health services throughout Minnesota. It summarizes the Educational Research Analysis of the State of Minnesota's (State's) current Medical Assistance reimbursement methods for adult and child mental health services commissioned by the Department of Human Services (DHS) and conducted by Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC.

Purpose of this Analysis

The purpose of this analysis is to review current Medicaid payment methodologies and to recommend strategies to provide adequate service payments to providers in support of better health outcomes, accountability, efficiency, and best practices. The study also suggests how to measure "adequate reimbursement to sustain community-based mental health services." Minnesota, like many states, has a complex set of payments and rules for community mental health services that evolved over time, resulting in payment differences for similar services across provider types. This presents some administrative burdens for the State and its mental health providers. As a result of this study, the State will work toward emphasizing transparency, equity and sustainability in the reimbursement process for quality services and the best health outcomes. By implementing a payment model that rewards providers for operating efficiently, achieving good service outcomes and allowing for ongoing investment in improvements, Minnesota will aid in supporting long-term sustainability of the community mental health system.

What is a sustainable system?

A sustainable community mental health system has at least seven characteristics:

1. service capacity and geographic access is adequate to meet demand;
2. payment for proven research based care;
3. reimbursement for effective care;
4. payment for new emerging practices;
5. a full continuum of services for adults and children;

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6. an operationally efficient system; and

7. payment covers cost components necessary to deliver efficient, effective, quality, and accessible care.

Each of these elements is necessary to achieve a stable community mental health care system capable of meeting the needs of children and adults with public insurance (i.e., a sustainable system), which is explained in more detail below:

1. **Build adequate service capacity and geographic access** — A sustainable community-based mental health system would ensure services for adults and children are geographically available when needed without long wait times. When services are not available or wait times are long, the mental health condition may worsen and the individual may require more intensive and costly care. Individuals with serious mental health conditions, when receiving the right services, can and do recover, gain resiliency, overcome lifelong effects of trauma, have meaningful lives, and participate in education, work, family, and social activities. Adequate access requires cultural- and linguistic-responsiveness, hours of operation that match clients' availability, and location that considers distance from clients and transportation availability. Development costs for geographically diverse and culturally-responsive services can be significant in a state like Minnesota.[1]

2. **Pay for services that are proven by scientific research to improve treatment outcomes** — An evidence based practice (EBP) is a combination of procedures and supportive activities conducted in a specified manner that has been proven by scientific, clinical research to be effective in improving an individual's health outcomes. A key characteristic of an EBP is that it is measurably effective and replicable.

3. **Measure short and long-term treatment effectiveness and reimburse for effective care** — Payments must include resources for measuring quality that allow the State and its providers to track the treatment outcomes and costs of care.

4. **Test and evaluate innovative and emerging practices for evidence of clinical and cost effectiveness** — The payment system must be flexible enough to support innovations in service models and emerging best practices. This ensures that Minnesotans have timely access to the best available practices and that providers are reimbursed for the additional expenses to stay abreast of emerging practices and to implement them if there are exceptional costs associated with those practices.

5. **Integrate a full continuum of proven and emerging best practices into Minnesota Health Care Programs (MHCP)** — The State must steer the mental health system in the direction that achieves the

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[1] Minnesota is one of the nation's healthiest states; however, below the surface we are also home to some of the largest inequities in health status and incidence of chronic disease between populations. http://mncm.org/wp-content/uploads/2015/01/2014-MN-Community-Measurement-Health-Equity-of-Care-Report.pdf. *2014 Health Equity of Care Report,* Minnesota Community Measurement, page 3. http://mncm.org/wp-content/uploads/2018/01/2017-Health-Equity-of-Care-Report_unencrypted-1.pdf. Health Equity of Care Report, 2017.

best outcomes over the long-term and to develop reimbursement approaches that support an "ideal service array." Selecting and supporting proven and emerging community-based mental health services that match population needs is critical to achieving best outcomes. A full continuum of services includes clinical, rehabilitative, peer support, care coordination, and supportive services. It includes prevention and deep-end residential services, such as Psychiatric Residential Treatment Facilities (PRTFs).

6. **Operational efficiency** — An efficient provider has the ability to keep its costs within a reasonable range of mental health and other health care providers within its labor and service market, acknowledging that the State, and other payers, must set rates in the context of all other medical and therapeutic provider sectors who are competing for the same healthcare dollar. Efficiency is a much larger issue than just the purchase of labor and expertise; it includes how competently the provider utilizes the resources necessary to provide the contracted services.

7. The seventh component of sustainable systems — **adequate reimbursement to sustain services** — is explained below.

What is adequate reimbursement to sustain community mental health services?

Payers in a sustainable community mental health system cover all of the required cost components that support State standards of efficiency, effectiveness, quality, and accessibility. Providers must be adequately reimbursed for the costs of delivering basic assessment, therapy, skill-building, and evidence-based services that meet State standards. It is important that the provider reimbursement is sufficient for continued investment in the service capacity. If payments do not adequately cover the cost of required training, supervision/consultation, materials, or quality improvement activities, the services will not keep pace with best practices and achieve the desired access and quality outcomes defined by the State. Adequate reimbursement does not mean that excessive or inefficient provider costs are covered; rather, it means that required and reasonable costs of the average provider will be covered with sufficient return on investment (i.e., profit) for the provider to continue to invest its resources in growing services necessary to meet communities' needs. Required costs include Medicaid's share of the costs of the training, accreditation and certification costs that providers must incur in addition to the basic licensure required to provide research-based practices that are cost-effective compared to institutional payments. The federal government has outlined allowable reasonable costs in its new Cost Reimbursement regulations located at 2 CFR 200. The Centers for Medicare and Medicaid has further defined appropriate Medicaid costs in its statutes and regulations requiring that costs only cover what is necessary and efficient for the proper administration of the Medicaid services.

In addition, most policy makers believe that creating more value in health care (i.e., paying for quality of care, not quantity of services[2]) is a basic principle in having a sustainable health care system in general.

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[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html

The new initiatives for value-based purchasing (VBP)[3] in Medicaid address these policy makers' concerns nationwide.

Financial viability is just one component of "sustainability." The State is responsible for development of a continuum of effective, quality services for people of all ages that are accessible across the state and supported through payment approaches. Making available community-based mental health services that match population needs, measuring quality, and providing incentives to achieve the best outcomes are all part of the process to achieve a sustainable and high quality mental health system. Capacity development of an effective, high quality service continuum is a particular shortcoming in a state like Minnesota with substantial geographic access gaps and culturally-responsive access gaps, resulting in wide mental health outcome disparities for Minnesota's increasingly diverse communities.[4]

Goals of System Reform

The payment and system reforms for delivering more research-based care discussed in this report focus on alternative payment models and/or reimbursement methodologies for community-based mental health services to achieve the following results:

- Reasonable, transparent,[5] and adequate provider reimbursement that compensates for State requirements of delivering mental health services for children and adults, allowing payers such as Medicaid managed care plans and the fee-for-service (FFS) delivery system to reimburse the services provided in a manner that is understandable.

- Clear strategies to guide both the FFS and managed care delivery systems with the implementation of research-based mental health care.

- Sustainability and expansion of EBPs to meet the needs of individuals and families and achieve efficiencies.

- A performance driven system centered on positive outcomes and improving care provided to children and adults accessing care.

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[3] Value-Based Purchasing (VBP): Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers. U.S. Centers for Medicare and Medicaid Services, https://www.healthcare.gov/glossary/value-based-purchasing-vbp/

[4] Minnesota has some of the worst racial disparities in the nation. http://minnesota.cbslocal.com/2017/08/22/minnesota-racial-inequality/ The website 24/7 Wall Street listed Minnesota as the second-most unequal state in the country behind Wisconsin. https://www.politico.com/magazine/story/2016/07/minnesota-race-inequality-philando-castile-214053 In metrics across the board—household income, unemployment rates, poverty rates and education attainment—the gap between white people and people of color is significantly larger in Minnesota than it is most everywhere else.

[5] Transparency contributes to the sustainability of a system through improved understanding of the fairness, accuracy, and accountability of the rate setting process. Transparent rate setting methodologies are necessary so that providers understand the service components that are included and excluded from reimbursement, - generally, any documentation, training, and certification costs. Without transparency, providers may be unable to understand what required service elements the State is compensating versus the optional elements that the State is not compensating.

Methodology and Data Collection

The study used six primary tools listed below to obtain data from Minnesota provider agencies, as well as Minnesota State staff and other relevant state programs, and verify the information that guided recommendations in this report. Summaries of the information collected are available for reference as appendices to the Educational Research Analysis. Mercer and DHS worked collaboratively to gather data through training providers on completing the provider cost reports and conducting interviews with providers, stakeholders, and other states as well as in-person focus groups. In addition, Mercer supplemented data through its own rate setting processes for similar services in other states, interviews with other states providing similar services and national cost data relating to EBPs. The data was compiled in partnership with representatives from the Minnesota DHS Mental Health Divisions and from the Minnesota DHS website and staff interviews. Specifically, data was collected from:

- Cost reports voluntarily submitted by 22 agencies in Phase One and 33 agencies in Phase Two[6] representing approximately 4.6 percent of the provider agencies;
- The Provider Survey completed by 95 child and adult serving agencies in Minnesota representing approximately 7.9 percent of provider agencies;
- 45 participants in in-person focus groups from a variety of child and adult serving agencies in Minnesota representing approximately 3.8 percent of provider agencies assuming one participant per agency;
- The EBP stakeholder questionnaire data submitted by 89 Minnesota providers recognized to deliver EBPs representing approximately 7.4 percent of provider agencies;
- 9 participants in state staff interviews from four selected states providing EBPs and participating in VBP initiatives; and
- Input from a Minnesota state staff EBP workgroup including 6 DHS staff members.

Following the data collection and analysis process, Mercer analyzed reimbursement methodologies in order to better understand fee schedule rates compared to the provider cost experience and the State's goals of increasing fiscal and programmatic accountability. The Mercer team and DHS followed a similar process to collect information and develop recommendations for performance measures.

[6] The number of providers responding to the State's requests for cost reports was extremely low. The agencies submitting cost reports were not selected by the State. The limited respondents were the agencies of the approximately 1,200 Medicaid billing mental health provider agencies that chose to submit their costs to the State agency for this analysis. Because of the voluntary nature of the study and the small number of respondents, Mercer is not able to conclude that these costs are representative of the larger provider industry in the State.

CURRENT STATE OF MENTAL HEALTH SYSTEM IN MINNESOTA

Reported costs exceed reimbursement rates for the respondents

The data submitted from the small number of cost report respondents reported that the cost of care exceeded reimbursement rates. As noted above, the number of providers responding to the State's requests for cost reports was extremely low. The agencies submitting cost reports were not selected by the State. The limited respondents were the agencies of the approximately 1,200 Medicaid-billing mental health provider agencies that chose to submit their costs to the State agency for this analysis. Because of the voluntary nature of the study and the small number of respondents, Mercer is not able to conclude that these costs are representative of the larger provider industry in the State.

In the first phase of collected cost reports, Mercer analyzed the costs of 37 different types of services.[7] The number of providers voluntarily submitting data for each service ranged from 1-13 providers per service. Of the providers who responded, the reported costs for 23 services that were higher than the providers were paid in calendar year (CY) 2015, including:

- Skills Training & Development — Family — Children's Therapeutic Services and Supports (CTSS)
- Adult Day Treatment Services
- Adult Medication Assisted Therapy Chemical Dependency
- Children's Crisis Response Services
- Children's Day Treatment Services
- Clinical Care Consultation
- Diagnostic Assessment — Brief
- Diagnostic Assessment — Interactive Complexity
- Diagnostic Assessment — Standard
- Diagnostic Assessment — Update
- Family Psychoeducation
- Mental Health Behavioral Aide (MHBA) Services
- Mental Health Provider Travel Time Services

[7] Mercer collected the cost and reimbursement data on a per unit basis — meaning the length of time that the provider would provide and be paid for the service. For example, for a mental health service provided for an hour, the provider reported the cost to provide an hour's worth of service versus how much he or she would be paid for that same hour of service.

- Neuropsychological Services
- Outpatient Psychotherapy Services — Crisis
- Outpatient Psychotherapy Services — Family
- Outpatient Psychotherapy Services — Group
- Outpatient Psychotherapy Services — Patient and/or family member
- Partial Hospitalization Services
- Psychological Testing and Explanation of Findings
- Rehabilitative Psychotherapy — Family — CTSS
- Rehabilitative Psychotherapy — Group — CTSS
- Skills Training & Development — Group — CTSS

The range of provider costs for these services was between 2.0 percent to 1129.0 percent higher than the payments received.[8] Only six services had reported costs lower than payments by DHS (ranging from 2.0 percent to 47.0 percent lower):

- Adolescent Outpatient Chemical Dependency
- Adult Crisis Response Services
- Adult Outpatient Chemical Dependency
- Adult Rehabilitative Mental Health Services
- Diagnostic Assessment — Extended
- Rehabilitative Psychotherapy — Patient and/or Family Member — CTSS

Six services did not have information submitted and are omitted from this analysis: Adult & Adolescent Hospital Chemical Dependency; Certified Peer Specialist; DC:0-3R and Required Outcome Measures; Dialectical Behavior Therapy (DBT); Functional Assessment; Individual Treatment Plan Development; Psychiatric Consultation to a Primary Care Provider. The overall finding, with the caveat of the voluntary

[8] This wide variance could be due to inconsistent provider allocation procedures or providers not aligning expenses and units to the DHS billing guidance.

nature of this study, is that behavioral health providers report that the cost of care is higher than CY2015 payments for most services.

Without mandatory reporting by providers, Mercer received insufficient data to verify the results of these respondents and determine if these costs are representative of the Minnesota Medicaid provider community. To supplement this information, Mercer utilized cost projections and rates from Medicare and other states to compare Minnesota reimbursement rates to similar services.

To determine how the Minnesota reimbursement rates compared for one of the categories where providers reported that rates equal costs, Mercer compared the rates paid for CTSS Individual Skills Training and Development to the rates currently paid in three other similar Medicaid programs. These three states were selected because all three utilize reimbursement rate setting methodologies using modeled rate reimbursement methodologies basing mental health rates on the expected costs of the average provider. These three states have a variety of rural and urban areas similar to Minnesota's diverse geography and are located in the Midwest, south and eastern portion of the United States. In addition, this service was selected because the providers in Minnesota reported that the costs were roughly equal to the payment rates. Finally, as noted later in this report, this rate is utilized to reimburse research-based services for which there are national standards not reimbursed by Minnesota. See Table 1.

TABLE1: COMPARISON OF REIMBURSEMENT RATES BY PRACTITIONER TYPE FOR UNLICENSED MENTAL HEALTH SKILL BUILDING

PRACTITIONER LEVEL	MINNESOTA	STATE A (SET 12/1/2015 AND STILL EFFECTIVE 1/1/2018)	STATE B (SET 7/1/2016 AND STILL EFFECTIVE 1/1/2018)	STATE C (SET 7/1/2017 AND EFFECTIVE 1/1/2018)
Skill-building — Bachelor's level practitioner	$13.44	$14.87	$16.80 in office; $21.51 in community	$19.96 in office; $25.46 in community
Skill-building — Master's Level (MA) Practitioner	$13.44	$18.06	$20.66 in office; $21.51 in community	$22.47 in office; $28.59 in community

Note: all rates are for 15-minute time increments.

As noted in the table, all of the comparison states have higher fee schedule rates than Minnesota. These states also pay higher amounts for more highly educated unlicensed practitioners. Two of the comparison states pay enhanced rates for community-based services where travel costs were factored in.

Complexity obscures ability to determine that legislative intent was met

Mercer determined that 83.0 percent of providers in the Phase I cost study were eligible for the legislatively mandated 23.7 percent rate increase for essential providers in July 1, 2007 – January 1, 2008. However, due to the complex nature of how these increases are applied to the rates (based on practitioner type,

effective date, service, etc.), Mercer was unable to distinguish the impact this rate increase had on these providers versus providers who were not eligible for the increase. This finding suggests the complexity of the current rate structure and lack of transparency in the application of legislative rate-setting makes it challenging to determine if support of essential providers was achieved. Please note: addressing this complexity would require legislative action.

Wage Data Underscores Recruitment Challenges

In the second phase of the collected cost reports, Mercer focused on the largest determinant of mental health service costs: labor costs. Because wages account for a majority of community-based outpatient mental health service costs, Mercer analyzed the salary and wage cost information reported to be paid by providers submitting cost reports and compared this to the U.S. Bureau of Labor Statistics (BLS) wage data specific to Minnesota.[9] Mercer found that, consistent with reports from providers on surveys and questionnaires, Minnesota Medicaid providers reported providing higher average salaries than the BLS median wage levels for like job positions in Minnesota. In some cases, such as an Advanced Practice Registered Nurse (APRN) and psychiatrist, the wage levels reported among the provider cost surveys is significantly higher than the 75th percentile of BLS wage data in Minnesota. This supported provider survey responses that recruitment of qualified behavioral health staff, especially medication prescribers, has been a challenge. Providers reported offering very competitive wages and salaries to have an adequate workforce even if the reimbursement rates do not include commensurate competitive salary reimbursement.[10]

Current Minnesota Reimbursement Methodologies

Mental health service fees to providers in the State of Minnesota are reimbursed with fees set by one of the five following rate-setting methodologies:

- Fee schedule developed based on Resource-Based Relative Value Scale (RBRVS) methodology (Current Procedural Terminology (CPT) codes)
- Fee schedule developed based on relational modeling (Health Care Financing Administration Common Procedure Coding System (HCPCS) codes)
- Cost-based prospective fees

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[9] In some cases (e.g., Psychiatrist), Minnesota BLS data was available at specific position levels. For other positions, such as Mental Health Practitioner, Mercer blended common BLS job classifications typical for this type of practitioner in Minnesota to provide a comparison point. This blending is consistent with that done in other states that developed a reimbursement rate for a specific job position. The Centers for Medicare and Medicaid Services (CMS) recommends that BLS data be utilized for Medicaid rate setting but does not specify the percentile that should be used, leaving that decision up to state rate setters.

[10] Though comparison of reimbursement of mental health professionals to professionals in other specialties is beyond the scope of this analysis, please note the recent study found that Minnesota insurance company payments were lower to psychiatrists than primary care providers and specialty doctors, even though psychiatrists are doctors and wages are commiserate with other physicians. This poor reimbursement resulted in lack of in-network access to mental health professionals and individuals seeking mental health care out-of-network. Star Tribune. *Rising cost of mental health care vs. other services draws Minnesota scrutiny.* December 24, 2017.

- County negotiated rates and County share of payments
- Time studies

A complete description of each of these methodologies as well as the deficiencies in the rate setting methodologies and gaps in payment structure is included in the Educational Research Analysis in Section 6.

The above methodologies pertain to fees reimbursed directly by DHS for Medicaid-enrolled individuals not enrolled in one of the State's Prepaid Medical Assistance Plans (PMAPs), which are the State's managed care plans. About two-thirds of all adult mental health services and about 80.0 percent of all children's mental health services are provided through the State's PMAPs. PMAPs are able to negotiate their own fees and utilize different rate-setting methodologies.[11] This additional flexibility allows PMAPs to create flexible fee schedules that can reward efficient providers or accommodate additional costs faced by providers. However, because the actual reimbursement schedule of providers can vary by PMAP, the flexibility can undermine the State's ability to compensate providers for making systemic changes or providing value-added services desired to meet State aims.

TABLE 2: MINNESOTA REIMBURSEMENT DELIVERY SYSTEM AND FEE SETTING METHODOLOGY BY SERVICE (PROCEDURE) CODE

SERVICE	REIMBURSEMENT DELIVERY SYSTEM	FFS FEE SETTING METHODOLOGY
Outpatient Assessment, Therapy, and Treatment reimbursed using CPT codes	FFS and Managed Care*	RBRVS
Outpatient Treatment reimbursed using HCPCS codes including peer support and crisis intervention	FFS and Managed Care*	Relational Modeling
Short-term Residential	FFS and Managed Care*	Prospective Cost Based Rates
Assertive Community Treatment (ACT)	FFS and Managed Care	Prospective Cost Based Rates
Long-Term Residential	FFS and Managed Care*	Prospective Cost Based Rates (Adults) & County Negotiated rates (Children)

*Note: Two-thirds of all adult mental health services and 80.0 percent of all children's mental health services are in PMAP capitated program. For the exact codes reimbursed under each methodology see the Educational Research Analysis.

[11] News articles highlighted concerns that the Blue Plus Medical Assistance Health Maintenance Organization (HMO), which is a Medicaid health plan, will pay less than the State's Medical Assistance fee schedule for behavioral health outpatient services. Star Tribune. *Blue Cross payment cuts prompt protest by Minnesota mental health providers.* September 6, 2017.

Resource-Based Relative Value Scale (RBRVS)

As noted in the table above, a large portion of the mental health outpatient rates in Minnesota are set using a RBRVS methodology. However, unlike in other states (e.g., Louisiana, Delaware), Minnesota does not index its Medicaid rates directly to the Minnesota Medicare fee schedule. Instead, while the RBRVS methodology is used by Minnesota to set all physician service fees, including many mental health service fees, DHS has created an RBRVS conversion factor that is lower than Medicare's conversion factor due to budget constraints and needing to stay below the Upper Payment Limit (UPL). DHS has also created a mental health conversion factor within the RBRVS method to make the rates more specific to mental health services. The mental health conversion factor pays 90 percent of Medicare rates before other mental health add-ons are applied that bring the total reimbursements for those mental health rates above Medicare payments. This is significant because the conversion factor for Medicaid Evaluation and Management services and Obstetrics services pays only 77 percent of Medicare rates, while other Medicaid physician services have conversion factors that pay only 71 percent of Medicare rates. Please note: the RBRVS rate methodology for setting Medicare rates is described in Section 5 of the Educational Research Analysis.

Over time, the application of add-ons to the RBRVS methodology for mental health services in Minnesota has led to the reimbursement methodology becoming increasingly complex administratively, and there is also considerable variation in fee levels substantiated by legislation resulting in various upward and downward adjustments to the rates.

The three key factors that result in variation of rates between provider types or practitioner levels are:

- A 23.7 percent increase for certain mental health professionals that generally are designated by the Minnesota Department of Health (MDH) as essential community providers (effective July 1, 2007, or January 1, 2008).[12]

- A 4.0 percent further increase for CTSS individual skills training and family skills training, effective January 1, 2008.[13]

- A 20.0 percent cutback for most clinical and rehabilitative services when provided by a master's-level enrolled provider, except for those provided in a community mental health center.[14]

One result of the complexity of the State's RBRVS fee methodology and the use of non-standard coding is that standard coding definitions have been modified, a two-tiered fee system has been established, and code combinations are no longer consistent with National Correct Coding Initiative (NCCI) and American Medical Association (AMA) guidelines.[15]

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[12] MS 256B.763, Critical Access Mental Health Rate Increase.
[13] Ibid.
[14] §256B.0625, subdivision 38
[15] The NCCI initiative is a mandatory Medicaid fraud and abuse requirement that requires states to utilize standard coding, definitions and Medicaid Information System edits and audits to ensure that Medicaid is a payer or last resort for services reimbursed by

As noted in the Educational Research Analysis, Minnesota's behavioral health physician RBRVS rates are lower than the Minnesota Medicare rates for physicians not designated as essential community providers; while rates are higher than Medicare for behavioral health physicians designated as essential and for children's mental health rehabilitation services. The DHS RBRVS mental health conversion factor is the highest conversion factor for all professional services paid in the Minnesota Medicaid program. The mental health conversion factor is dependent on the legislature to increase, resulting in higher mental health rates. The "non-essential" physicians tend to be the state's smaller non-profit clinics and individual practices, which tend to include culturally-specific providers. However, Minnesota pays both "non-essential" and "essential" non-physician providers at the same rate as physicians, which is more than what Medicare and other states pay non-physician providers.

While DHS and the Minnesota Legislature have developed specific factors and other adjustments pertaining to the RBRVS fees, providers have also expressed concern that the basis for the RBRVS rate does not accurately capture the costs and challenges they face for the Medicaid population. This is consistent with the general feedback on RBRVS methodologies for mental health services, as described in Section 5 of the Educational Research Analysis. Specifically in Minnesota, providers note that no-show rates are higher for the Medicaid population than the Medicare populations, which results in lower productivity due to missed appointments. Additionally, some agency providers note that their role as safety net providers for this population results in a higher acuity of individuals, which require more resources than are captured in the Medicare-based methodology. The RBRVS methodology has different factors for services performed in a facility versus a non-facility and assumes that the physician bears higher overhead/practice costs in a non-facility setting than if the physician performed the service in a facility. This is typically true of medical practitioners or licensed practitioners directly enrolled in Medicaid in independent practice who may utilize an office setting as well as perform duties in a hospital where the hospital is paid a separate facility chart. However, a reimbursement methodology for mental health agencies based solely on RBRVS may not be appropriate for larger agencies which are more like a clinic setting and would not be reimbursed for the overhead charges associated with provision of twenty-four hour crisis management, after-hours access, operations in areas with accessibility issues and extensive service arrays utilizing unlicensed staff. Nevertheless, this methodology might be appropriate for licensed mental health practitioners practicing independently and directly enrolled in Medicaid or enrolled as a group with a group billing entity that is not similar to clinic or outpatient hospital settings.

Medicare and private insurers. Mercer's review of Minnesota's coding found that while national codes were utilized, there were definitions and units of services that were not consistent with national standards (e.g., 90791 assessments). For example, CPT code 90791 pays assessments using a three-tiered rate that is not consistent with NCCI and AMA guidelines. This is a statutory requirement from Minnesota statute 256B.761(c). The inconsistencies found in Minnesota's coding appeared to be found when the State tried to utilize standard codes in a manner that was inconsistent with the national definitions and coding structure or when Minnesota was attempting create a state-specific benefit, address state-licensure issues or implement an innovative practice for which there was previously no national definitions and coding practices. When the State does not utilize the NCCI coding definitions and units, there is a risk that providers using the State-specific definitions and units will bill all costs to Medicaid erroneously rather than billing private insurance and Medicare first. If third-party billing is not enforced by the State using audits for non-industry standard coding such as 90791, this results in cost-shifting from private insurers and Medicare to Minnesota Medicaid and Minnesota Medicaid paying for a larger share of behavioral health costs.

Upper Payment Limit (UPL)

In Minnesota, the rates for physicians and licensed practitioners reimbursed by Medicare are subject to the Center for Medicare and Medicaid Services (CMS) UPL under the Medicaid program. The federal UPL test does not allow a state Medicaid program to reimburse more in aggregate for the licensed practitioners including physicians than Medicare would pay for services by the same individual practitioners. Minnesota permits the essential mental health physicians and non-physicians to be paid more than Medicare only because other non-mental health physicians and non-physicians are paid less than Medicare. This imbalance between physical health and mental health practitioner type rates results in Minnesota being able to meet its aggregate UPL test to the federal government. The State is able to justify this differential in rates partially due to the mental health agency overhead costs which are higher compared to an independent practitioner.[16] Services provided in outpatient hospital departments and clinics are subject to similar UPL tests under the Medicaid program, but services under the rehabilitation option are not subject to a UPL test.

Relational Modeling

Other Minnesota Medicaid fees have been developed by relational modeling, which is similar to RBRVS and utilizes the relative resource costs for providing a service. Limited information or documentation was available from DHS to determine the details of these calculations, but the relational modeling was described as a process whereby DHS staff would identify services most similar to the service requiring a new fee and either use the RBRVS fee for that service or develop the fee for the other service based on adjustments to the similar RBRVS fee. In many cases, it seems the fee set based on relational modeling was established several years ago and due to staff turnover, specific detail on the rate-setting rationale is not available.

One general challenge with this methodology is that accuracy of reimbursement is dependent upon whether the services selected for relational modeling are actually similar to the chosen comparison over time. However, this could not be verified due to the lack of documentation. As discussed, some providers expressed concern with the basis of the RBRVS fees. To the extent these services are used in the relational modeling to develop other rates, any Medicaid allowable costs not reflected in the relational rate would consequently not be included in the other rate.

Due to the differences in the activities and staff qualifications for services that do not use CPT coding (i.e., HCPCS codes that are flexibly defined by Medicaid agencies), many states typically utilize market-based modeling approaches to FFS reimbursement, as it best captures the specific policies, goals, and landscape of mental health service delivery for non-standardized services.

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[16] An alternative for the State would be to only pay independent practitioners operating outside of mental health agencies using the RBRVS system and move the mental health agencies with significantly different infrastructure costs to the Rehabilitation Option authority not subject to a UPL test. A further discussion of this potential “tiered” reimbursement methodology approach is discussed below under the subsection “Use of a Consistent Reimbursement Methodology Would Improve Sustainability”.

Prospective Cost-Based Methodologies

For the intensive adult services of ACT, Intensive Residential Treatment Services (IRTS), and Residential Crisis Services (RCS), DHS has been using a prospective cost-based system to establish reimbursement rates on an annual basis. This methodology involves collecting annual cost information from the providers of these services, reviewing the cost reports and including an additional component for indirect costs to set the prospective rate. To the extent that provider costs are predictable and similar across providers, the use of a provider-specific prospective cost-based methodology may be more labor-intensive than necessary.

One of the primary drawbacks of this current methodology from a provider perspective is that federal requirements regarding cost reports outline reasonable cost requirements and limit the costs that may be included in Medicaid reimbursement.[17] Cost reports are subject to federal limitations and intensive federal scrutiny to ensure that federal reimbursement does not exceed reasonable standards. Because prospective payment systems trend existing costs forward, States must develop change in scope processes to recognize extraordinary changes in provider practices over time. Because of the time lag in prospective rate setting utilizing cost reports, if there is no change in scope process that is recognized immediately, then providers may not be compensated for necessary changes in practice until the next rate setting period. While there is some flexibility in each State's ability to recognize anticipated costs through change in scope processes for provider specific rates, statewide or regional fee schedules based on cost reports are based on average projected costs. With any reimbursement methodology setting standardized rates, there will be agencies that are not fully compensated for their costs while other providers are overcompensated (i.e., some agencies will have costs above the average and some agencies will have costs below the average).

Other Reimbursement and Funding Sources

In addition to the methodologies listed above, mental health rates are also set using the following methods, which were excluded from this analysis[18]:

- Children's residential services have rates that are set based on a negotiation process between counties and the providers of these services.

- Targeted case management rates are set using time studies, as well as to claim other federal administrative funds for government activities.

Drawbacks to use of Inconsistent Reimbursement Methodologies for a Single Set of Services

Minnesota's mental health system utilizes multiple reimbursement methodologies with legislative add-ons (e.g., resource-based relative value scale, relational modeling, legislative rate increases, provider specific cost-based rates, and county contracting) sometimes for a single rate for a service. (See the Educational Research analysis for a more thorough explanation of these methodologies.) The multiple methodologies,

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[17] See 2 CFR 200 et al.

[18] The children's residential services were not analyzed or considered in the reimbursement study. Other payment methodologies exist for services not included in this analysis, which include inpatient services, mental health Targeted Case Management (TCM) and all Substance Use Disorder (SUD) services.

which are not consistently applied, result in a lack of understanding of how the fees relate to state requirements and provider costs, confusion among providers and misaligned incentives for the delivery of care. The complexity can make it difficult for providers to understand Medicaid rules compared to other payers, stay current with State requirements, and grasp the impact of healthcare reimbursement changes. Such complexity and process inefficiencies can lead to gaps in service coverage and structural barriers to the provision of the health care each individual needs most and contribute to uneven delivery systems, leading to inappropriate care and unnecessary institutionalization. In short, the variability in rules related to the current reimbursement systems, where each provider is reimbursed using multiple methodologies across different services, and the differences in reimbursement methods used by the PMAPs create an administrative burden for providers. Well-executed payment reform, where each type of provider has more consistent reimbursement methodologies for a single service, can significantly offset this complexity by reducing the need for micro-accountability, standardizing rules and incentives across providers, and increasing transparency.

Use of a Consistent Reimbursement Methodology for Each Service Would Improve Sustainability
The use of consistent reimbursement methodologies that fully compensate for State service delivery standards such as practitioner qualifications, training, certification, and accreditation requirements, and others would improve system sustainability. The two primary methodologies that could accomplish Minnesota system goals are listed below. Consistent reimbursement methodology does not mean that Minnesota should necessarily adopt a single reimbursement methodology. Instead, Minnesota should ensure that providers are reimbursed using transparent methodologies that are easily understood and compensate for the State-required activities, components, and requirements.

For example, use of RVRBS reimbursement methodologies might continue to be appropriate for individual licensed practitioners directly enrolled in the Medicaid program who provide services reimbursed solely under CPT coding or who are enrolled as independent groups of licensed practitioners.[19]However, comprehensive and specialty rehabilitation agencies[20] may be better served through a prospective cost based rate setting or market based rate setting reimbursement methodologies that would compensate for higher state standards such as twenty-four hour access to care, accreditation, fidelity standards for EBPs, operations in provider shortage areas, and close supervision of unlicensed staff. These methodologies

[19] Individual and group licensed practitioners enroll directly in the Medicaid program. These practitioners are permitted by law and organization to provide care and services without direction or supervision within the individual's license and consistent with the privileges granted by the organization. Psychologists and Licensed Clinical Social Workers are examples of individual licensed practitioners in Medicare who may enroll directly with Medicare individually or as a group.
[20] Comprehensive rehabilitation agencies refers to large community mental health centers and other private sector agencies that provide a comprehensive array of non-hospital outpatient mental health services utilizing both licensed and unlicensed practitioners. Some of the services provided under the Comprehensive rehabilitation agencies would be covered under the The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Rehabilitation Sections of the Medicaid State Plan (especially mental health services provided by unlicensed practitioners) and some of the services would be provided by licensed practitioners such as physicians, psychologists, and licensed clinical social workers under other sections of the State Plan. Most notably, the unlicensed practitioners would be provided supervision by the licensed practitioners in a comprehensive rehabilitation agency. Specialty rehabilitation providers may provide a more limited set of services that includes unlicensed practitioners such as an agency specializing in children's evidence based practices; however, there is still an expectation that unlicensed practitioners are supervised by licensed practitioners within the specialty rehabilitation agency.

might be better suited to agencies with higher overhead associated with the provision of a more comprehensive or specialized array of services and more intensive services.

This type of tiered approach to rate setting might bring more consistency and transparency to the mental health system and result in compensation linked to state purchasing requirements in a more systemic manner.

If the State were to adopt this type of tiered reimbursement methodology through legislative, administrative rule, and State Plan changes, then the State's provider enrollment system and Medicaid Management Information System (MMIS) would need to be examined. Many states approach this by assigning individual licensed practitioners and groups of individual licensed practitioners to limited taxonomies and provider types that are different than agency entity taxonomies. However, in each case, that state's MMIS was able to pay different rates for different taxonomies or provider types. The limitations of the MMIS in terms of number of rates that will be set and the complexity of the rates must also be analyzed. For example, statewide fee schedules for a single provider type would be relatively less difficult to operationalize than regional rates or rates that differ by urban versus rural providers. Most states adopt a statewide fee schedule but there are some notable exceptions that adopt one or two regional or urban versus rural rates.

CMS has supported this type of tiered enrollment practices. For example, under the new fraud and abuse screening requirements in Medicaid enrollment, individual licensed practitioners could be considered low risk and have a different process for enrollment than rehabilitation agencies, which are considered moderate risk. Other States have not been able to reimburse differently by provider type or taxonomy and have therefore needed to utilize standard modifiers for billing. If this were to occur in Minnesota, the State may need to seek approval from the Administrative Uniformity Committee before implementation.

Option 1: Prospective Cost Based Reimbursement Methodologies

The State could utilize prospective cost-based reimbursement methodologies to establish rates prior to the beginning of the rate year. A fee is developed using cost information from a base rate year. The rate is trended forward to account for inflation in future years. CMS also allows states to build in changes in scope[21] for ***anticipated costs*** (e.g., states are required to modify Federally Qualified Health Center rates for anticipated changes in scope). In true prospective systems, there is no reconciliation between the fees and actual costs. However, when changes in scope for anticipated costs are permitted, most states require that the current year actual costs be compared to the costs that had been anticipated for the current year to ensure that prospective adjustments are accounted for accurately. In contrast, under retrospective payment systems, interim payments are made and the difference between payments and costs are reconciled and recouped or paid to the provider.

[21] For example, a provider anticipates additional clinical salary costs during the upcoming rate year to meet the demands of a newly-enacted benefit or to achieve the state's access standards.

If the state sets rates prospectively, the provider would be paid a predetermined fee for each unit of service delivered. The advantage to this approach is that the cost per unit is predictable for both the state and the provider. It is also easier, administratively, to implement than a cost settlement process.

A ***prospective cost-based approach*** typically uses historical cost levels from the provider to establish either a provider-specific cost-based reimbursement fee that is paid prospectively or a service-specific cost-based reimbursement fee that is paid prospectively. Typically, there is no reconciliation at the end of the period. This type of reimbursement structure involves slightly more risk than ***cost-settlement approaches*** for the provider, since their cost structure may have changed from the historical period, which is the basis of the cost based payment, and the contract period. This risk can be mitigated to some extent by annual rebasing of prospective payment system (PPS) rates to actual costs or shortening the intervals between re-basing the rates (i.e., revising rates based on the most recent cost period).

Under this approach, the state defines the reasonable costs incurred by providers delivering each covered service. CMS permits states to establish a statewide prospective fee on 100 percent of the average provider costs or a provider-specific prospective fee with required productivity measures. [22]This approach typically results in a fee schedule, based on provider cost reports.[23] Some reasonable costs states are permitted to recognize include:

- CMS allows cost-based rates to calculate a reasonable profit (for-profit providers) or return on investment (private non-profit organizations) to fund investments.

- States may also recognize provider agency costs necessary to meet the states' service delivery standards including cultural/linguistic access, quality requirements such as accreditation costs, and the costs to comply with required reporting.

In cost-based rates, the State must determine how to incorporate anticipated changes in scope prospectively or changes in scope that occurred between cost reporting periods. A "change in the scope of such services" is typically defined as a change in the type, intensity, duration, and/or amount of services. A change in the cost of a service is typically not considered in and of itself a change in the scope of services. In addition, simply providing more units or sessions of a given service is also not considered a change in scope because the provider will be paid more of the unit rates for more services provided.

The State must develop a process for determining a change in the scope of services for provider specific rates that would either require a supplemental cost report for that provider or recognize required changes in the system prospectively. The State would then monitor provider compliance with those changes and penalize providers if they fail to realize the changes for which they are compensated. While states have

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[22] For example, prior to the ACA, every Federally Qualified Health Centers (FQHC) physician in Medicare was required to count productivity using at least 4,200 visits and every Physician Assistant (PA), Nurse Practitioner (NP) or Certified Nurse Midwife (CNM) was required to utilize 2,100 visits).

[23] Cost reporting — through which an agency must identify its total annual costs according to standard, federally-allowable cost categories — is time-consuming, complex, and challenges the accounting capabilities of Minnesota's mental health providers, even the relatively large community mental health centers.

some flexibility regarding Change in Scope policy application, federal guidelines and state finances still prescribe the state's ability to make reimbursement changes for activities that are not implemented; that do not result in per unit increases in reimbursement; or that are not consistent with federally-allowable cost limitations (i.e., compensating for lobbying a governmental unit or overcompensating administrative leadership).

Providers have expressed concern regarding the lack of reimbursement for several activities considered to be necessary for effective care. Specifically, providers requested that cost-based reimbursement allow for changes in scope when provider practices change to include more travel for community and home based services, and higher costs due to more acute clients being seen over time (e.g., higher clinical supervision qualifications).

For some behavioral health rates, CMS has recognized the following considerations in approved cost-based rates:

- Salary cost of direct practitioners and supervisors engaged in clinical activities (not supervisors or support staff performing administrative tasks).

- Employer-related expenses such as the employer cost of health insurance, Medicare and Social Security contributions, and unemployment insurance.

- Administrative costs that are based on CMS expectations, regarding acceptable levels for outpatient services in the community, home and clinic settings, and need to be justified by the state.

- Transportation costs and other program-related costs.

- The State may factor in costs associated with non-billable time (e.g., staff travel time, time spent documenting services, time spent in required training or certification activities, or loss of productivity for home-based services,[24]). CMS has accepted rates that contain some cost for paid State holidays, required training time and vacation in the calculation of non-billable time. The State must provide documentation, such as State statute, to support the amount of non-billable time factored into the rate. Whenever a **time study** is used to determine time not available for billable activities, it must be approved by CMS. In addition, the rate methodology must help to assure that billed time does not exceed cost and/or the time available for providers to render services.

Cost-based fees and cost settlements should be used when a state reimburses governmental providers for services. The purpose is to ensure that the government is being reimbursed for the total cost of delivering the service to Medicaid enrollees. For cost-based fee development, the costs included must be supported by documentation that represents the costs incurred by governmental entities within the state. The fees are not reconciled and may be trended forward or updated (by rebasing or applying a federally-approved inflation factor) from year toyear.

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[24] A clinician delivering home-based services may bill for 3 or 4 clients per day, while a clinic-based colleague bills for 10.

This methodology would "provide adequate reimbursement to sustain community-based mental health services regardless of geographical location" (urban, rural and frontier) and would work in Minnesota's Medicaid environment. However, several drawbacks to this approach should be considered.

Provider Cost Reporting. This type of rate setting methodology establishes a rate specific to each provider. This requires a cost report from each provider. Cost reporting is a complex and time-consuming annual exercise, which was shown during this analysis to exceed the present managerial and accounting capabilities of many community mental health provider agencies. While cost reporting is common among health care providers such as hospitals and nursing facilities nationwide, Minnesota requires few mental health providers to complete cost reports, because cost-based rate setting is not the typical fee setting methodology. This effort might require a legislative mandate to have each provider submit a cost report. Implementation would require substantial State technical assistance. If the State chose to develop cost-based rates with a large percentage of Minnesota's Medicaid providers, or if many non-standard service definitions are covered, then the State may have a difficult time implementing changes in the system.

Third-Party Billing Mandate. To avoid shifting undue costs to Medicaid (payer of last resort under federal law), the State would need to closely enforce its usual third-party billing[25] mandate with providers receiving cost-based rates. Enforcement poses a technically-complex administrative burden on a state's management information system and, as demonstrated during the Certified Community Behavioral Health Clinic (CCBHC) demonstration, administering third-party billing is particularly challenging for Minnesota's "legacy" MMIS. One disadvantage of this model may occur if clinics are not incented to bill other insurance such as Medicare and private insurance first for Medicaid clients, especially if the Medicaid procedure coding differs from the Medicare or private insurance coding.[26]

Average Costs. This methodology can produce a single regional or statewide rate for a particular service. If it does, the statewide or regional fee schedules are based on actual average costs experienced by the providers in the past. Those actual costs may not include all costs that a provider is required to expend to provide the service as defined necessitating a change in scope process as noted above. Some providers will find that their actual costs exceed the fee schedule. Other providers will be more efficient than the fee schedule. Regional rates or urban-rural rates could allow for expected cost differences in healthcare market areas. However, a regional rate structure, which pays regionally-differentiated rates for the same mental health service, substantially increases state administrative complexity (expenditures and time delays) with regard to policymaking and claims-system programming.

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[25] *Third-party billing* requires providers to first bill other insurance such as Medicare and private insurance for Medicaid clients with dual coverage — common with anyone over age 65 and higher-income persons who are eligible for Medicaid based on a disability.
[26] Under the new Certified Community Behavioral Health Clinic demonstrations, other insurers would need to pay before Medicaid for all CCBHC services using the coding prescribed by Medicare or the private insurer. Then, if the Medicaid PPS is still higher than what was paid, the clinic would be paid the remainder of a higher Medicaid rate. For example, a dual-eligible Medicare-Medicaid patient receives two CCHBC services. PPS is $200 an encounter for services rendered in a single day. Medicare pays on a FFS basis: $50 for the first service and $125 for the second service on the same day, for a total of $175. Medicaid would pay the remaining $25 ($200–$175).

Option 2: Market-based Modeled Reimbursement

Using market-based, or market-modeled, reimbursement methodologies that utilize expected Minnesota provider costs, can simplify rate setting, and yet can accurately reimburse providers for the costs of meeting Federal and State access and quality standards. Such rates would be set for all State-defined services using Healthcare Common Procedure Coding System codes, definitions, and units. Market-based rates may be paid to private and governmental providers. These rates are developed according to the economic factors that determine the payment amount required to attract willing and qualified private providers. To pay market-based rates, the State must currently enroll and actively reimburse private providers. The pool of private providers must be significant so that competitive market forces help determine the components built into rates. This approach typically is used in the establishment of a fee schedule for HCPCS coding.

The typical steps in development of market based rates are as follows:

1. Determine the direct costs of delivering the service (e.g., salary costs for direct care workers, supplies, transportation, etc.).

2. Determine the indirect costs of the service (e.g., supervisory staff).

3. Determine the overhead and administrative costs associated with provision of the direct service (e.g., occupancy costs, administrative staff, etc.).

4. Determine the amount of non-productive time (e.g., the portion of each workday that is spent on usual and required activities related to service delivery).

5. Determine how costs related to non-Medicaid activities performed by the provider will be excluded.

6. Determine how billed time will not exceed available productive time by the practitioner to deliver services and billing limits in the service definition. Market-based rates are thus cost-informed rates using assumptions standard in the industry.

This methodology would also provide adequate reimbursement to sustain community-based mental health services regardless of geographical location (urban, rural and frontier), which was a goal of this legislative study, and would work in Minnesota’s particular Medicaid environment. One of the advantages of this type of approach is that when there are a large number of providers, the state can set a fee schedule based on the average costs of efficient providers and a component for a fair return on investment for private providers.

Average Expected Costs. Market-based rate structures are based on average expected costs that account for the costs that the state expects that providers will face to provide the services as outlined. This methodology produces a single regional or statewide rate for a particular service. Some providers will find that their actual costs exceed the market-based rate. Other providers will be more efficient than the

modeled rates. Regional rates or urban-rural rates could allow for expected cost differences in healthcare market areas. However, a regional rate structure, which pays regionally-differentiated rates for the same mental health service, substantially increases state administrative complexity (expenditures and time delays) with regard to policymaking and claims-system programming.

Third-Party Liability. The American Medical Association standard coding under the National Correct Coding Initiative defines coding for licensed practitioners to utilize standard CPT coding over HCPCS coding. HCPCS coding is utilized for psychosocial model behavioral health services that are not provided in Medicare or private insurance and may be used by the State to establish unique benefits for the Minnesota Medicaid population (e.g., ACT). One disadvantage of this model may occur if licensed practitioners utilize only HCPCS coding under Medicaid instead of the CPT codes that other insurance such as Medicare and private insurance utilize primarily. This could result in cost-shifting to Medicaid if the Medicaid procedure coding differs from the Medicare or private insurance coding. This disadvantage could be addressed through explicit billing guidance where providers are directed to bill other insurance including Medicare first using the coding required by those payers.

Example: ACT — The service definition, rates, and coding utilized by Medicaid for physician prescribers on ACT teams is different than Medicare physician services using a medical model. The reimbursement that Medicaid pays reflects additional certification, training, and documentation costs. In this case, while behavioral health services by a physician are covered, the EBP of ACT is not covered by Medicare. As a result, Medicaid would need to outline the billing expectations for unique Medicaid behavioral health services having costs unique to Medicaid if there is an expectation that Medicaid would be billed only after Medicare pays the base amount for the “traditional” medical model behavioral health service. Many states do not require Medicare to pay for physician components of Medicaid specific EBPs such as ACT based on CMS 1989 guidance that a liable third party resource exists only if the Medicaid service is covered by the third party and because of the complications that arise through crossover claims.[27] However, CCBHC demonstrations have been required to work through these issues.

Purchasing Standards. Under this option, the State must determine the services and requirements to purchase. The State’s Uniform Standards, which sets out requirements for providers, should be considered part of the “state policy” that drives payment options. The State should ensure that it examines the overall landscape measures dependencies before finalizing any proposed rate change methodologies.

For example, the State must determine licensing, certification standards, and accreditation standards for the agencies. The State must also determine the minimum level of training for agency staff including unlicensed practitioners. This training may include culturally competent training, specific training such as Cognitive Behavioral Therapy training for all licensed practitioners, or required use of promising practices such as Managing and Adapting Practice (MAP) for children. The State could also include allowances for return on investment (i.e., profit) and productivity factors for required lost time due to missed appointments

[27] July 14, 1989 Medicaid-Third Party Liability Versus Freedom of Choice, CMS ARA memo. “A liable third party resource (Medicare coverage) exists only to the extent that the services the recipient receives from the provider of his choice are covered by the third party entity.”

or certification elements such as team meetings, travel to client homes, or concurrent clinician engagement with a child and a parent. Agency standards for different types of agencies might range from requirements for comprehensive rehabilitation agencies, specialty requirements for agencies providing culturally competent care to underserved areas or populations, and narrow agency requirements for agencies solely providing a single service for children with unlicensed staff (e.g., CTSS).

The greater precision the State uses to outline service requirements and the more finitely providers understand the reimbursement links to purchasing standards, the less likely providers will be undercompensated under the new system by providing activities or staffing not fully compensated by the State. Conversely, providers are more likely to support access and quality standards when the providers are clearly compensated for requirements. Where the state's goal is to achieve a financially sustainable provider network, this approach produces viable rates by reimbursing providers for the expected costs of complying with requirements rather than by reducing standards to cut costs. For example, the State could require all comprehensive agencies to be accredited and then build the costs for that accreditation into the rates. Different rates could be set for different staff qualifications that included agency costs for supervision including individuals with high school diplomas (rehabilitation workers and behavioral aides), individuals with Bachelor's degrees (mental health practitioners), and individuals with Master's degrees (mental health professionals).

It should be noted that any prospective changes that compensate providers for expected costs should be monitored for compliance and evaluated for quality. If there are no state penalties for providers' failure to make the changes for which they are compensated, then the providers could face federal compliance issues in the event of a federal audit.

Option 3: Tiered Payment Structure

A tiered payment structure, which retains the current RBRVS rate setting methodology for individual and small-group practices while utilizing a separate fee schedule based on market-based modeled rate setting for full-service agency providers, could minimize the impact of system transition for state administration and the majority of providers. Non-licensed and non-certified practices could retain the current level of administrative simplicity for delivery of limited outpatient therapy under the current CPT coding structure. The State could recognize the more complex infrastructure required for agency providers utilizing a reimbursement methodology that recognizes the cost components required for a fuller array of services.

Tier 1: A fee schedule set using RVRBS reimbursement methodologies might continue to be appropriate for individual licensed therapists directly enrolled in the Medicaid program and for small-group practices not certified or licensed by the State (e.g., a group of Licensed Marriage and Family Therapists (LMFTs) in practice together). These would continue to provide services reimbursed solely under CPT coding. These individual licensed mental health professionals or independent groups[28] of licensed practitioners are

[28] Practices organized as a limited liability company (LLC) of licensed providers who do not employ unlicensed practitioners would be an example.

currently enrolled in the payment system under a consolidated provider type of which mental health may be one sub-category.

Tier 2: Comprehensive (full-continuum) and cross-disciplinary rehabilitation agencies may be better served through a separate fee schedule using prospective cost based rate setting or market based rate setting reimbursement methodologies that would compensate for higher state standards such as twenty-four hour access to care, home-based services, accreditation, fidelity standards for EBPs, operations in provider shortage areas, and close supervision of unlicensed staff. A separate fee scheduling using these methodologies might be better suited to agencies with higher overheads and broader cost categories associated with serving disparate populations and people with complex conditions and intensive service needs.

This type of tiered approach to payment and rate setting has the potential to bring more consistency and transparency to the mental health system and result in compensation linked to state purchasing requirements in a more systemic manner.

Considerations with using a Tiered Payment Approach: Enacting a payment system capable of achieving the State's sustainability goals will be an intensive undertaking that will make resource demands on both providers and state administrators, especially if the goal is statewide reform. The State may want to consider an approach that creates two fee schedules each with a different rate setting methodology that balances universal achievement of goals against a phased administrative burden. For example, a provider-specific, cost-based rate structure would require each participating provider to submit annual cost reports. While cost reporting is a common practice among Medicaid providers in other states, it would place a new administrative burden on community mental health providers in Minnesota, who are not accustomed to this type of reporting requirement. In addition, provider-specific rates could create additional information systems and state administrative challenges. On the other hand, market-based rate-setting avoids provider cost-reporting requirements, but only produces statewide or regional rates that compensate average expected costs for efficient providers.

Maintaining the current FFS rates schedule for individual practitioners or small providers who deliver less-than a full-continuum of mental health services, averts the multiple burdens of cost reporting, additional data reporting, and revamping billing systems. Additional analysis would need to be made to determine if the individual practitioners and small providers' costs in the Minnesota mental health industry are met utilizing a fee schedule more geared to those practices.

A single fee schedule compensating both individual practitioners and large comprehensive agencies may not meet the needs of both types of providers. Instead the State may need to consider a fee schedule for independent practitioners using RBRVS rate setting methodologies with a separate rehabilitation fee schedule for comprehensive rehabilitation agencies that reimburse for state required service infrastructure

Cultural/Ethnic Minority Equity. Culturally-specific providers, who tend to work in individual or small-group practices, could be excluded from the advantages of payment reform under a tiered approach that keeps smaller providers under the existing RBRVS rate structure. Only payment reform equally available to all

providers (regardless of size) would build statewide capacity for culturally-responsive services. Furthermore, given the resource demands of participation in the reimbursement models presented in this study, additional administrative and financial support may be needed for providers of color and tribal providers in order to achieve the State overall goal reducing disparities in healthcare outcomes.

MMIS Limitations. If the State were to adopt this type of tiered reimbursement methodology through legislation, administrative rule, and State Plan changes, then the State's provider enrollment system and MMIS would need to be examined. Many states approach this by assigning individual licensed practitioners and groups of individual licensed practitioners to limited provider types. However, in each case, that State's MMIS was able to pay different rates for different taxonomies or provider types. The limitations of the MMIS in terms of number of rates that will be set and the complexity of the rates must also be analyzed. For example, statewide fee schedules for a single provider type would be relatively less difficult to operationalize than regional rates or rates that differ by urban versus rural providers. Most states adopt a statewide fee schedule but there are some notable exceptions that adopt one or two regional or urban versus rural rates (e.g., New York has upstate and downstate rates).

CMS has supported this type of tiered enrollment and reimbursement methodology practices. For example, under the new fraud and abuse screening requirements in Medicaid enrollment, individual licensed practitioners could be considered low risk and have a different process for enrollment than rehabilitation agencies, which are considered moderate risk. Some states have not been able to reimburse differently by provider type and have therefore needed to utilize standard modifiers for billing. If this were to occur in Minnesota, the State would need to seek approval from the Administrative Uniformity Committee before implementation.

It should be noted, though, that any prospective system changes that compensate providers for costs should be monitored for compliance and evaluated for quality against performance measures. If there are no state penalties for providers' failure to make the changes for which they are compensated, then the providers could face federal compliance issues in the event of a federal audit.

Sustainability and Improved Reimbursement Methodologies, Service Array and Research

Minnesota's goal of a sustainable community mental health system requires the State to tackle the intertwined needs of a full continuum of services with sufficient provider capacity. Covering a full continuum of care services requires Minnesota to reimburse for measurably-effective interventions for persons with all combinations of diagnoses and demographics. Full provider capacity means that all persons have access to effective services "regardless of geographic location". To do this, Minnesota must have a baseline analysis of the current industry conditions with a detailed action plan for a prescribed transition period.

Ideally, research based care such as EBPs would be utilized to fill the service gaps in the service array. In the short term, research is insufficient to fill all gaps in the continuum of services with evidence-based practices. Until clinical science advances, Minnesota must:

- develop a financially sustainable reimbursement methodology for standard State Plan and Home and Community Based Services (HCBS),

- encourage wider use of existing practices with research support through policy reforms, payment incentives, and state-supported clinical training, and

- explore developing its own evidence, using a coverage-with-evidence-development approach.

This three pronged approach will also build provider capacity for improved access to the currently covered services across the existing service array. The lack of EBPs is not the only gap in the State's service-delivery capacity. Improved reimbursement of existing services as well as the enhancement of EBP service provision and exploration of supporting new research will go a long way in improving accessibility and capacity in the system.

Funding for Research Based Care and Evidence-Based Practices

The criteria for a sustainable community mental health service system include payment for proven research based care, reimbursement for effective care, payment for new emerging practices, a full continuum of services, and payment for cost components necessary to deliver effective, quality, and accessible care. Providers have found that they cannot financially maintain EBPs due to additional costs, like training and certification costs that are required, when they are not reimbursed by payers such as Medicaid. Other states have found that utilizing grant or state-only funding, which are typically available to providers for a limited-time only, do not support provider's ongoing training and certification costs due to staff turnover and loss of organizational momentum. Instead, states have found that when ongoing provider expenditures are required for EBPs such as ACT, Multi-systemic Therapy (MST) [29] and Functional Family Therapy (FFT)[30], sustainable community mental health systems must have established reimbursement rates including all required EBP cost components in EBP-specific rates.

EBPs are currently supported in Minnesota through Medicaid, grants, or a combination of both Medicaid and grants. There are some EBPs with limited funding or no specific funding. Medicaid provider rates generally do not compensate for training or certification costs or for additional resources necessary to deliver the EBP except for ACT, an intensive team-based intervention, and Dialectical Behavioral Therapy (DBT), a cognitive behavioral therapy using both individual therapy and group skills training classes. Both EBPs have specific fee schedule rates, with ACT rates set on a prospective cost-based rate system..

Cost Data on EBPs

Of the cost reports submitted in Phase 1 of this study, half indicated the provision of EBPs by their organization. Of those, only a handful provided cost data specific to EBPs. A barrier noted by the providers was that they do not normally separate and track EBP costs. Even in the cases where cost data was provided, it did not indicate the EBP to which the costs were attributed. However, providers reported additional costs for staff training and development, provider certification to offer the EBP, monitoring fidelity[31] to the required standards, additional supervision, and consulting fees and materials, such as

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[29] Source: http://mstservices.com/index.php/resources/funding-and-medicaid-standards
[30] Source: http://fftllc.com/
[31] "Fidelity" means preserving the components that made the practice effective in the research testing, maintaining integrity or fidelity to the original approach.

training manuals. These costs are in addition to the standard delivery of the basic State Plan mental health service. The table below summarizes the reported additional cost ranges by groups of EBPs.

TABLE 3: EBP COST REPORT DATA SUMMARY

COST CATEGORY	EBPS/SERVICE MODELS	RANGE OF MINNESOTA PROVIDER REPORTED COSTS
Staff Training and Development	Illness Management and Recovery (IMR), Enhanced Illness Management and Recovery (E-IMR), Cognitive-Behavioral Therapy (CBT), Trauma-Focused Cognitive Behavior Therapy (TF-CBT), MAP, Mental Health First Aid (MHFA), Motivational Interviewing, Child Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT)[32]	$2,130–$8,281
Provider Certification	PCIT, TF-CBT, DBT, MAP,	$1,061–$2,685
Provider Fidelity	PCIT, TF-CBT, DBT, MAP,	$38,300–$121,855
Supervision and Consulting Fees	CBT, MHFA, Motivational Interviewing, PCIT, TF-CBT, DBT, MAP, TFCBT, Eye Movement Desensitization and Reprocessing (EMDR), TF-CPP	$206–$215,756
Program Supplies	IMR, E-IMR	$1,847–$3,633

Note: Social Communication, Emotional Regulation and Transactional Support (SCERTS), Developmental Individual-difference Relationship-based model (DIR), and Applied Behavioral Analysis were also raised as practices with similar costs but is outside of the scope of this analysis.

Mercer also researched nationally available cost data related to certification, training, supervision, fidelity, and materials for the provision of common EBPs and found that each EBP has unique costs that must be considered when building rates. (These costs are more fully described in the Educational Research Analysis.) For example, as described by one Minnesota provider, “Parent Child Interaction Therapy (PCIT) will usually require two rooms available in the clinic and specific technology support.” A two way mirror, headsets to provide the parent instruction during the session and the cost of additional space are examples of the additional costs for this EBP. See the table below for the reported costs of PCIT that are in addition to the regular State Plan service costs. Other data for the additional cost of providing EBP that is not included in State Plan mental health service reimbursement rates is available in the Educational Research Report.

[32] Providers also mentioned the high cost of training and provider certification for Social Communication, Emotional Regulation and Transactional Support (SCERTS), Developmental Individual-difference Relationship-based model (DIR), and Applied Behavioral Analysis (ABA) for children with Autism, which is outside of scope of this analysis.

TABLE 4: ADDITIONAL COSTS TO PROVIDE EBPS NOT REIMBURSED IN BASIC MEDICAID RATES

EBP	CERTIFICATION	TRAINING	SUPERVISION/ CONSULTATION COSTS	MATERIALS
PCIT	$450-$500	$4,000	$5,200-$10,400	$2,000-$15,000

Source: The State of Minnesota Department of Human Services, Mental Health Division, provided data to Mercer on PCIT. Mercer researched and provided the costs DBT based on publically available data and interviews with the purveyors of these EBPs.

Without the reimbursement of certification, training, supervision, consultation, fidelity, and materials, the reimbursement rates paid for the research-based practices do not reflect the providers' costs and are not financially sustainable.

In the table below, Mercer has utilized two of the States' office based skill-building rates from the earlier comparison to demonstrate how the lack of reimbursement for additional EBP costs creates rates significantly below rates including those costs.

TABLE 5: COMPARISON OF REIMBURSEMENT RATES BY PRACTITIONER TYPE FOR UNLICENSED MENTAL HEALTH SKILL BUILDING VERSUS EBPS

PRACTITIONER LEVEL	MINNESOTA	PERCENT INCREASE FOR RESEARCH-BASED COSTS	STATE A	PERCENT INCREASE FOR RESEARCH-BASED COSTS	STATE B	PERCENT INCREASE FOR RESEARCH-BASED COSTS
Skill-building — Bachelor's level (BA) — BASE RATE	$13.44		$14.87		$16.80	
EBP: Multi-systemic Therapy-BA	$13.44	0%	$30.23	103%	43.06	156%
EBP: Functional Family Therapy-BA	$13.44	0%	$31.70	113%	40.88	143%

Note: MST and FFT are provided primarily in the community. MST has certification costs of $6,000, initial training costs of $12,860, and materials costs of $31,000 per team plus $5,000 annual ongoing cost. FFT has a Phase 1 certification cost of approximately $36,000 per team plus $1,114 per therapist and $8,773 per supervisor. Phase 2 certification costs are approximately $18,000 per team plus $2,270 per supervisor.

As noted earlier, each of these states set mental health rates utilizing the expected cost to the average provider for provision of the service. In each state, the rate is set by estimating the cost of the basic provision of the service by practitioner level and adding the required cost components for providing the research based service (e.g., certification, training, supervision, consultation, fidelity, and materials costs). The resulting EBP-specific rates are around 103 percent to 156 percent higher than the comparable rates in that state. This comparison allows Minnesota to understand how the current reimbursement rates do not cover the costs of similar EBPs.

Impediments to Provision of EBPs

Child EBP providers reported that there are several factors leading providers to avoid investing in practices that are shown by research to be effective in the treatment of mental health conditions and prevent more costly treatment in institutional settings.

- Difficulty in retaining trained staff, who after being trained move to more competitive employment sites, such as large hospitals because of an inability to pay competitive wages.

- Flat payment rates which do not account for travel or team based care required when delivering certain EBPs. For example, some very effective community-based interventions occur outside the “clinic walls” necessitating travel time to the home, school, or another site to deliver services.

- Providers reported that PMAPs are paying less than the FFS rates. (Providers expressed hope that HF1176, SF927 (2017-2018 Biennium, 90th Legislature) would pass and regain reimbursement equity across FFS and PMAPs.)

- Worry that pay-for-performance may actually create a disincentive to work with the most distressed families because the providers wouldn’t see gains as quickly. Providers are concerned that incentives may not target EBPs or the delivery of services to populations with health outcome disparities.

Adult EBP Providers raised similar concerns regarding the cost structure in Minnesota that undermines EBP implementation.

- Uncompensated costs for training and supervision, and staff turnover after the agency has invested in training a staff member in an EBP.

- Conflicting messages from DHS that support and encourage EBPs, and the County Mental Health Authorities that do not generally purchase EBPs.

- Concerns about how performance measures will be implemented.

- Concern that incentives will not tie to performance, including requests from providers that the State should consider: 1) individual outcomes, 2) fidelity, and 3) customer feedback.

Priorities for Implementation of Services to Support a Continuum of Care

DHS has prioritized the use of EBPs that promote system improvements and the sustainability of an effective behavioral health continuum of care for adult, and children, and their families (Medicaid and non-Medicaid populations). DHS is in the process of training and certifying providers in several EBPs and has established Medicaid benefits and specific payment rates for others. The EBPs endorsed by DHS are listed in table 6 below (and more fully described in the Education/Research Report).

TABLE 6: MINNESOTA CHILD AND ADULT PRIORITY EBPS

EVIDENCE-BASED PRACTICES FOR CHILDREN	EVIDENCE-BASED PRACTICES FOR ADULTS
TF-CBT	ACT
PCIT	DBT
Incredible Years Parenting Programs	Integrated Dual Disorder Treatment (IDDT)
Trauma Informed — Child-Parent Psychotherapy (TI-CPP)	Supported Employment — Individual Placement and Support (SE-IPS)
Attachment Biobehavioral Catch-up (ABC)	IMR

Evidence-Informed Practices

Minnesota also endorses several evidence-informed practices and excellent tools such as:

- The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood manual (DC:0-3R/DC: 0-5.), which is a clinical diagnostic manual designed to be a guide for screening, assessment, and diagnosis of children ages birth to five.

- The MAP system that provides access to a database with the most current scientific information, measurement tools, and clinical protocols. MAP matches children to evidence-based treatments that have proven effective on a wide diversity of treatment targets and ages. The system can suggest formal evidence-based programs or, alternatively, can provide detailed recommendations about discrete components (practice elements) of evidence-based treatments relevant to the specific individual. A clinical dashboard is provided to track outcomes and practices.

- Navigate is Minnesota's approach to treatment of First Episode Psychosis (FEP). FEP refers to the first time someone experiences psychotic symptoms or a psychotic episode. This promising practice is consistent with the Recovery After an Initial Schizophrenia Episode (RAISE) Early Treatment Program research. Other EBP models for this condition include Oregon's Early Assessment and Support Alliance (EASA)[33]; the Portland Identification and Early Referral Service (PIER) in Portland, Maine; and the National Institute of Mental Health programs, the Connection Program and OnTrackNY.[34]

Other research-based practices commonly utilized for children but not endorsed by Minnesota include MST and FFT which are both commonly used for youth with oppositional defiant disorder, substance abuse

[33] Mercer's Subcontractor, TriWest Group, recently developed an alternative payment model for EASA in collaboration with the Mid-Valley Behavioral Care Network and Marion and Polk counties.
[34] Heinssen, Robert K., Goldstein, Amy B., and Azrin, Susan T. Evidence Based Treatment for First Episode Psychosis: Components of Coordinated Specialty Care. (April 14, 2014 RAISE Recovery After Initial Schizophrenia Episode, National Institute of Mental Health White Paper. Retrieved at: https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

disorder and youth involved with juvenile justice; Homebuilders[35], which is designed to work with children in the child welfare population; Wraparound [36]; Dialectical Behavior Therapy-Adolescent (DBT-A), which is used with high risk, multi-problem adolescents; and Adolescent-Community Reinforcement Approach (A-CRA)[37], which is designed for adolescents with substance use disorder being discharged from residential facilities. These are all highly research based practices that Minnesota may want to consider adopting as priorities. Many of these research-based practices are effective alternatives to out-of-home placements and over-reliance on residential treatment facilities, which are costly and have limited evidence for good outcomes except for a subset of children and youth whose safety requires such placements.

EBPs in Managed Care

As DHS continues efforts toward building statewide EBPs and payment for performance, a key challenge to address is related to how payment and delivery of EBPs are prioritized by the PMAPs. Currently, the FFS delivery system and managed care delivery system operate separately. While the PMAPs are contractually obligated to provide the identical state-defined benefit, they have discretion to manage the benefit according to proprietary authorization criteria, professional credentialing standards, negotiated rate structures, and provider networks (within minimum capability criteria). These differences challenge providers in terms of determining which EBPs to prioritize for implementation, obtaining adequate reimbursement, and designing appropriate data collection tools tracking outcomes.

The State could consider three options to encourage Managed Care Organizations (MCOs) to offer priority reimbursement to evidence-supported practices:

- Contract negotiations. Many managed care organization recognize the quality and cost-effectiveness of EBP and may be willing partners with a state Medicaid agency that places a high priority on financial incentives on proven practices. This may be especially appealing if the MCO contract were to pledge the State's continuing resource-support for clinician training and certification.

- Medicaid benefits. Establishing a nationally-recognized EBP as combined benefit in Statute and the State Plan would encourage MCOs to view an EBP's component activities as a distinct benefit and set their own rate structure to incent network providers to deliver services with fidelity.

- Rate floors. CMS allows states, under certain strict conditions, to require MCOs to pay the state's FFS rates for a limited number of services. (See the discussion in Recommendation 3, under "Mandate rate floors in PMAPs".)

Strengths in EBP Implementation

Minnesota has endorsed and implemented several EBPs for adults and children and has incorporated most into the State's Medicaid program. However, the type of state support varies by EBP: from sponsoring EBP training; certifying provider organizations applying to provide specific EBPs; certifying

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[35] Source: http://www.cebc4cw.org/program/homebuilders/detailed
[36] Source: https://nwi.pdx.edu/
[37] Source: http://www.cebc4cw.org/program/adolescent-community-reinforcement-approach/detailed

individual professionals in specific EBPs; monitoring providers for fidelity and providing technical assistance regarding particular EBPs; and reimbursing providers for EBP services for uninsured and underinsured individuals. DHS has several strengths with regard to its EBP implementation. For example, DHS sponsors trainings for trauma-focused cognitive behavior therapy, MAP, PCIT, TI-CPP, and attachment bio-behavioral catch-up.

Minnesota has strong state national certification requirements. The process for deeming providers as certified (at both the practitioner and organizational levels), allows DHS to determine if all conditions of delivering the EBP are met. DHS or its sister state agency, Department of Employment and Economic Development-Vocational Rehabilitation Services, provide monitoring for fidelity for ACT, DBT, Navigate for FEP, and SE-IPS. DHS deems individual professionals as certified for the early-childhood EBPs: PCIT, Incredible Years, TI-CPP, and ABC. It also deems individual professionals for the child EBP of Trauma-Focused-CBT. The State also has an outlined process for Integrated Dual Disorder Treatment. Lastly, a process for IMR has not yet been developed but is being contemplated.

Two EBPs (ACT and TF-CBT) utilize a State-directed fidelity oversight process through DHS. The State utilizes the fidelity tool called the Tool for the Measurement of Assertive Community Treatment (TMACT) for monitoring ACT and a fidelity dashboard for TF-CBT. These processes are relatively new according to State produced documentation. SE-IPS also has an established State-directed fidelity oversight process led by the Department of Employment Economic Development — Vocational Rehabilitative Services. This process was described by providers as a useful process for program improvement and technical assistance.

Standardized tools are being used more consistently across the children's endorsed EBPs. Those tools include the Trauma Symptom Checklist for Children (for TF-CBT), Trauma Symptom Checklist for Young Children (for TI-CPP), the Eyberg Child Behavior Inventory (for PCIT) and the Child Behavior Checklist (for children ages birth to five). Specific performance measure tools were not noted for any of the adult EBPs.

Gaps in EBPs

The top three priorities identified by respondents of the provider questionnaire as critical to the success of EBPs included: more and better clinical training, additional administrative funding (i.e., materials, supervision, monitoring of fidelity), and improved clinical consultation. These priorities are consistent with provider focus group results.

Provider focus group participants reported offering many EBPs that are not considered to be "endorsed". Only the endorsed EBPs of ACT and DBT have specific Medicaid FFS reimbursement methodologies and service-specific procedure code/modifiers that adequately reimburse for the models. Other endorsed EBPs are billed using standard group and individual therapeutic behavioral services and psychotherapy procedure codes. The use of standard procedure codes means that the State is unable to run EBP specific claims data to assess current EBP utilization or have EBP specific funding. Even for ACT and DBT, the rates may differ between FFS and PMAPs, so the reimbursement is inconsistent for EBP training costs, supervision/clinical consult requirements, materials, etc., Providers pointed out that these were two of the

reasons that there are no statewide EBPs available to the Medicaid population and that the only statewide best practice utilized is the DC: 0-3R/DC: 0-5 diagnostic assessment.

Other states reported that their Medicaid agencies are also not consistently paying differential rates for EBPs and differently compensating licensed practitioners based on credentials. Because all states interviewed use managed care, each state pays a capitated rate to the PMAPs, which determine reimbursement to the provider networks. None of the states interviewed currently have incentives for managed care companies to utilize EBPs providing cost-effective care although at least one state interviewed was developing a ***VBP*** reimbursement system which included behavioral health.

In the provider questionnaire, providers recommended that new incentive and reimbursement models include the development of policy, financial and program infrastructure. Needed policy infrastructure included rule changes, extensive provider education, and the phase-in of performance measures. Needed new financial infrastructure included the need for consultation resources, guidance for billing system changes, and the development of differential rates. Finally, needed program infrastructure included developing realistic timeframes for achieving milestones and staffing changes.

Value-Based Purchasing (VBP)

VBP is an umbrella or collective term used to describe the numerous ways purchasers approach the task of linking payments to quality indicators and better value, such as improved health outcomes, cost management and effective care coordination. The purpose of VBP models is to link financial incentives to providers' performance on a set of defined measures of quality and/or cost, or resource use. The historic health care system payment method is FFS, which pays providers a certain amount for each service that is delivered. However, FFS can create disincentives because it is based on the volume of care delivered and does not have any incentives for providing high quality care.

VBP approaches aim to deliver high quality care while creating incentives to slow the long-term growth of medical costs (i.e., "bending the cost curve"), resulting in improved value of care.[38] Many states have begun incorporating VBP into their integrated managed care programs. This is in response to the United States Department of Health and Human Services (HHS) announcement of aims to reward high quality care by moving away from the traditional FFS payments and into alternative payment models. Most policy makers believe that creating more value in health care (i.e., more high quality care with lower inflation of medical costs) is a basic principle in having a financially viable, sustainable health care system in general. Many states are moving away from cost-based or FFS reimbursement methodologies because of the concerns about the financial sustainability of continued high medical inflation associated with those reimbursement models.

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[38] Damberg, C., Sorbero, M., Lovejoy, S., Martsolf, G., Raaen, L., & Mandel, D (2014, December 30). Measuring Success in Health Care Value-Based Purchasing Programs. *Rand Health Quarterly*, 4(3):9. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5161317/.

Minnesota's innovations in creating value in health care and implementing VBP are consistent with ***IHI Triple Aim***[39] thinking, for example: Accountable Care Organizations (ACOs), bundled payments and other innovative financing approaches, new models of primary care, such as patient-centered medical homes; sanctions for avoidable events, such as hospital readmissions or infections; and the integration of information technology.

VBP Advantages Found in Certified Community Behavioral Health Clinic Initiative

Minnesota has participated in the CCBHC initiative included in the Protecting Access to Medicare Act of 2014, which required the development of a model to provide a specific set of services for which the clinic is paid a PPS rate. These rates are considered to be a VBP model.[40] The model requires clinics to provide a comprehensive set of services for both children and adults including screening, assessment, and diagnosis, treatment planning, outpatient, and rehabilitative mental health and substance use services, and peer and family supports.

The development of CCBHCs is intended to encourage states and local communities to provide a comprehensive way to provide integrated services with a wide array of substance abuse and mental health services in one setting so that individuals can experience a seamless delivery of services. Likewise, developing a cost-based system will allow long term sustainability of this integrated package of services. CCBHCs must coordinate care across the spectrum of health services, including helping individuals to access physical health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. CCBHCs improve behavioral health care by advancing integration with physical health care, utilizing evidence-based practices on a more consistent basis and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring CCBHC care is, indeed, an improvement over existing services.

As part of the federal demonstration project, a new PPS has been established for CCBHC services. A PPS creates an incentive for high-quality care by paying providers for coordinating activities and non-therapeutic supports that clinics either have not been providing or have been providing at a financial loss.[41] Similar to other PPS reimbursement systems, like FQHCs, the CCBHC allows anticipated costs associated with enhancing clinic capacity to achieve CCBHC service delivery standards to be built into the PPS. The PPS model also permits the State to use quality bonus payments to stimulate good care, a mechanism that the states, including Minnesota, have been using successfully with Medicaid managed care plans.[42]

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[39] Institute for Health Care Development promotes a health care approach in which a single entity is responsible for: (1) Improving population health, (2) Improving patient experience of care; and (3) Reducing per capita costs of health care. www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

[40] SAMHSA

[41] P. 8, https://mn.gov/dhs/assets/excellence_in_mental_health_demonstration_tcm1053-166459.pdf

[42] *"Medicare "Accountable Care Organizations" Shared Savings Program – New Section 1899 of Title XVIII, Preliminary Questions & Answers" Centers for Medicare and Medicaid Services. Retrieved April 18, 2015.*

As one of the eight states selected to operate the two-year CCBHC demonstration project, Minnesota certified six participating clinics as meeting the federal certification criteria[43] for the demonstration program effective July 1, 2017 through June 30, 2019.[44] During the 2017–2018 demonstration period, CCBHCs will receive a daily, cost-based bundled payment rate for the services they provide and states will receive additional federal financial participation for these services. Additional payments are limited to the six CCBHCs participating in this demonstration program, and are only available for services provided to recipients of Medical Assistance (MA), which is federally-funded Medicaid. These additional CCBHC payments are not available to recipients of MinnesotaCare or other types of health care coverage which do not include federal Title XIX funding. These payment limitations do not absolve the CCBHC from serving people regardless of ability to pay under CCBHC criteria.

CCBHC providers are required to provide or have access to the full array of CCBHC services and need to be enrolled as an eligible MHCP provider for each service. Required CCBHC services include existing MHCP services in addition to an expanded set of billable services unique to CCBHC providers.[45] Existing MHCP services required to be provided by CCBHC are to be billed in accordance with the current corresponding MHCP Provider Manual section.[46] For more information on the CCBHC demonstration and Minnesota's participation see the Educational Research Analysis.

Alternative Payment Models (APMs)

Several states are using the Health Care Payment Learning and Action Network (LAN) APM as their framework for VBP (see table 7 below). The LAN was developed by HHS in partnership with several stakeholders and consists of four categories commonly used by the CMS, several states, and other providers to define the different levels of VBP models according to risk and complexity.[47] The levels range from one to four, with increasing risk and rewards. Healthcare systems are being encouraged to move toward LAN APM Categories Three (APMs with payments based on targeted cost performance) and Four (population-based payments) in appropriate markets with appropriate patient populations. However, efforts at implementing VBPs for behavioral health (BH) are newer, and examples of full-risk implementation are scarce.

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[43] https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf
[44] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-294813
[45] https://mn.gov/dhs/assets/ccbhc-scope-services-procedure-codes_tcm1053-301943.pdf
[46] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000094
[47] Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group. (2016, January). "Alternative Payment Model (APM) Framework: Final White Paper." Health Care Payment Learning and Action Network. Retrieved from https://hcp-lan.org/workproducts/apm-whitepaper.pdf

TABLE 7: HEALTH CARE PAYMENT LEARNING AND ACTION NETWORK FRAMEWORK

LAN APM CATEGORIES			
1	2	3	4
FFS payments not linked to quality and value.	FFS payments linked to quality and value via: 1. Foundational payments for infrastructure and operations. 2. Pay for reporting. 3. Rewards for performance. 4. Penalties for performance.	APMs built on FFS with payments based on targeted cost performance via: 1. Upside gainsharing. 2. Upside gainsharing/ downside risk. 3. Bundled/episodic payments.	Population-based payments which are either: 1. Condition-specific. 2. Comprehensive (for example, global or capitated PMPM payment).

Minnesota has the opportunity to use different alternative payment methods that promote value and efficiency in the delivery of mental health services.

Accountable Care Organizations (ACOs)
An ACO is a healthcare organization that ties payments to quality metrics and the cost of care. According to the CMS, an ACO is "an organization of health care practitioners that agrees to be accountable for the quality, cost, and overall care of beneficiaries who are enrolled in the traditional FFS program who are assigned to it".[48] ACOs in the United States are formed from a group of coordinated health-care practitioners. The ACO adopts alternative payment models (e.g., capitation). The ACO is accountable to patients and third-party payers for the quality, appropriateness, and efficiency of its services. Providers can share ownership of the ACO or contract with the ACO to deliver services. Providers that deliver care can obtain higher payments for achieving successful outcomes or penalties when outcomes are not achieved. Medicare offers several ACO programs including the following:

- Medicare Shared Savings Program (MSSP) — a program that helps Medicare FFS program providers become an ACO.
- Advance Payment ACO Model — a supplementary incentive program for selected participants in the Shared Savings Program.
- Pioneer ACO Model — a program designed for early adopters of coordinated care.

[48] www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO

In 2008, Minnesota passed health care legislation to improve affordability, expand coverage and improve the overall health of Minnesotans. In addition, the 2010 Legislature mandated that the DHS develop and implement a demonstration testing alternative health care delivery systems, which includes ACOs.

This led to the development of the Integrated Health Partnerships (IHP)[49] demonstration (formerly called the Health Care Delivery Systems demonstration), which strives to deliver higher quality and lower cost health care through innovative approaches to care and payment.

With this demonstration, Minnesota is one of a growing number of states to implement an ACO model in its Medical Assistance (Medicaid) program, with the goal of improving the health of the population and of individual members. In their first year of participation, provider-led systems can share in savings. After the first year, they also share the risk for losses. Provider-led systems' total costs for caring for Medical Assistance members are measured against targets for cost and quality.

Medicare Alternative Payment Methods

Medicare has its own APMs including the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Methodologies (AAPMs).[50] These alternative payment methods are resulting providers being paid less often or with less of their reimbursement based on fee schedules developed using RBRVS rate setting methodologies. An increasing amount of physician reimbursement in Medicare, especially for primary care providers, is being paid through VBPs, such as MIPS and eligible AAPMs. The expected result of this Medicare system transformation is that physician rate setting in the industry will be less reliant on the RBRVS rate setting methodology in general and more reliant on payment structures improving value in health care. MIPS adjusts payment to eligible providers based on performance in four performance categories:

- Quality — based on the Physician Quality Reporting System (PQRS).
- Cost — based on the Value-Based Purchasing Modifier (VBPM).
- Advancing Care Information (ACI) — based on the Medicare Electronic Health Records (EHR) Incentive Program (Meaningful Use).
- Improvement Activities (IA) — a new category.

AAPMs are available for primary care[51] including:

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[49] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441

[50] https://www.aafp.org/practice-management/payment/medicare-payment/aapms.html and https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/CPIA-Performance-Category-slide-deck.pdf

[51] While these VBP models are currently available only for primary care, these are the test models that will inform VBP into integrated primary and behavioral health care.

- MSSP Track 2
- MSSP Track 3
- Comprehensive Primary Care Plus (CPC+) initiative
- Next Generation Accountable Care Organization (NGACO), which allows higher levels of financial risk and reward than the current Pioneer and Shared Savings Program
- Vermont Medicare ACO initiative (as part of the Vermont All-Payer ACO Model)

For the 2017 performance period, an AAPM entity must do one of the following for all of its eligible clinicians to be qualifying participants:

- Receive at least 25 percent of its Medicare Part B payments through the AAPM, or
- See at least 20 percent of its Medicare patients through the AAPM.

Qualifying Participants (QPs) will receive an annual 5 percent lump-sum bonus. The bonus applies in payment years 2019-2024. QPs will be excluded from the MIPS reporting requirements and will receive a 0.75 percent increase to their Medicare physician fee schedule (PFS) beginning in 2026. AAPM entities that do not meet either the payment threshold or the patient threshold can opt to participate in MIPS and will be scored using the APM Scoring Standard.

Performance Measures

When using any VBP arrangement and related cost based payments for EBPs, it is important for the State to have a performance measurement system that tracks outcomes, quality, and efficiency. The selection of performance measures should be guided by the ease of collection; the meaning of the data and the standard for measuring performance; this is the information really necessary to guide the system to an expected level of quality of care. In this manner the data do not create undue burden to calculate; and in the absence of national benchmarks, allow for time to establish local baselines.

Bonus or incentive payments can be tied to achieving performance milestones. Mercer recommends establishing measures at the system level as well as the client (member) level. Client level measures may include reduction in out-of-home admissions/placements, reduction in hospitalization, or improvement in member functioning (based on standardized tools for specific populations), or success across social determinants of health (e.g., success in school or work, independent living, positive social relationships, etc.). The system level measures can be tied to structure and fidelity to the EBP. Measures should also include cultural and regional collection and trending. For example, the school age population in aggregate may appear to be improving its success in school. However, if you disaggregate the data, it shows that this is not true with a population in a certain community. Therefore, you may miss an important community need and create an incentive that is counter-productive.

Quality bonus payments can also create incentives to reduce racial disparities and could be utilized either with the existing system or with a payment-reform option. However, participation would still demand a sophisticated provider data-collection and reporting system.

Additional Services and "In Lieu of" Services under Managed Care

PMAPs have flexibility under risk contracts to provide additional services or alternative services, or services in alternative settings. Each of these types of services — additional and in lieu of services — has different requirements that will be discussed below.

Additional Services

Additional services for beneficiaries may be provided at PMAP option. Additional services are addressed in the new Medicaid managed care regulations at 42 CFR 438.3(e)(1). These services do not need to be listed in the PMAP contract. There are two types of additional services: services at PMAP option and services necessary to comply with Mental Health Parity and Addiction Equity Act (mental health parity).

Because PMAP optional additional services are paid for out of the PMAP's profit, the utilization from these services may not be included in future capitation rate setting. These services could include child care during a parent's clinic visit.

Many states have PMAPs that provide additional services. Florida, for example, calls these services Expanded Benefits. Examples of Expanded Benefits in the Florida Invitation To Bid for 2018 that is in final negotiation include:

- Election of the Dental benefit for adults,
- Election of the Over-the-Counter Pharmacy benefit for adults,
- Election of the Occupational Therapy benefits for adults,
- Election of the Physical Therapy benefit for adults,
- Election of the Hearing benefit for adults,
- Election of the Vision benefit for adults,
- Election of the Respiratory Therapy benefit for adults,
- Election of the Speech Therapy benefit for adults,
- Election of the Additional Primary Care services benefit, and
- Election of the Newborn Circumcision benefit.

Unlike PMAP optional services paid for out of profit, the final capitation rates for Medicaid PMAPs must include the cost of additional services deemed by the State to be necessary to comply with the requirements of the Mental Health Parity and Addiction Equity Act. This includes any services that the State agrees that PMAPs must provide to comply with mental health parity rules such as inpatient substance use disorder treatment.

In Lieu of Services

In lieu of services are alternative services or services in alternatives settings in lieu of covered services or settings, if cost-effective, on an optional basis. In lieu of services are addressed in the new Medicaid managed care regulations at 42 CFR 438.3(e)(2). There is a 15-day limitation on the use of Institution for Mental Diseases (IMD) settings for adults ages 22–64 under this authority. Historically, managed care programs have also implemented alternative payment arrangements under this authority as well. There are four criteria for in lieu of services under the managed care contract:

- The state must determine that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan. This determination must be made under the contract, rather than on an enrollee-specific basis.

- The enrollee cannot be required by the PMAP to use the alternative service or setting.

- The approved services must be authorized and identified in the PMAP contract and offered at the PMAP's discretion.

- The utilization and cost of in lieu of services are taken into account in developing the component of the capitation rates that represents the covered state plan services.

Many states have PMAPs that provide in lieu of services. Florida, for example, has the following in lieu of services:

- Nursing facility in lieu of inpatient hospital services.

- Crisis stabilization units (CSU) and Class III and Class IV freestanding psychiatric specialty hospitals may be used in lieu of inpatient psychiatric hospital care.

- Licensed detoxification or addictions receiving facilities may be used in lieu of inpatient detoxification hospital care.

- Partial hospitalization services in a hospital may be provided in lieu of inpatient psychiatric hospital care for up to 90 days annually for adults ages 21 and older; there is no annual limit for children under the age of 21.

- Mobile crisis assessment and intervention for enrollees in the community may be provided in lieu of emergency behavioral health care.

- Ambulatory detoxification services may be provided in lieu of inpatient detoxification hospital care when determined medically appropriate.
- The following services and corresponding HCPCS or Revenue codes may be used in lieu of community behavioral health services:
  - Self-Help/Peer Services in lieu of Psychosocial Rehabilitation services.
  - Respite Care Services in lieu of Specialized Therapeutic Foster Care services.
  - Drop-In Center in lieu of Clubhouse services.
  - Infant Mental Health Pre and Post Testing Services in lieu of Psychological Testing services.
  - Family Training and Counseling for Child Development in lieu of Therapeutic Behavioral On-Site Services.
- Community-Based Wrap-Around Services in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services

RECOMMENDED ACTIONS FOR SYSTEM SUSTAINABILITY

A viable provider network is essential to sustain statewide access to effective community-based mental health care and equitable treatment outcomes for all Minnesotans. Financial viability requires adequate and efficient reimbursement to ensure that qualified treatment and support professionals can deliver quality care, when and where clients need it and to ensure that providers can invest in best practices for diverse and changing populations with complex conditions and increasingly intensive needs. For these Medicaid-insured populations, sustainable and effective mental health service delivery requires reimbursement methodologies that integrate substance use treatment, primary care, and other family and community-based services in the setting most effective for persons receiving care and with consideration to the social determinants of individual, family, and community health.

A sustainable community mental health system has at least six characteristics: service capacity and geographic access, payment for proven research based care, reimbursement for effective care, payment for new emerging practices, a full continuum of services for adults and children and payment for cost components necessary to deliver effective, quality and accessible care.

To be sustainable, a mental health system must move people toward wellness in the most time and cost-effective manner possible. A sustainable mental health system requires the ability to draw on, and reimburse for, a comprehensive continuum of services, based on well-defined clinical standards and scientifically-supported delivery practices. It must also be capable of measuring the effectiveness of the treatment it provides, with incentives to improve quality and achieve the best outcomes for population

needs. A sustainable mental health system must constantly replenish a well-trained and experienced work force.

Cost-effective and sustainable service delivery must incent both timely intervention and accurate determination of condition in order to plan appropriate services for the person's desired results, knowing that the wrong intervention not only consumes resources intended to achieve wellness but can actually do harm.

In recent years, the federal Medicaid system has committed itself to value-based purchasing healthcare innovations. States have been expected promote reforms (particularly for managed care programs) that improve quality, access, and outcome. The CMS does not entertain proposals based solely on cost savings. Here, DHS and its contractor (Mercer) put forward recommendations to achieve the Legislature's stated intent to ***provide adequate reimbursement to sustain community-based mental health services regardless of geographic location,*** proposing methodologies that are ***consistent with the intent and direction of the federal Centers for Medicare and Medicaid Services.***

Recommendations to Improve the Service Continuum and Capacity (Sustainability)

As described in this report, Minnesota's current Medicaid *rate-setting methodology* does not reimburse for required behavioral health service components or provide capacity-building investment necessary to ensure geographic access to a full continuum of publicly-insured mental health services. As a result, providers may not be financially able to provide the service needed by any one individual and may be forced to provide less effective services than may be expected from their clinical capabilities, state standards, and more expensive research-based practices. Currently, for providers to offer the more effective practices, they must fund a significant amount of the costs through non-sustainable sources such as grants or fundraising. Research shows that without a full continuum of care with sufficient capacity to serve all individuals using research based practices, a community mental health system will have a higher number of emergency room visits and hospital admission and higher overall costs.

Conclusion 1: Reimbursement methodologies are not linked to the State's required elements of providing community-based mental health services. A comparison of Minnesota mental health rates to other Medicare and state licensed practitioner fees demonstrated that the Minnesota rates for essential licensed practitioners are competitive. A closer examination of research-based EBPs, promising practices, and comprehensive rehabilitative services such as crisis intervention; however, found that the current reimbursement methodologies may not be compensating providers for Medicaid's share of the required certifications, training, provider qualifications, travel, and lost productive time required for these cost-effective services.[52] The current medical model coding and reimbursement structure may be sufficiently reimbursing the costs of individual practitioners in solo practice, but it does not appear to be taking into consideration the totality of the costs in the more complex comprehensive rehabilitation providers. Creating

[52] As noted earlier, EBPs require clinicians to spend a large amount of non-productive time (e.g., the portion of each workday that is spent on usual and required activities related to service delivery) relative to the delivery of medical model services. The lost productive time is spent in additional documentation, travel, collateral contacts, certification activities, and supervision activities to ensure that the EBP is delivered in fidelity with the national model.

a new transparent reimbursement methodology with tiered rate schedules that better accounts for the input costs associated with more comprehensive treatment settings would help providers understand how they are being compensated for the necessary elements within the State's standards and would differently reimburse providers with distinct state requirements.

Recommendation 1: Establish reimbursement methodologies to reflect the cost of providing required elements of community-based mental health services.
The State should create a payment structure capable of providing adequate reimbursement to sustain community-based mental health services. This requires understandable rate setting methodologies for all behavioral health services: methodologies that account for resources necessary to provide services; align provider interests with the State goals; and offer its citizens quality services. A sound methodology more clearly and adequately compensates providers for required resource costs. It also makes apparent to providers the financial rewards for supplying quality mental health care services that promote recovery and resiliency of individuals. However, transparency and additional funding do not guarantee quality services and good outcomes if it does not result in an array of research and evidence-based practices that is accessible to members and address individualized needs. State goals should also include accountability, measuring performance, and rewarding efficient providers who address the needs of the individuals they serve.

Rate Setting Models to Support Sustainable Mental Health Services: Based on analysis of Minnesota's existing service delivery environment and its sustainability goal, Mercer recommends adoption of one of the reimbursement methodology options, described above, using the following chart to weigh policy priorities.

TABLE 8: A SUMMARY OF THREE REIMBURSEMENT METHODOLOGY OPTIONS

	OPTION 1: PROSPECTIVE COST BASED REIMBURSEMENT METHODOLOGIES — PROVIDER SPECIFIC RATES	OPTION 2: MARKET-BASED MODELED REIMBURSEMENT — STANDARD FEE SCHEDULE	Option 3: TIERED FEE SCHEDULE
Labor Intensive for providers	Yes — requires provider to submit cost reports and State staff to perform desk audits	Relatively less — State can research practices, survey providers, and rely on national data	Least labor intensive — State will continue to set RBRVS rates for CPT codes. State can research practices, survey providers, and rely on national data for modeled rates for HCPCS codes for comprehensive providers.

	OPTION 1: PROSPECTIVE COST BASED REIMBURSEMENT METHODOLOGIES — PROVIDER SPECIFIC RATES	OPTION 2: MARKET-BASED MODELED REIMBURSEMENT — STANDARD FEE SCHEDULE	Option 3: TIERED FEE SCHEDULE
Requires provider-specific cost reports	Yes[53]	No	No
Requires provider-specific anticipated changes in scope to be reported and integrated.	Yes	No	No
Requires information about Medicaid's share of anticipated provider costs: • Salary cost • Employer-related expenses • Overhead and administrative costs • Staff Travel costs and other program-related costs • Training • Accreditation/Certification • Productivity[54] • Inflation	Increased costs associated with changes in scope may be phased in over time with future cost reports resulting in a delay in reimbursement for innovation	Yes[55]	Yes for fees set using HCPCS (tier 2); No for fees set using RBRVS (tier 1)

[53]Cost reports would require the State to define "reasonable costs"; would require providers to complete cost reports; would require State resources to perform desk reviews; might require a legislative mandate to require cost report submittal; and if there are a large number of providers or non-standard service definitions, then the State may have a difficult time implementing system wide changes if there are provider-specific rates.
[54] The State may factor in costs associated with time not eligible for billable activities (e.g., staff travel time, time spent documenting services, time spent in required training or certification activities or loss of productivity when a clinician delivering home-based services can bill for 4 clients per day, while a clinic-based colleague bills for 10 clients). CMS has accepted rates that contain some cost for paid State holidays, required training time, and vacation in the calculation of non-billable time. The State must provide documentation, such as State Statute, to support the amount of non-billable time factored into the rate. Whenever a ***time study*** is used to determine time not available for billable activities, it must be approved by CMS. In addition, the rate methodology must help to assure that billed time does not exceed cost and/or the time available for providers to render services.
[55] Determine how billed time will not exceed available productive time by the practitioner to deliver services and billing limits in the service definition. Market-based rates are thus cost-informed rates using assumptions standard in the industry.

	OPTION 1: PROSPECTIVE COST BASED REIMBURSEMENT METHODOLOGIES — PROVIDER SPECIFIC RATES	OPTION 2: MARKET-BASED MODELED REIMBURSEMENT — STANDARD FEE SCHEDULE	Option 3: TIERED FEE SCHEDULE
Provider specific encounter rates are set. The provider would be paid a predetermined fee for each unit of service delivered	Yes	No	No
Statewide prospective fee on a specified percentage of allowable costs can be set: • Results in some providers having some portion of “non-efficient” costs not paid • Can be set specific to base mental health services versus Evidence based practices (EBPs)/promising practices with higher cost structures One of the advantages of this type of approach is that when there are a large number of providers, the State can set a fee schedule based on the average costs of efficient providers as determined by the State	Possible — if the State uses the cost reports to set an average fee schedule.	Yes	Yes — Not paid more than the applicable fee schedule which is differentiated based on provider type

	OPTION 1: PROSPECTIVE COST BASED REIMBURSEMENT METHODOLOGIES — PROVIDER SPECIFIC RATES	OPTION 2: MARKET-BASED MODELED REIMBURSEMENT — STANDARD FEE SCHEDULE	Option 3: TIERED FEE SCHEDULE
Would need explicit billing guidance to ensure that Medicaid is payer of last resort.	Clinics must have guidance to bill other insurance such as Medicare and private insurance first for Medicaid clients, especially if the Medicaid procedure coding differs from other payer coding.	Other insurance such as Medicare and private insurance reimburse licensed practitioners using CPT codes. Explicit billing guidance must direct providers to bill other insurance including Medicare first, using the coding required by those payers before billing Medicaid using Medicaid-specific HCPCS coding.	Yes
Subject to Medicare UPL	Hospitals and clinics reimbursed under Medicaid authorities authorizing overhead provided within a hospital or clinic are subject to Medicare UPL	Reimbursement for individual licensed practitioners under Medicaid authorities for physician, licensed clinical social worker, psychologist, and nurse practitioners are subject to Medicare UPL	CPT codes would be subject to Medicare UPL; HCPCS under Rehabilitation authority would not be subject to Medicare UPL

Considerations for Choosing a Sustainable Reimbursement Methodology: The three options presented above include pros and cons. The State should consider the following:

- **Regularly Updated Rate Setting Models**: Mercer recommends regularly updating rate setting models. Such rate setting methodologies should include regular comprehensive updates to the fee schedule to ensure that the rates maintain their viability. Higher rates would have state budget implications.

- **Consistent Reimbursement Methodologies**: The use of consistent reimbursement methodologies for rehabilitation agencies that adequately compensate for State purchasing requirements improves system sustainability. Adopting a tiered approach to rate setting will likely bring greater consistency

and transparency to the mental health system and result in compensation linked to State purchasing requirements in a more systemic manner. Minnesota should ensure that providers are reimbursed using consistent methodologies that are easily understood and compensate for the State required activities, components, and requirements.

Use of RBRVS reimbursement methodologies may continue to serve as the most appropriate for individual and group licensed practitioners directly enrolled in the Medicaid program who provide services reimbursed solely under CPT coding or who are enrolled as independent groups of licensed practitioners.

Comprehensive and specialty rehabilitation agencies may be better served through reimbursement methodologies that couple compensate for higher State standards such as twenty-four hour access to care, accreditation, fidelity standards for EBPs, operations in provider shortage areas, and close supervision of unlicensed staff. These methodologies might be better suited to agencies with higher overheads associated with the provision of a more comprehensive or specialized array of services and where transparent reimbursement methodologies that identify covered reimbursement elements would be useful to the provider agency.

- **Sustainability is more than rates:** As noted above, a sustainable community mental health system includes more than the financial viability of the system. A sustainable mental health system would thus also include:
  - Establishing a financially-sustainable, transparent (easy-to-understand) service reimbursement methodology, as recommended by this study.
  - Incorporating a full continuum of services in the State/Federal healthcare finance and delivery system, Minnesota Health Care Programs.
  - Continuing strategic use of grant funding for innovation, gap-filling and uninsured/under-insured persons.
  - Insuring that new reimbursement methodologies include development of innovative policy, financial and program infrastructure:
    - The needed policy infrastructure includes rule changes, extensive provider education and the phase-in of performance measures.
    - New financial infrastructure includes the need for expert consultation resources, guidance for billing system changes and the development of differential rates.
    - Program infrastructure should include development of realistic timeframes for achieving milestones and staffing changes.

- **Service Continuum:** New treatment services to fill in the gaps for levels of need/complexity for which there are no services; and additional covered services which include essential activities that are not reimbursed under Medicaid; e.g., *Service Plan Development*. (See original CCBHC service guidelines.)

- **Workforce Recruitment**: A secondary, but nonetheless important objective of this financial reimbursement recommendation includes DHS working with other payers and with the mental health association industry to develop workforce recruitment and retention programs, such as training and career paths for unlicensed workers. By reducing the nearly statewide professional shortage that results in high costs to Medicaid, providers will address financial sustainability of the system.

- Either of these methodologies would require that the State start with an identification of the services and requirements that Minnesota wishes to purchase. For example, clearly defining services and provider requirements including training and accessibility to culturally competent practitioners, as well as the needed changes to State statutes, regulations and the Medicaid State Plan would be a first step.

Conclusion 2: Because the cost report responses did not produce sufficient information to draw conclusions, this study found through research into the required costs of providing the nationally recognized cost effective practices, as well as from survey responses from Minnesota providers of EBPs, that Minnesota is not reimbursing behavioral health providers for elements of research-based practices in rehabilitation agencies. A comparison of Minnesota rates to other states' rates for EBPs highlighted the deficiency in the State's reimbursement rates. The State's ability to encourage research-based community mental health services has been undermined because it is not reimbursing providers for all of the required components of cost-effective practices. As a result, community-based providers do not have financial incentives to provide services that prevent institutionalization and emergency room visits such as crisis intervention and community-based EBPs.

Recommendation 2: Reimburse Evidence-based Practices using EBP-specific reimbursement that pays for performance.

Because EBPs are a key to the overall sustainability of the community mental health system, Mercer recommends adoption of a pay-for-performance reimbursement methodology that incents providers to deliver State-endorsed EBPs with substantial ongoing costs, using EBP-specific billing codes and rates specific to each EBP. This recommendation requires the State to establish separate rates for different EBPs with ongoing costs and eventually developing and implementing an alternative payment model tied to providers achieving higher compliance scores.[56] If the State were to continue to reimburse EBPs under the current reimbursement models that do not compensate for nationally required elements of the services, providers would continue to face disincentives to providing the more effective research-based practices.

[56] Compliance with national EBP standards is referred to as "fidelity". For EBPs with required ongoing reviews that measure the extent to which the provider maintains integrity to the research-based approach, the provider is awarded a higher "fidelity score".

For other EBPs that do not have substantial ongoing costs, Mercer recommends that the State utilize Value-Based Purchasing reimbursement structures linked to performance standards including establishment of performance measures and paying incentives for achieving indicators. See the discussion under Recommendation 3 related to VBP.

For EBPs with ongoing costs, the State should adopt a reimbursement option to compensate providers for all required costs for the provision of evidence-based practices. The two potential options are outlined in this report:

- Option 1: Prospective Cost Based Reimbursement Methodologies
- Option 2: Market-based Modeled Reimbursement

It is not necessary for the State to select a single methodology across all services. For example, today ACT and DBT are reimbursed using cost-based reimbursement.

This recommendation requires several steps: (1) a more transparent and complete reimbursement methodology with fee schedule rates for priority EBPs, (2) a prospective monitoring and certification system for all providers and practitioners billing EBPs requiring ongoing certification, (3) a billing system with specific procedure codes and modifiers for each EBP, and (4) selection and expansion of additional EBPs and promising practices, including formation of a workgroups with providers, individuals, and family representation to determine priorities for implementation of EBPs.

- **Transparent Reimbursement Models**: The State should develop and use a reimbursement model that recognizes Medicaid's share of the costs of certification, training, clinical supervision, consultation, measuring, and reporting treatment outcomes for delivering the service in compliance with the recognized EBP model, materials, and staffing with the qualifications, experience and roles required to meet compliance including the necessity to provide priority EBPs to target populations. The reimbursement models should consider the following items:
  - Structural requirements including staffing qualifications (for degrees and experience, supervision ratios, and caseload limits.)
  - Minimum performance standards that providers must meet to qualify for the enhanced funding of EBPs including the standardized tools that measure fidelity (e.g., TMACT for ACT), the minimum scores that must be achieved, and the frequency in which the provider must be reviewed. The State should consider whether higher fidelity providers should have longer fidelity review cycles (i.e., every three years instead of annually). The State should also include any outcome measures that must be met for individuals receiving these services.
  - A rate setting methodology that accounts for services delivered in accordance with EBPs and takes into consideration the costs of required materials, supervision, and other activities that are

specific to EBP models of care. The methodology should account for verification of certification at a designated frequency in order to qualify for the EBP rate.

  - When an EBP rate covers the cost of training, certification, staffing, and ongoing supervision, and payment is tied to achieving both fidelity and predefined outcomes, the payment supports quality and effective utilization. Several states are already using EBP specific rates for ACT, Inpatient Psychiatric Care and FEP. FFT and MST among other EBPs that could be added to the VBP list when the payment is tied to achieving both fidelity and pre-defined outcomes in an EBP-specific rate. PMAPs may also use alternative payment arrangements for services that are either cost effective alternatives to State Plan or waiver services, or allowed by managed care rules for additional services.

- **Certification and Monitoring**: Beyond a more transparent and complete reimbursement model, this recommendation requires the State to certify and monitor all providers and practitioners wanting to bill for these more expensive EBPs (for example, ensuring that the EBP provider has received the training prior to reimbursement). DHS should develop the certification requirements specific to each EBP. DHS should determine whether an acceptable national certification exists for each EBP and establish state Medicaid rates that receive a federal match and reimburse the provider for obtaining acceptable national certifications. If there is no acceptable national certification, the State may certify compliance with the EBP internally or it may establish or designate a Center of Excellence for training and consultation on EBPs.[57] When a Center of Excellence option is utilized, the State should ensure that Medicaid administrative claiming or provider rates offer a payment mechanism to support the Center for Medicaid's share of the clients served.

  Service specific performance measures related to each EBP can be incorporated into the reporting requirements to strengthen quality oversight. Increasing the viability of the State's approach to the oversight and contracting for EBPs will support the State's adoption of a transparent reimbursement methodology for cost-effective EBPs.

- **Billing System Modifications**: The recommendation would also require that the billing system be modified to discretely recognize more EBPs. Mercer recommends expanding the use of billing codes, modifiers, provider types, specialty codes, or enhanced service indicators to include billing processes for all EBPs requiring certification and ongoing fidelity monitoring. This will allow the State to have EBP-specific reimbursement rates that include the totality of the costs for each service. To reimburse EBPs for required elements, the State will need to add additional EBP specific HCPCS codes, provider types, specialty codes, or modifiers to the billing system that would require system changes to the State's MMIS.

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[57] The State has designated the University of Minnesota as a Center of Excellence for training and technical assistance with EBPs. That center also provides an individual certification for IDDT (E-IMR) clinicians. www.mncamh.umn.edu. DHS could expand on this designation, take on these responsibilities within the State Mental Health Authority, or designate another entity for other EBPs.

By adopting reimbursement, monitoring, and billing procedures for EBPs in Medicaid, Minnesota could ensure that provider costs currently reimbursed by State and grant funding are covered under Medicaid. These modifications would minimize the cost shift from Medicaid to State funding and grants for EBP provision to Medicaid beneficiaries. This change would reduce the reliance on State funding to supplement EBPs by ensuring that Medicaid reimburses the totality of the required costs for the cost-effective EBPs. Grants could then be prioritized for supporting the start-up, expansion of and sustainability of EBP for non-Medicaid eligible individuals. Medicaid could then fund elements such as training, technical assistance, and required supplies for Medicaid. The EBPs then become more sustainable because there is an entitlement funding source.

- **Expansion of Endorsed EBPs**: Mercer recommends expansion of the State-endorsed EBPs to include more common EBPs and promising practices that cross the full age continuum. This will allow the State to create service-specific reimbursement rates where there are ongoing costs and provide incentives for providers to continue to invest in EBPs and help improve member outcomes.[58]

  To determine the priorities for EBP implementation, Mercer recommends the mental health division form a workgroup in collaboration with the provider community and PMAPs to review a broader range of EBPs and promising practices by assessing community need, utilization, and expertise. The workgroup should have representation from people with lived experience[59] and their family members. The results of this analysis can be utilized to determine research based services that would receive DHS endorsement. Information available as a starting point includes provider survey self-report on existing evidence-informed initiatives, and promising practices currently being offered by their organizations. These provider survey responses included: MST, FFT, Homebuilders, A-CRA, motivational interviewing, EMDR, mental health first aid, solution-focused brief therapy, and SCERTS for children with autism spectrum disorder.

  At a minimum, Mercer recommends, prioritizing MST, FFT and Peer Support Services (adult, youth, and family). (See the Educational Research Analysis for additional information on specific practices.) Stakeholder sessions with the PMAPs could also be established to discuss and obtain buy-in on the approach for rolling out and sustaining EBPs and choosing and implementing a pay-for-performance program consistent with those EBPs.

- **Developing evidence**: As noted earlier in this analysis, research based care can be utilized to fill service gaps in the service array, but the mental health industry does not currently provide sufficient EBPs to fill all gaps in the continuum of services. At least temporarily, Minnesota must adopt an approach to build provider capacity that goes beyond developing a financially sustainable reimbursement methodology for standard State Plan and HCBS services, as noted in Recommendation 1, as well as encouraging existing evidence-based practice as noted above.

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[58] If there is no difference in the cost of the promising practice over a traditional service, then the State can incent the promising practice using VBPs and performance measures as noted in Recommendation 3. This recommendation only addresses reimbursement methodologies where there is an underlying cost difference in the provision of the State-recognized

[59] Lived Experience is the term of art for knowledge gained by having lived with, or raised a child with mental illness. It is considered a qualification for a Peer Specialist or Family Peer Specialist.

Minnesota must also explore developing its own evidence, using an approach like coverage-with-evidence development until clinical science advances. This three pronged approach which includes the exploration of new research will further development of sustainability of the system.

One such evidence developing initiative is MAP that providers are using to guide treatment decisions. As noted earlier, MAP uses several decision and practice support tools to assist in the selection, review, adaptation, or construction of promising treatments to match particular child characteristics based on the latest scientific findings. MAP is one way in which Minnesota can rely on research based practices without expanding the list of state-endorsed EBPs.

Conclusion 3: Provider focus groups, interviews with State staff, and survey responses found that Minnesota has financial tools that are being underutilized to create incentives for community mental health goals. Specifically, PMAPs have the ability through "in lieu of" authority to provide cost-effective alternative services. The State's IHP program for value-based purchasing does not currently have extensive performance measures and financial incentives for improving the health outcomes of individuals with behavioral health diagnoses. However, if the State permits PMAPs to reimburse community-mental health providers less than State funded programs, cost-shifting from Medicaid to State funded or charity care could result. As a result, DHS will need to ensure that the overall financial incentive structure of financing innovations sets base reimbursement rates and financial incentives that sustain community-behavioral health.

Recommendation 3: Build on the State's healthcare financing innovations to capitalize on recent federal commitments to efficiency and value-driven reimbursement.
Minnesota is currently engaged in several distinct healthcare financing demonstrations with the federal government. These demonstrations include new opportunities to link provider payments to improved performance by health care providers. This opportunity allows Medicaid to consider value-for-cost, rather than simply demanding the cheapest possible care. This includes adopting payment structures that encourage efficiency in the system, consistent with the intent and direction of CMS, by implementing innovative reimbursement under the broad rubric of CMS Innovation Models that develops new payment and service delivery models under 1115A Demonstration waivers; ACA; a number of specific demonstrations to be conducted by CMS, including Quality Payment Program. To enhance the current direction, Mercer recommends the following strategies.

- **Mandate rate floors in PMAPs**: Recent CMS Medicaid managed care regulations and policy guidance[60] make it clear that states cannot dictate the amount of payments PMAPs pay to providers: Such "directed payments" are explicitly prohibited. However, the regulations and policy guidance allow the State to mandate the managed care plans to "adopt a minimum fee schedule for network providers that provide a particular service under the contract" so long as the state achieves certain specific policy goals and demonstrates ongoing success in achieving these goals.

[60] 42 CFR 438.6(c)(1)(iii) and CMCS Informational Bulletin dated November 2, 2017. The CIB may be accessed at: www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf

CMS gives the example of states utilizing existing mechanisms to evaluate the effectiveness of the payment arrangement, such as external quality review or an existing consumer or provider survey. The State could also utilize the common set of performance measures across all of the plans to ensure that quality services are provided where the minimum fee schedule is required. For example, the State could require that the State FFS fee schedule for ACT is paid by the PMAPs and then have a set of performance measures requiring that all ACT providers achieve certain fidelity scores on particular subscales of the TMACT fidelity reviews in order to receive that reimbursement rate.

The most recent CMS guidance outlined two situations which are exempt from the "directed payment" guidance: (1) requiring managed care plans to increase provider reimbursement without mandating a specific payment methodology or amount with the managed care plan retaining discretion for the amount, timing, and mechanism for making such provider payments; and (2) states requiring plans to utilize value-based purchasing or alternative payment arrangements when the state does not mandate a specific payment methodology and plans retain the discretion to negotiate with network providers the specific terms for the amount, timing and mechanism of such value-based purchasing or alternative payment arrangements.

There are several recent examples of states that have adopted minimum mental health fee schedules in their managed care programs to promote system stability and reduce cost-shifting. One state, Delaware, currently requires PMAPs to adopt the State Medicaid FFS fee schedule for crisis intervention providers; while another state, New York, requires PMAPs to adopt the state Medicaid FFS fee schedule for mental health and substance use disorder clinic providers to prevent cost-shifting from Medicaid to state general funding and block grant funding. Those states found that without minimum fee schedule requirements in Medicaid, providers relied on block grants and state general funds to offset losses. This deficit financing of Medicaid was financially unsustainable in the long term in both states.

- **Develop Value-Based Purchasing arrangements in Integrated Health Partnerships**: As noted above, over the past five years, DHS has contracted with innovative health care delivery systems to provide high-quality, efficient care to Minnesota's Medicaid population. Participating providers enter into an arrangement with DHS, by which they are held accountable for the costs and quality of care their Medicaid patients receive. Providers showing an overall savings across their population, while maintaining or improving the quality of care, receive a portion of the savings. Providers who cost more over time may be required to pay back a portion of the losses.

  Minnesota utilizes shared savings for primary care providers through the IHP program and has been exploring ways to leverage partnerships with behavioral health providers through this model. As the IHP model grows, the State could utilize IHP as a vehicle for saving with behavioral health providers with relationships to larger provider systems.

- **Link reimbursement to individual treatment outcomes**: Minnesota should enhance payment incentives built on individual treatment outcomes or progress measures in FFS and managed care delivery systems. This initiative could go beyond common provider/payer performance measures or

Healthcare Effectiveness Data and Information Set (HEDIS)-like population measures. Instead, it would measure an individual's treatment progress, using state-adopted symptomology and functional outcomes tools.[61]

- The state could implement shared savings arrangements using simple financial incentives or penalties that encourage providers to comply with performance goals. Bonus or incentive payments can be structured to achieve desired behaviors, such as quality or clinical outcomes. A common approach to implement a bonus or incentive arrangement is to withhold a portion of the capitation payment and have the provider earn the withheld amount based on achieving certain targets associated with the quality measures. The targets should be prospectively established and based on desired outcomes related to quality or clinical improvement measures. The payment of bonuses or incentives typically also requires that the State creates a baseline measurement of where the State is today on each measure and what goals the State hopes to achieve. For example, increasing community tenure, reducing emergency room use and reducing recidivism — these are all goals on which states have successfully developed and paid incentive payments to providers.

Recommendation 4: Work with the State's Medicaid division to examine the Medicaid reimbursement structure, to improve the transparency of reimbursement methodologies, and to address reimbursement deficiencies in a comprehensive manner.

To better serve Medicaid individuals, the divisions of DHS should work in partnership to systematically analyze the overall Medicaid reimbursement structure. Partnership between the Health Care Administration and the Mental Health Division should initiate a methodical approach to address all services for individuals served by Medicaid regardless of the type of service (e.g., physical health, behavioral health, etc.).

[61] Instruments currently exist that have been validated by age, gender, and major racial/ethnic group.