

**CWAC Medicaid Committee Teleconference Minutes**  
September 25, 2015, 10:30 -12:00

Call-In Number: 888-494-4032 then press 8573238421#

Attending: Deb McCarroll Jason Keeler, Debbie Reed, Kristine Herman, Lizzie Kepler, D.D. Fisher,

- 1) Welcome/Review of Agenda
- 2) Feedback on Recommendations from Foster Care and SOC Committees

As a general statement, people have been very supportive of the overall recommendations. There was some concern expressed about using terms such as “bundled” or “capitated.”

- All agreed that we have to work toward having already certified and not yet certified providers maximizing their billing
- Group acknowledged we may end up going with a flat split rate, but are also aware that other payers are starting to go with a more capitated rate structure.
- Group really wanted this committee to drill down on the payment side.
- Detailed questions are reflected in the comments

Deb M asked for a copy of the comments to review.

Deb expressed that from the SOC side, requiring certification was not a big deal, but revising the way the payments are structured caused some concern. It seems like we had been moving away from bundling rates instead of toward it. Beyond concerns about rate structure, the rest of the recommendations seem in line with SOC goals.

At this point, the recommendations will come go from this group to the CWAC SOC committee, then it will be their choice to bring it to full CWAC group. The group agreed that we really need to take a look at word-smithing the recommendations so that terms like capitation and bundling do not become a road block at this stage.

- 3) Discussion on Recommendation to revise Medicaid payment system

The group discussed alternative ways of describing the payment side of the recommendations – including terms such as “hybrid” to reflect some method by which providers are assured of a fixed amount and within that are required to bill Medicaid without a hard billing target or split rate.

In general, the FC community is very willing and understands that billing is currently marginal in terms of claiming vs. obligations (<2%). That said, all still understand the importance of financing it effectively.

Kristine told the group about an idea that had been raised at the SOC meeting -- that we could look implementing a voluntary process for FC providers, in which providers who opt in would have some portion of the rate moved to the Medicaid side. On the Medicaid side of the contract, providers would be eligible to be paid for whatever they bill even if it amounted to more than the previous placement rate had been. There would be an opportunity to increase revenue through increased service billing, but there is a risk of loss if the services are not produced.

Residential providers now have contracts split up this way. While there are increases and decreases within specific contracts, the overall level of claiming is very similar to pre-split levels. However we would hope to see some increases in billing and claiming levels with the new proposed service types.

One major difference with the SFC contracts is that we know current billing levels are not anywhere near what they could be even before expansion into new service types. The challenge was restated that it was very difficult to figure out how much to take \*out\* of the current rate to put on the Medicaid side.

- One option would be to set a flat Medicaid portion for each contract. For example, a flat \$20 could be set aside as the Medicaid portion of any SFC rate. We don't have standardized SFC rates, so a percentage across the board would be a problem. A flat \$ amount could address that piece.
- Another option could be to set the Medicaid portion based on the amount that has already been billed. The challenge there is that the current billing levels are so random and tiny right now, it would almost amount to offering contracts the whole rate with an open window to increase on the Medicaid side. (When the MRCs were created, the Medicaid portion of the rate was not based on billing, but on Random Moment Sample (RMS) data the department already had.)
- A third option was suggested, that we consider doing a pilot program in order to get a better sense of what SFC providers can reasonably produce in Medicaid billing, and use the expanded service array as another carrot. We would need to change the rate structure to figure out what percentage of the foster care rate would be carved out to bill against.

Discussion of other Department Initiatives and Directions – Therapeutic Foster Care, NB Legislation, & Managed Care

How is Therapeutic Foster Care different from Spec Foster Care?

- In IL, one of the cornerstones of Therapeutic FC is professional foster parents, and also looking at specific treatment models.
- There is nothing in the RFP related to specific funding structures. around Medicaid (other than what is already in place) The RFP seems very vague in terms of how the funding stream will be organized.
- Therapeutic FC also appears to have event-based billing rather than FFS.

Some other states do Therapeutic FC under a 1915i waiver, where Therapeutic FC is a totally claimable intervention. We don't know whether DCFS is considering doing this, but if DHS does, we would want to get a foot in that door too – it would need to be available to Medicaid recipients, not just DHS kids. 1915i does not require cost neutrality, but there is some capacity requirement. In other states, if they have more in the service array then there is also more opportunity to bill for other activities.

The group acknowledged that DCFS has an antiquated service delivery and payment system where kids have to step up in level of care to get the services they need. That doesn't necessarily mean DCFS is moving away from SFC, but they are also exploring Therapeutic FC to see if that will work.

DCFS has used professional FP programs in the past, and have pockets of it still. Some hired FPs as staff, others just paid them a lot more because the role was intended to be a job -- the professional foster parent payments in 2006 or 2005 were supposed to be equivalent to a bachelor's level starting salary. Foster parents were required to be at all the staffings, meetings, and consults, and they can't give 14 day notice. Hiring professional FPs has been problematic in several ways-- terminating the parents as employees means you have to move the kids. Also disincentivizes permanency. Rates were not consistent across the state either. One of the reasons it started to shut down was that the costs were not sustainable.

Therapeutic FC is coming back in in an effort to find the services and outcomes we want. In Spec FC, we have FPs that sign on to do this, but end up getting resistance to attending and participating in all the treatment and consultation activities. The department is left without any leverage in these cases – DCFS doesn't want to move the kid, and can't keep the home if they take the SFC payment back.

This group may have to make a decision if we want to push forward on restructuring the claiming and payment now, knowing that larger changes are coming with NB and expansion into Therapeutic FC. Also, managed care is here and not going away. At some point down the road, DCFS kids will be involved in some sort of managed care product. Don't know what it will be, but right now what we have is the Choices model. If we can frame all of this in a way that fits into that kind of conflict-free case management model then we won't have broken anything.

The group further discussed the merits of going with a Choices-informed SFC pilot project.

- Choices enrollment is the next step up in services so that the placement does not have to change.
- Includes extra flex funds for the foster parents to do additional things. Maybe we can try to carve out the flex funds piece to have the C&F team deploy those dollars in a spec pilot.
- Involving Choices would put the pilot on the road to where the state is going overall -- bringing a level of service to the child

- Splitting the funding up gives us the flex funding we need to increase or decrease services and supports in the same homes. The Child and Family Team would need to have the authority to assign those flex funds where they are needed.
- Choices can assist the group in determining what the payment model should be – if that’s the flat \$20 rate model, or something else based on the group’s feedback
- As another topic for this pilot, we also need to talk about more robust Child and Family Teams, even if we don’t have a CME in play. To get investment, we need C&F Teams to be able to actually be able to affect what happens and what gets approved.
- C&F Team set up for anyone not in Choices pilot areas define it very differently – will need to help providers understand what the C&F Team can be and can do. Need to educate and clarify what we are talking about with C&F Teaming – and outside folks will be understandably anxious about risk and change.
- The pilot advisory group will be comprised of:
  - o Volunteer representatives from 5-6 of the top ten Medicaid billing Spec Foster Care Providers
  - o Choices Leadership
  - o Department and Provider Advocacy Leadership – Kristine Herman, Deb McCarrell, DDFischer

4) Additional revisions to recommendations?

We need to create a new recommendation around the pilot program to present to SOC. Our recommendation would be pretty broad – the more detailed payment and contract structures would be created by the actual pilot group we bring together. Kristy will plan to present new recommendation to SOC group next week.

5) Next Steps

- Kristy will present this new recommendation at SOC next week.
- Lizzie will put the list of high Medicaid performers together and forward to the group.
- Kristy will identify who will participate from Choices.
- KH will interface with Budget and Finance to make sure we are still in line with where the budget is going.

6) Adjourn