

## Comments for: SPA 16-001, Residential Child Care Services Billing Methodology

The Bureau for Medical Services received a total of 97 public comments regarding the Residential Child Care Services Billing Methodology SPA. Below, please find the summary of comments with responses:

Total	Comment	Response
13	The financial impact will have a devastating effect on youth emergency shelters and residential treatment facilities throughout the state unless other funding has been identified that will adequately fund these programs. The facilities will not be sustainable in a fee-for-service model.	The Fee For Service (FFS) model, depending on the needs of the individual, could produce more revenue or less revenue. The level of service and amount of revenue will be based on the needs of the child.
20	The State Plan Amendment results in diminished access to services for the target population; no review was conducted within the prior 12 months.	The services will still be provided; just using a FFS model for payment.
7	Input from beneficiaries, providers, and other affected stakeholders regarding beneficiary access to the affected services was not sought or received.	A full public comment period, which ran between April 12 and May 12, was held and meetings to discuss residential changes were held prior to the comment period.
6	The State of WV did not provide adequate notice to providers of this change.	A full public comment period, which ran between April 12 and May 12, was held and meetings to discuss residential changes were held prior to the comment period.
63	The public and affected parties have not received an adequate written rationale to the proposed elimination of the current rate structure.	This model assures accountability and promotes individualized service planning to meet the child's need.
45	The SPA does not reflect any goals regarding the improvement of outcomes, the lowering of costs, or increasing access to care.	The SPA would not address these issues. This SPA is simply to change payment methodology.
7	Consideration of other more effective, efficient (and more innovative) models of behavioral health and related services were not pursued.	This SPA allows for additional accountability to begin the change. Risk based models could be considered in the future.
6	The Amendment will not allow providers to capture unfunded mandates.	The FFS Medicaid behavioral health services do not have unfunded mandates.
19	Residential and shelter providers will not be sufficiently reimbursed and will be unable to provide the behavioral health and other services the children need.	The Fee For Service (FFS) model, depending on the needs of the individual, could produce more revenue or less revenue. The level of service and amount of revenue will be based on the needs of the child.
4	The amendment takes away residential services, but doesn't add anything.	This amendment does not remove services; it is just changing the current rate structure. The behavioral services remain the same.
5	I urge you to remove the proposed amendment to the state's Medicaid Plan and work together with West Virginia based non-profit residential facilities, communities and providers.	We will continue to work with providers to educate on the current array of behavioral health services that are available to provide to children with behavioral health needs.
4	I am concerned about what will be billable for my nursing staff. I would like to know what the billing codes for our nursing department will be. It is my understanding that nursing services at this time are not a billable service as	Many of the services that nursing staff are performing such as linking and referring to doctor appointments can be considered billable under targeted case management.

	a bundled rate. I am concerned about how nursing services will be incorporated into this mix of payment. I need to help provide some information that will help my staff feel they have job security in the future.	
11	More children/adolescents would often be sent to treatment facilities in other states, (costing the state even more money for their care), or, these Individuals could end up in the Juvenile Justice System, instead of in a treatment program.	This spa does not change treatment that is offered in state, it just changes the payment methodology.
6	It is extremely irresponsible and shortsighted to surrender Medicaid funding (estimated to be between 20-30 million dollars) back to the Federal Government. The new Governor will be faced with the impossible challenge of finding 20-30 million dollars absolutely essential to fund these residential treatment programs. Once these funds are surrendered, they will no longer be restored, and the governor will not be able to recover these funds without cutting other essential programs.	The Fee For Service (FFS) model, depending on the needs of the individual, could produce more revenue or less revenue. The level of service and amount of revenue will be based on the needs of the child. There is no Medicaid funding being surrendered as services are not changing; just the reimbursement methodology.
55	The regression to fee-for-service is counter to agreements now being made with MCOs. MCO agreements are based on a bundled rate. Is bundling, unbundling, and rebundling productive?	This SPA allows for additional accountability to begin the change. Risk based models could be considered in the future. Further, MCO's work under waiver authority and will have the flexibility to negotiate rates and payment models with providers.
13	The unbundling process is just an additional disincentive to remain a Medicaid provider.	The Fee For Service (FFS) model, depending on the needs of the individual, could produce more revenue or less revenue. The level of service and amount of revenue will be based on the needs of the child.
54	A request for a one week review period before a vote was taken by the Medical Services Fund Advisory Council. The request for a review period was denied, justified by the fact that concerned entities could express comments by visiting the SPA Public Comment webpage.	The MFSAC bylaws do not require that the MFSAC be provided a week for review of a draft SPA prior to holding an advisory vote. Acting Commissioner Beane appropriately pointed out during the meeting that beyond the MFSAC advisory vote, there would be a full thirty (30) day comment period on the draft SPA. Additionally, Acting Commissioner Beane clarified that all MFSAC members could voice their objection to the time provided for review by voting against approving the SPA in the advisory vote. When the advisory vote was held, it was approved with a majority of votes; only one (1) person voted against the MFSAC approving the SPA – the same individual who objected to lack of sufficient time to review it in advance of the meeting. Finally, WV BMS emphasizes that the MFSAC is advisory in nature, and there is no legal requirement that a SPA be approved by the MFSAC prior to the single state agency moving forward with the same.

55	The url link for the SPA webpage took the viewer to a page that included only the comment "Intentionally Left Blank." The SPA not being made available via the given email link or at local DHHR offices has created barriers to allow full understanding and access to both the current and revised State Plan. The SPA deletes the current methodology but fails to substitute any new language as to how services will be billed.	The purpose of this SPA is to remove the bundling payment methodology for residential child care services. Since the fee for service methodology is already found elsewhere in the State Plan, the bundling methodology language was stricken in the State Plan and not replaced with any language. It is clearly explained in the notice what the purpose of the SPA is. Regarding the SPA not being available at local DHHR offices, BMS believes the SPA and public notice was available at local DHHR offices during the stated public comment period. Further, it was made available online, in newspaper notifications, and on the Secretary of State's website. All stakeholders had sufficient notice of this SPA from various resources and time to comment on it. This is the standard process for all Amendments.
1	Numerous times over the past month, my clients have sought and requested from the county offices to see the so called SPA "documents detailing these proposed actions". The response received from such county offices when asked was that no such documents are available.	The documents posted/available at the County Offices were the same ones available online – the SPA and the public notice explaining it. The notice is the "document detailing the proposed action". All stakeholders had sufficient notice of this SPA from various resources and time to comment on it.
45	The proposed changes will in all actuality bog providers down in the amount of paperwork that they generate and severely decrease the amount of time that will actually be spent on/ with the client.	Documentation of services will remain the same as it was under the previous model. All Medicaid services must be documented in order to receive federal matching funds.
5	Treatment will be at risk of being dictated by available codes, not clinical need.	Medicaid services are based on medical necessity which considers clinical need.
4	We have heard that BMS does not have the workforce to manage the additional authorizations and claims.	BMS is ready and has the capacity to process claims in the FFS environment.
2	The service limits in effect for outpatient are inadequate for residential treatment and would necessitate acquiring new authorizations at a frequency that will place an undue administrative burden on providers <i>and</i> the ASO.	BMS will work with providers based on the needs of the child to extend authorizations when medically necessary.
4	Psychiatric services are woefully underfunded by Medicaid fee for service. Telehealth has it limits, one being that psychiatrists don't necessarily want to assess children via this medium. The cost of psychiatric services far out exceeds the fee-for-service rate, thus creating an unfunded mandate and limiting quality service delivery. Providing intensive substance abuse services requires the flexibility that a bundled treatment rate affords.	85% of all codes pertaining to mental health services are available via telehealth. Non-residential treatment providers have successfully been providing behavioral health services under West Virginia's Medicaid plan without an "unfunded mandate" and BMS does not believe this SPA will create any such unfunded mandate.
3	WV's residential treatment providers brainstormed how the industry might look going forward, reimagined residential care to improve delivery, decrease length of stay, advance aftercare, and develop community-based services, offered suggestions and edits to the provider agreements, and	This comment does not pertain to the SPA that is on line for comment. This comment was referred to the Bureau for Children and Families.

	suggested models for cost reimbursement, the BCF was quietly working behind the scenes to dismantle the level system, unbundle the daily rate, and present a provider agreement that in its present form will create undue hardships for providers, but also for child protective and youth services workers, and certainly for children in out of home care. It is BCF's contention that the Bureau partnered with residential treatment providers from the outset. This is disingenuous.	
43	Unbundling the rate for Residential Care is going to add costs to the Bureau for Medical Services as well as to Providers. Management of authorizations, reauthorizations and utilizations alone will increase costs and it is clear that capacity will need to increase to transition to this proposed methodology.	BMS has a fixed fee for authorizations thus an increase in authorizations will not increase our administrative cost.
41	The increase of the sheer volume of authorizations/reauthorizations and invoice management does not seem to indicate this change will be cost neutral.	BMS has a fixed fee for authorizations thus an increase in authorizations will not increase our administrative cost.
43	What is the proposed plan to manage the significant increase in the amount of required authorizations/reauthorizations for each of the unbundled services?	BMS is ready and has the capacity to process claims in the FFS environment.
42	This proposed SPA is also not in alignment with national trends which have moved away from the unbundling of services in residential care in favor of bundled rates with focus upon value-based contracting.	This SPA allows for additional accountability to begin the change. Risk based models could be considered in the future.
41	It would be critical to consider the following or a combination of the following in making a decision of this magnitude: (1) no authorizations required for services for youth in 'residential care, (2) if authorizations are required-allow for authorization of services to cover at least 180 days for each youth, (3) require only higher end services require authorization, (4) refrain from requirement of authorizations for a 1 year period to allow for providers, Molina and APS to transition to this new methodology without penalty.	BMS will work with providers based on the needs of the child to extend authorizations when medically necessary.
41	Not all current Medicaid behavior health service codes are set-up or defined to be delivered in a residential treatment setting. When will codes be revised with appropriate application and made available to providers?	The behavioral health service codes are defined as they are nationally with CPT® and HCPCS® definitions and guidance for states. The codes are developed to be used in any setting as there are multiple place of service identifiers that can be used for the individual codes. These are the same codes which have been used to identify the services that children's residential providers have had open to them historically.
3	The language that currently exists in the fee for service section of the State Plan is insufficient for addressing the unique treatment concerns in a residential setting. Treatment services such as individual and group	All of these services can currently be combined in the FFS environment and tailored to meet the individual need of the member. There is no limit of just 15 minutes. The length of

	counseling, individual and group therapy, targeted case management, clinical assessment, etc. are typically provided in some combination on a daily basis, and for more than 15 minutes.	service and amount of service is based on medical necessity.
2	The proposed amendment eliminates an objective, quantitative reimbursement method, but does not replace it. There is a lack of clarity as to the intent of the amendment and because of that, a thorough evaluation of its impact has not been possible. These deficiencies preclude its adoption as proposed.	This model assures accountability and promotes individualized service planning to meet the child's need.
1	A major concern with this SPA is the lack of ethical behavior of WVDHHR and BMS. There has been no preparation for this change to deal with any potential consequences. There has been no training or unveiling of what treatment codes will be allowed to meet the needs of those in residential treatment, other than the use of Targeted Case Management.	BMS and the DHHR strongly deny any allegation that BMS and/or the DHHR engaged in any un-ethical behavior in preparing this SPA. There were 4 (four) face-to-face trainings that were completed in each of the 4 BCF regions as well as 3 webinars for providers for the new TCM manual as well as an overview of the Rehab codes that can be billed by providers. APS Healthcare is available for trainings to individual providers at their request. Each provider has a trainer consultant assigned to them to help train, educate, and offer guidance to providers concerning any services that are being provided.
4	The providers and the WVDHHR decided to move to the current bundling system through a partnership approach to create and implement a cost-based reimbursement system. This system has accountability contained within due to the caps that are inherent in the cost reports that are submitted every six months.	This model under the SPA (FFS) assures accountability and promotes individualized service planning to meet the child's need.
2	No fiscal impact statement or analysis has been prepared to show the impact of such changes on the West Virginia Medicaid budget.	Medicaid believes this change will be cost neutral to the Medicaid budget. A fiscal impact statement was provided in the public notice stating that there is no expected fiscal impact.
1	I have heard that if the "bundled daily rate" is removed from the State Medicaid Plan, it will never be permitted to be re-added at a later time by CMS as it was essentially grandfathered in to WV's plan.	CMS approval in the future cannot be determined. However, CMS does expect assurances that payment is for only services provided that meet medical necessity.
1	I have also heard that in the near future, behavioral health benefits for youth at residential treatment facilities (foster care youth) will move from APS to one of the MCOs and when that happens, they would like to re-bundle residential treatment services. Will the proposed change in the State Medicaid Plan preclude that from being allowed?	MCO's work under waiver authority and will have the flexibility to negotiate rates and payment models with providers.
1	I have been informed that there is a shortage of qualified professionals to provide community-based services, particularly in the less urban areas of the State. If it is your intention to shift to community-based services, has there been a state-wide survey or audit of providers to determine if there are sufficient qualified professionals available to provide the needed	This SPA is only about payment methodology for residential and does not address community based services.

	services?	
1	Implementing this proposal on September 1, 2016 could limit the options available to the new administration in dealing with this issue after it takes office next January. Accordingly, I am respectfully requesting that you discontinue your effort to amend the state plan in this respect, or at least delay this decision until after the new administration is in place and has an opportunity to consider whether this change is desirable.	The SPA will still provide for all the current behavioral health services being provided, just with a different reimbursement methodology. The implementation date is scheduled for September 1, 2016.