

4.19 Payments for Medical and Remedial Care and Services

REIMBURSEMENT TO WEST VIRGINIA (DFMB) SITES

A. Reimbursement Methodology for DFMB Sites

Rate Development has been built on two important assumptions:

1. That payments will be established on a per-member-per-month (PMPM) basis.
2. The PMPM rate is designed to reimburse care coordination activities related to MOM services, with other discrete services associated with MOM considered separately billable.

This methodology represents a “bottom-up” approach that incorporates costs for all the time, expertise, and materials needed to deliver the service. Key care coordination rate components include:

Caseload Data

Caseload assumptions are crucial to the rate, as they are used to establish member months for distributing costs, as well as modeling appropriate service standards.

Data sources available for West Virginia include:

1. Historical DFMB site caseloads
2. DHHR Office of Drug Control Policy 2019 Semi-Annual Report
3. Prescribed caseloads based on best practice research and other existing models

Staff Time and Activities

A model of staff time reflects the cost of purchasing the time needed for care coordination and is particularly important for distinguishing care coordination activities from time spent by practitioners performing separately billable services. Available data sources include:

1. Historical DFMB time study
2. Time estimates based on best practice research and other existing models
3. FY21 DFMB budget data

Build-Up Components and Data Sources

This methodology represents a “bottom-up” approach that incorporates costs for all the time, expertise, and materials needed to deliver the service.

Key care coordination rate components include:

Staff Compensation

Personnel costs are the most expensive component for delivering MOM services and a critical rate driver.

Potential personnel cost benchmarks specific to West Virginia include:

1. FY21 DFMB budget data.

2. Federal Bureau of Labor Statistics compensation (wage and benefits) data.

Indirect Cost Data

While personnel costs drive most of the rate, the model should also include costs for administrative overhead, supervision, and program supply costs required to deliver the service. Sources for indirect cost data include:

1. DFMB budget data.
2. Provider data available from comparable cost studies.
3. Research data on general health care cost.
4. "Target" indirect cost thresholds established by BMS policy on maximum reasonable costs.