

# JLHSS: Brief Introduction to Community Mental Health and Substance Abuse Funding in Wyoming

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April, 2016

## Background on Behavioral Health Division

The Behavioral Health Division (Division) of the Wyoming Department of Health (WDH) was created in 1979 with passage of the Community Human Services Act, W.S. §35-1-611. The purpose of the Act was to “establish, maintain and promote the development of a comprehensive range of services in communities of the state to provide prevention of, and treatment for individuals affected by, mental illness, substance abuse, or developmental disabilities, and to provide shelter and crisis services...”

W.S. §35-1-620 through 624 provide that the WDH may, through the Division, enter into cooperative contracts for human services programs. The statute does not, however, designate a specific funding formula to be used, outside of general guidance included in:

- **§35-1-620(b)(iii).** The WDH shall “Establish a uniform schedule of fees which will act as a guideline for state purchased services provided to clients by human services programs under this act.”
- **§35-1-621.** The WDH shall “Expend the funds in accordance with W.S. §9-2-102 and this act.”
- **§35-1-622.** Requires that the WDH’s budget request to the legislature recommend “The levels of services that the Division shall purchase based on population, needs assessment, regional cost differences necessary to provide reasonably similar access to services and other criteria...”

There is currently no statutory language or language in WDH rules that *specifically* defines a funding formula to be used for the reimbursement of mental health and substance abuse (MHSA) treatment services.

## Development of Current Community Funding Model

The original funding model was developed by Division staff in collaboration with providers and legislators in the 1980s, and was applied to outpatient services only. The formula included:

- **Base payments.** These were payments made to each community mental health and substance abuse center (CMHC/SAC) as the minimum amount required to operate an office with a support staff. Originally the base amount per contracted CMHC/SAC was \$20,000 per year. The most recent legislative change to the base amount occurred during the 2007 General Session under SEA 0077 which increased the base amount paid to CMHC/SACs to \$77,000. The Division currently makes base payments in the amount of \$90,000 per year.
- **Populations.** On top of the base payment, each contracted CMHC/SAC was to be awarded funding based on the population of the service area in which they operated.

## Current State Funding for MHSa Services in Wyoming

Wyoming's system of community behavioral health providers is funded largely by two separate and distinct payers: **Medicaid** and **State General Fund block grants**. Reimbursement systems differ by these two pay sources.

Medicaid reimburses any enrolled providers who deliver “medically necessary” behavioral health services to eligible Medicaid clients<sup>1</sup>. Providers are reimbursed on a fee-for-service (FFS) basis, meaning services (i.e. therapy) are tied to a specific billing code with a defined reimbursement amount. When a provider delivers a unit of service to a Medicaid-eligible client, the provider bills Medicaid for the unit of service and is subsequently reimbursed. Note that Medicaid may reimburse **any** Medicaid-enrolled provider for behavioral health services provided to Medicaid clients. State General Fund block grants (contracts) for behavioral health services however, are **only available to a select group** of contracted Community Mental Health and Substance Abuse Centers (CMHC/SACs).

Service delivery and payment for MHSa services delivered under state-funded contracts with CMHC/SACs differs from Medicaid. Behavioral health services are available at CMHC/SACs to any Wyoming resident with no eligibility criteria. The Division contracts directly with this select group of providers. Contracts mandate specific “required services” that each CMHC or SAC must make available to clients; contracts also define a menu of “optional services” which a CMHC or SAC can make available. Some services (like crisis stabilization) are provided regionally, as determined by the Division. To comply with contracts, CMHC/SACs must deliver a specified **quantity** of service units for each of the required services, typically quantified as “service hours” for outpatient mental health and substance abuse services. The Division multiplies the mandated service hours by a rate of \$87 per service hour to determine the CMHC's or SAC's annual contract amount.<sup>2</sup> This amount is paid to the provider in twelve monthly installments over the course of the fiscal year.

Contracts are not “priority” population-based. In other words, contracts generally do not require certain services (or funds) be provided to priority populations. Contracts are essentially based on a quota system, wherein a provider is required to deliver a specified quantity of service hours each year. Reimbursements are not based on need. Instead, service hour requirements, or quotas, are based loosely on historical and projected utilization of all outpatient and residential service units, which are dependent on population size.

Comparison of MHSa service delivery and payment between pay sources is challenging. For Medicaid, it is relatively easy to look at claims data for specific units of service that were delivered to a client; accordingly, it is easy to know the exact reimbursement amount paid to the provider for that unit of service.

For Wyoming's state-funded contract system with CMHC/SACs, this is not possible. Because providers in this system are paid in an aggregate lump sum for all services delivered, it is more difficult to know exactly what the state paid a provider for a specific unit of service. Calculating the quantity of service hours delivered by each provider for specific services and multiplying the hours by an average rate of \$87 is currently the best method for estimating “per service per unit” costs within the state contract system.

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<sup>1</sup> To be eligible for Medicaid in Wyoming, an individual must be low income and also meet certain eligibility categories (pregnant women, aged, blind, disabled, etc.).

<sup>2</sup> The \$87 per hour rate is applied to all outpatient services equally, irrespective of the cost of delivery, case severity, or acuity of the patient.

## Current MHSA Community Block Grant Funding in Wyoming

Table 1, below, depicts current funding (budget and expenditures) for MHSA outpatient and residential treatment services delivered by CMHC/SACs for State Fiscal Year (SFY) 2015.

**Table 1:** Total Mental Health and Substance Abuse Treatment Budget, SFY 2015<sup>3</sup>

Service Type	Total <i>Biennium</i> 2015/16 Budget	Fiscal Year 2015 Budget	SFY 2015 Expenditures
Mental Health – Outpatient	\$41,979,734	\$20,649,321	\$20,747,948
Mental Health – Residential	11,223,518	6,903,116	6,881,762
Substance Abuse – Outpatient	18,883,079	9,000,703	8,588,682
Substance Abuse – Residential	26,638,163	13,473,818	13,279,106
<b>MH/SA Total</b>	<b>\$98,724,494</b>	<b>\$50,026,958</b>	<b>\$49,497,498</b>

Note that the data in Table 1 do not include Medicaid reimbursements to CMHC/SACs for services provided to eligible, enrolled Medicaid clients. The majority of CMHC/SAC revenue comes from the treatment contracts in Table 1, but CMHC/SACs also generate revenue through Medicaid, private insurance, and self-pay.

### SFY 2006-2007 Mental Health and Substance Abuse Legislation

During the Budget Session of 2006 and the General Session of 2007 in Wyoming, a significant amount of additional monies were appropriated to the mental health and substance abuse division and programs. These appropriations were used for a variety of purposes and distributed according to various legislative guidelines (e.g., some monies were distributed regionally, others based on population, etc.). Additional appropriations for Mental Health and Substance Abuse in 2006 and 2007 totaled approximately \$44,877,770 through HEA 0021 (2006) and SEA 0077 (2007).

### Budget Footnote 13 (2014-2015 Sessions)

Budget footnote 13 was passed in the 2014 Budget Session and amended in the 2015 General Session of the Wyoming Legislature. The 2014 footnote effectively rendered state general funds “payer of last resort” for mental health and substance abuse services delivered to clients at CMHC/SACs. The amendment in 2015 changed footnote 13 to ensure that MHSA services provided to Medicaid clients do not count toward CMHC/SACs required service-delivery quotas.

Footnote 13 took effect on July 1, 2015. The Division is currently in the process of monitoring compliance with footnote 13 by analyzing current CMHC/SAC service delivery to Medicaid clients as a percentage of their total service hour delivery mandated by contracts.

Note that Footnote 13 was not renewed during the 2016 Budget Session, and will not be in effect for SFY 2017.

<sup>3</sup> Data provided by the Fiscal Division, Wyoming Department of Health. These data represent MH/SA treatment contracts only.  
Wyoming Department of Health | Director’s Unit for Policy, Research, and Evaluation | Page 3

# JLHSS - MH/SA Payment Reform Discussion

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## Title 25 Subcommittee Directive

In response to increasing demand and exploding costs in Wyoming's Title 25 system, the Management Council authorized the formation of a Joint Subcommittee to study Title 25 issues. The Subcommittee identified the lack of priority funding for high-need clients in the community system as a main driver involuntary hospitalization increases. Accordingly, the Joint Subcommittee directed the Wyoming Department of Health (WDH) and the Wyoming Association of Mental Health and Substance Abuse Centers (WAMHSAC) to work together on the development of payment reform options for Wyoming's State-funded community mental health and substance abuse system of care. The information that follows outlines both the desired outcomes of a reformed system as well as a conceptual model for MH/SA payment reform prepared by the WDH. WAMHSAC and the WDH are currently vetting and workshopping the proposed model.

## MH/SA Payment Reform: Desired Outcomes

The Wyoming Department of Health, in conjunction with community providers and stakeholder groups, should design a payment model for its state-funded MH/SA system of care that:

- Achieves meaningful outcomes for priority populations by implementing genuine incentives for community providers to treat high-need clients. These outcomes should include, at a minimum:
  - Reduced reliance on involuntary hospitalization;
  - Employment;
  - Independent housing; and,
  - Treatment engagement.
- Creates flexible and demand-driven funding opportunities for needed social support services for priority populations (e.g., employment, housing, stabilization, etc.);
- Ensures transparency and eliminates duplicative administrative structures and wasteful spending across the continuum of care;
- Consistently tracks outcomes and utilization data for a defined population across the continuum of care while easing the data-entry burden on providers;
- Maintains adequate access to MH/SA services in rural areas of the State; and,
- Is capable of being integrated with other broad reform efforts within the WDH (e.g., potential Medicaid expansion).

Proposed elements of the payment model are described in further detail on the following page.

## MH/SA Payment Reform: Conceptual Elements of Proposed Model

(1) **Base payments** (~\$10.0 million) are intended to ensure general access to MH/SA services and to compensate centers for care rendered to non-priority populations on a per-capita basis. Total base payments would include the following:

- (a) Fixed. Approximately \$100K per CMHC/SAC per year, paid for overhead and operations. This would be greater than the \$77K required by statute and the \$90K currently paid.
- (b) Population-weighted. Additional ~\$12.0 million divided among centers on a population-weighted basis (using current US Census estimates produced by A&I's Economic Analysis Division) and, if centers are serving the same county or multiple counties, split based on the proportion of total clients served.

(2) **Capitated Payments for Priority Populations** (~\$15.0 million) are intended to provide incentives for CMHC/SACs to treat an identified list of high-need priority clients. This model could involve the following elements:

- (a) Identification. The WDH would authorize the enrollment of high-need priority populations at appropriate CMHC/SACs. Many of these may be from the Title 25 system or at risk for hospitalization.
- (b) Tracking. Case managers from existing networks (DD and long-term care waivers) would be assigned to report outcomes to the WDH for each client on a monthly basis.
- (c) Payment. Per-member per-month (PMPM) payments would be made to CMHC/SACs based on the assigned client panel as well as tracked outcomes reported each month (e.g., hospitalization, employment, housing, treatment goal completion, etc.). Below is an example of this potential concept:

(i) Base PMPM = \$1,200

(ii) Outcomes PMPM = \$600 *available*.

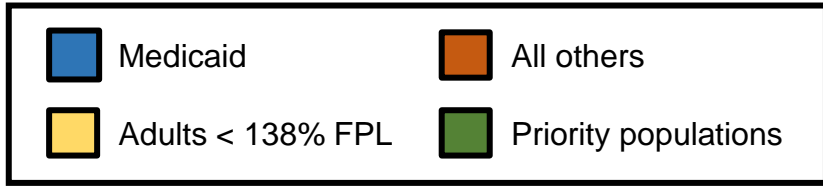
**Total PMPM available = \$1,800.** This total amount would be held at risk for emergency detention and involuntary hospitalization costs. PMPMs for priority populations would carry limited reporting requirements.

(3) **Pseudo Fee-for-service** (~\$39.5 million) would round-out the remainder of funding. FFS would be implemented through existing Medicaid (Chart A) and by creating a Chart B (State General Fund only) benefit plan with customized eligibility criteria.

- (a) Indigent MH/SA Benefit. 100% SGF, Chart B benefit with capped total funding. Medicaid would implement new eligibility codes; providers would bill Medicaid for services delivered to beneficiaries of the Indigent MH/SA Benefit plan. All clients would be run through a central eligibility system, and any Medicaid-eligible (Chart A) clients would automatically be shifted to Medicaid.

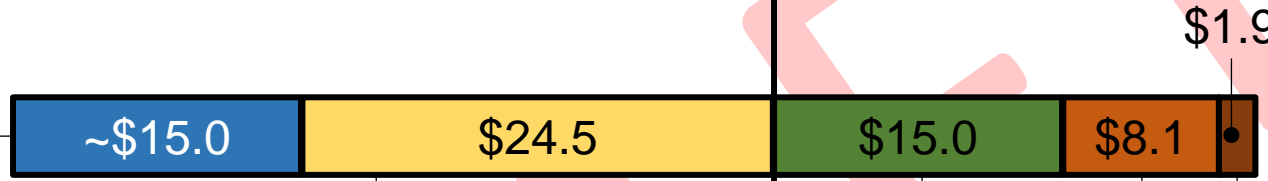
# MHSA Payment Reform Model Concept

Clients



Data via MMIS | Contracts – limited reporting requirements/defined services

Medicaid Billing Value + active treatment services (e.g. for SA residential)



~\$64.4 total\*  
\$56.9 SGF  
\$7.5 FF

**Base Payments**  
Fixed (\$100K/center @ 19 centers)  
Population-weighted (service area)

**Indigent Mental Health Benefit**  
(Chart B – FFS)  
100% SGF, capped  
Expanded menu of services (e.g. room and board)  
Billing restricted to CMHCs/SACs

**Priority PMPM (Tiered)**

**Outcomes for all Tiers – Per-member-per-month (PMPM)**

- Not hospitalized; monthly monitoring
  - Employment; competitive and integrated
  - Housed in place they own or lease
  - Recovery stable or improved
  - Primary healthcare/pharmacy available
- Outcomes evaluated monthly by independent case managers and used to pay or withhold PMPM.
  - Outcomes encourage independence
  - Entire PMPM at risk for hospitalization

*\*Note the total system value depicted (~\$64m) is the approximate annual value in the CMHC/SAC system.*

# MHSA Payment Reform Model Concept – Medicaid Expansion

Clients

