The Addiction Treatment Landscape: The California Transformation

The 2017 OPEN MINDS Management Best Practices Institute
Wednesday August 16, 2017 | 11:15am – 12:30pm

Steve Ramsland, Senior Associate, OPEN MINDS

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Agenda

I. The Shifting Addiction Treatment Market

II. The California Addiction Treatment Transformation

III. Roles and Strategic Implications for Managed Care Health Plans

IV. Questions & Discussion
Addiction is a major public health concern...

On par with other major health issues

- Obesity: 147 billion
- Smoking: 157 billion
- Diabetes: 174 billion
- Addiction: 193 billion
- Heart Disease: 316 billion
- Mental Illness: 100 billion
The Emerging Addiction Treatment Continuum

- Prevention, Identification & Early Intervention
- Integration With Medical Care
- Extended Patient Engagement (Recovery Coaching)
- Whole Family Involvement
- Medication Assisted Treatment
- New Technologies
Medicaid Is The Largest Payer Of Addiction Treatment Benefits

48 states and DC offer some addiction treatment benefits

37 states offer intensive outpatient services

29 states offer non-hospital based detoxification

48 states offer outpatient services

33 states offer methadone maintenance

22 states offer residential support services

Six states offer the full continuum of addiction treatment benefits:

1. District of Columbia
2. Kansas
3. Michigan
4. New York
5. Oregon
6. Vermont
Residential Addiction Treatment Limits

Under current regulations, state Medicaid programs may not provide services to adults age 21-64 who reside in an institution for mental disease (IMD) – commonly known as the IMD exclusion.

There are two new options for providing residential addiction treatment:

1. Partial Repeal Of IMD Exclusion
2. 1115 Medicaid Waiver Demonstrations
Partial Repeal Of IMD Exclusion

- In April 2016, CMS partially repealed IMD exclusion for managed care enrollees only.

- Consumers can now receive services in an IMD for up to 15 days a month and their MCO will still receive payment.

- The IMD services are an in-lieu of service. This means that the state must designate them as such in the Medicaid state plan and MCOs can agree to cover them in their contract with the state.

- Enrollees can refuse to receive in lieu of services and MCOs can refuse to offer them on a case by case basis.
In July 2015, CMS released guidance on amending or implementing a 1115 Medicaid demonstration waiver to improve the care and outcomes of consumers with addiction disorders.

At this time, one state has elected this option: California
Medicaid 1115 Waivers With Addiction Treatment Expansions Is Increasing

Three States Have Approved Waivers
- California
- Maryland
- Virginia

Five States Have Pending Waivers
- Illinois
- Indiana
- Kentucky
- Michigan
- West Virginia

California was the first state with a waiver approval
California Institute for Behavioral Health Strategies

Elizabeth Stanley-Salazar, MPH, Consultant, Project Manager, California Institute for Behavioral Health Strategies
The Addiction Treatment Landscape:
The California Transformation

Open Minds Management Best Practices Institute
August 16, 2017

Elizabeth Stanley-Salazar, MPH
Consultant, Project Manager
CIBHS, DMC-ODS Waiver Forum
Objectives

▪ Understand managed care principles as applied to DMC-ODS Waiver
▪ Understand the new county role as a PIHP in managing the provider network
▪ New provider standards and requirements
▪ Care coordination & integration of services for improved client outcomes
DMC-ODS Waiver Forum creates a collaborative learning environment to support county behavioral health and substance use disorder leaders and administrators in the planning and implementation of the DMC–ODS 1115 Waiver in California

- There have been four forums and three webinars
- Web site access to the white papers and other information at
  https://www.cibhs.org/dmc-ods-waiver-forum
- County Staff Resource Library
- Adolescent Continuum of Care Design Conference coming in November
- Two additional forums: Assessment and Transitions between LOC and Regionalization and Innovation Models
The SUD Landscape in 2010

In 2008, researchers at the Institute for Healthcare Improvement (IHI) proposed the Triple Aim, which became a cornerstone of the Affordable Care Act in 2010.
The Patient Protection and Affordable Care Act Accelerated Pathway to Transformation

2014 Medi-Cal Eligibility Expansion in California
New beneficiaries now include single adults without children, with income up to 138% Federal Poverty Level (FLP)

August 2015 CMS approves the DMC-ODS Waiver
Expands available levels of care, adopts ASAM criteria, supports quality assurance/utilization management

January 2016 CMS approves the Medi-Cal 2020 Waiver
Builds on the 2010 Bridge To Reform Waiver to expand access, improve quality and outcomes, and control the cost of care

April 2016 CMS issues Final Rule on Managed Care
Implements MH/SUD benefits, overrides IMD exclusion & implements MHPAEA
DMC-ODS Implementation

DMC-ODS is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program  California Medi-Cal 2020 Demonstration

- Riverside, San Mateo, and Marin County started service delivery in April 2017
- Contra Costa, Los Angeles, Santa Clara, and San Francisco started in July 2017
- Fiscal Plans approved for Santa Cruz, Napa, Monterey, San Luis Obispo, Sonoma and Alameda.
- A total of 32 counties have opted to participate in the Waiver, covering 85% plus of the state Medi-Cal population
- 8 of these northern small counties are forming a regional model with Partnership Health Plan as allowed in the Special Terms & Conditions
- DHCS has started implementation discussion with Tribal & Indian Health Providers – Phase V
California Medi-Cal 2020 Demonstration
DMC-ODS 1115 Waiver Amendment (pages 89-123)

• Authorizes DHCS to test a new paradigm for the organized delivery of health care services for Medi-Cal eligible individuals with a substance use disorder

  ▪ Authorizes the implementation of a new SUD evidenced-based benefit design covering a full continuum of care, requiring providers to meet industry standards, and a strategy to coordinate and integrate across systems of care

  ▪ Seeks to demonstrate how organized substance use disorder care will increase the health outcomes and success of Medi-Cal beneficiaries

  ▪ Demonstrate how organized SUD care improves outcomes for DMC beneficiaries while decreasing other system health care costs
California Medi-Cal 2020 Bridge To Reform Waiver

- Improve health care quality and outcomes for the Medi-Cal population
- Strengthen primary care delivery and access
- Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency
- Address social determinants of health and improve health care equity
- Use CA' Medicaid Program as an incubator to test innovative approaches to whole-person care
Whole Person Care and Carve Out Funding
Key Administrative Elements

- Use of the American Society of Addiction Medicine Criteria (ASAM) for client placement, utilization management, and transition to the appropriate level of care
- Counties have the authority to selectively contract with providers following managed care methodology to create a provider network based on network adequacy
- Counties must establish a continuum of care that will meet the need/demand for services and allow adequate and timely access
- Like Specialty Mental Health Services, Counties are required to coordinate SUD services with the Medi-Cal Managed Health Plans; however unlike SMHS there is no legislative mandate
- DHCS retains Drug Medi-Cal Provider Certification authority through the Provider Enrollment Division
- Counties retain quality assurance and utilization management through contracts with providers and prescribed Quality Assurance & Utilization Review mandates
Key Financial Elements

- Counties submit a Fiscal Plan based on volume of services projected
  - Projections for each service modality
  - Projections for each level of service
  - Rates are submitted for approval to DHCS and CMS as a component of the Implementation
  - County holds flexibility in negotiating rates with providers
- Counties can re-negotiate the financial plan/proposal annually

- Organized Delivery system is broader than just DMC-financed services defined in the Waiver
  - Fiscal Plan must calculate all funds and expenditures, both federal and matching local funds
  - Fiscal Plan must include all other funding including SAPT Block Grant, Realignment and DUI programs
Industry Reimbursement Moving from Volume Transactions to Value Based Performance
- Policies and procedures for the selection, retention credentialing and re-credentialing provider agencies

- Pre-Authorization of residential services

- Beneficiary Access Number/System and defined service Referral process

- Care Coordination – MOU – with Managed Care Plans

- State-County contract with detailed requirements for access, monitoring, appeals process etc

- County Implementation and Fiscal Plans

- Culturally competent services

- Fidelity to evidenced-based practices

- Billing systems that meet managed care standards

- Compliance with Medicaid Final Rule Section 438

- Annual review by External Quality Review Organization (EQRO)
Key Service Elements

- Each SUD clinic shall have a **licensed physician** designated as the substance use disorder medical director. *(Title 22, § 51000.70)*

- Expansion of the role of Licensed Practitioners of the Healing Arts in assessment and other SUD treatment activities consistent with their scope of practice

- Reimbursement for SUD treatment in residential programs
  - *Medi-Cal does not allow reimbursement for room and board paid using SAPTBG funds*

- Integration of Medication Assisted Treatment into all levels of care

- Permits Recovery Residences and Recovery Support Services
  - *Medi-Cal does not allow reimbursement for room and board paid using SAPTBG funds*

- Reimbursement for defined Case Management Services

- Requirement for the use of established SUD evidence-based practices
Licensed Practitioner of the Healing Arts (LPHA) and SUD Treatment Professional

*LPHA* includes physicians, nurse practitioners (NP), physician assistants (PA), registered nurses (RN), registered pharmacists (RP), licensed clinical psychologists (LCP), licensed clinical social workers (LCSW), licensed professional clinical counselors (LPCC), licensed marriage and family therapists (LMFT), and licensed-eligible practitioners, registered with Board of Behavioral Health Services and working under the supervision of licensed clinicians.

- Provides medically necessary, clinical services prescribed for beneficiaries admitted, registered, or accepted for by the substance use disorder clinic
- LPHA must enroll in Medi-Cal Program using DHCS 6010 form

*SUD Treatment Professional* includes an intern registered with BBS or with Board of Psychology and/or an alcohol and other drug (AOD) counselor that is registered or certified pursuant to Title 9
What is this about for SUD . . .

- Expanding availability of SUD treatment by expanding the network of selected service providers
- Creating a defined and accessible continuum of evidenced-based SUD services
- Improving outcomes in the recovery management and maintenance of the gains achieved in treatment
- Adopting standards of practice with improved consistency and quality of services
- Implementing managed care administrative methodology to meet the PCACA Triple AIM Goals
- Development of a sustainable and viable financing structure and reducing costs
Designed to assess four key areas of beneficiary access, outcomes, utilization, health care costs and integration and coordination of care utilizing a comparison between comparable populations in opt-in counties and others.

- Impact of providing intensive outpatient SUD services in the community
- Effectiveness of drug based SUD treatments
- Impact of providing residential SUD services
- Whether the length of stay of residential services affects the impact of such services
- Whether residential treatment methods affect the impact of such services
## Benefits required in the DMC-ODS – ASAM LOC

<table>
<thead>
<tr>
<th>Service</th>
<th>Required</th>
<th>Optional</th>
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<tbody>
<tr>
<td>Early Intervention</td>
<td>Provided &amp; funded by MCP</td>
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<tr>
<td>Outpatient Services</td>
<td>Required level 1.0</td>
<td>Partial Hospitalization 2.5</td>
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<tr>
<td>Intensive Outpatient</td>
<td>Required level 2.1</td>
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<tr>
<td>Residential</td>
<td>At least one level in year 1</td>
<td>Additional ASAM Levels</td>
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<tr>
<td></td>
<td>Level 3.1, 3.3, 3.5, 3.7 within 3 years</td>
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<td></td>
<td>4.0 provided &amp; funded through FFS or MCP</td>
<td></td>
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<tr>
<td>NTP (rates set by DHCS)</td>
<td>Required County Contract</td>
<td></td>
</tr>
<tr>
<td>Withdrawal Management</td>
<td>At least one level of five service levels</td>
<td>Additional ASAM Levels</td>
</tr>
<tr>
<td>Recovery Services</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>Required</td>
<td></td>
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<tr>
<td>Physician Consultation</td>
<td>Required</td>
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</table>
The Provider Challenges and Complexity

- Provider Enrollment Division
- Entity Disclosures
- Clearances
- LPHA Disclosures
- 6-8 month process

- Medical Director
  - Licensed/Certified
  - Training Pre-requisites
  - EMR/County IT

- Drug Medical Clinic Certification
- AOD Design and Certification
- Operations Workforce Technology Components
- Specialty DMC Service Contract with County

- DHCS Certification
- Use/business/permit
- Fire clearance
- Program Statement
- Hours of operation
- Staffing plan
- Network to meet demand
  - Pre-Authorization
  - Access Line
  - Loss of autonomy

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- Entity
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Pathway to Licensing, Certification and Selective Provider Contracting

Residential Programs

- AOD License & Certification MHSUDS, SUD Compliance Division
- ASAM Level Designation
- DMC Certification Provider Enrollment Division
- Incidental Medical Services Certification MHSUDS, SUD Compliance Division

Outpatient and Intensive Outpatient

- AOD Certification MHSUDS, SUD Compliance Division
- DMC Certification Provider Enrollment Division

There is no uniform pathway for those providers which are not currently licensed or certified by DHCS
Care Coordination – The Heart of Integration

- Care Coordination is the cornerstone of many healthcare redesign efforts, including primary and behavioral healthcare integration.
- It involves bringing together various providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care.
- Research shows that care coordination increases efficiency and improves clinical outcomes and patient satisfaction with care.

SAMHSA – Center for Integrated Health Solutions

https://www.integration.samhsa.gov/
Care Coordination defined in the 1115 Waiver
Special Terms & Conditions

- Counties must develop a structured approach to care coordination to ensure beneficiaries transition between levels of SUD care without disruptions.
- Indicate which beneficiaries will receive care coordination and who will deliver these services.
- Focus on access to recovery supports and services following discharge or upon completion of an acute stay.
- County shall enter into a MOU with any Medi-Cal managed care plan that enrolls beneficiaries served by DMC-ODS.
- Can be met through an amendment to the Specialty Mental Health MOU.
SYNERGY with Managed Care Plans

- Shared Goals of the Drug Medi-Cal Organized Delivery System (DMC-ODS) and Managed Care Plans
  - Improved health outcomes for California beneficiaries with a substance use disorder (SUD)
  - Reduced costs to the Medi-Cal program
- Efforts that can support care coordination between SUD and health services, include
  - Payment for targeted case management services,
  - Physician consultation for medication assisted treatment (MAT),
  - Requirement for memorandum of understandings (MOUs) between counties and managed care plans
  - Dedicated Care Coordinator for high risk / high utilizer client
Note: Chart is for illustrative purposes only and may not include all relevant providers or funding streams serving this population. Source: LA Care Health Plan, January 2016.
Managed Care Carve-outs: Behavioral Health Services

Medi-Cal beneficiaries enrolled in managed care with serious mental health needs must navigate two separate health care delivery systems: the county mental health plan and the Medi-Cal managed care plan. In 2012, passage of Proposition 30 added language to the State’s Constitution codifying the counties’ role in the delivery of mental health services.

**County Mental Health Plans**

**Services:** Range of interventions to assist beneficiaries with **serious** emotional and behavioral challenges, including acute psychiatric inpatient care, treatment from psychiatrists and psychologists, and a host of rehabilitation services.

**Medi-Cal Managed Care**

**Services:** Beginning in January 2014, interventions to assist beneficiaries with **mild to moderate** needs, including psychotherapy, psychological testing when clinically indicated, psychiatric consultation, substance use screening and brief intervention for adults.

**Funding:** Medi-Cal spending on mental health services was estimated to be $3.3 billion in FY 2012-13 from federal, state, and county funding sources.

**Memorandums of Understanding (MOUs):** In each county, the mental health plan and Medi-Cal managed care plan(s) are required by their respective contracts with the state to have an MOU specifying roles and responsibilities for coordinating the delivery of mental health services.

*Sources:* A Complex Case: Public Mental Health Delivery and Financing in California, CHCF, July 2013; Proposition 30 Text of Proposed Law, California Secretary of State, 2012; Behavioral Health Services Transition to Medi-Cal Managed
## Managed Care Program Models

Counties operate managed care through four main models and two additional models - Imperial / San Benito

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Enrollment (Dec. 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two-Plan</td>
<td>The Department of Health Care Services (DHCS) contracts with one county-developed plan called a Local Initiative (LI) and one commercial plan.</td>
<td>6,540,360</td>
</tr>
<tr>
<td>County Organized Health System (COHS)</td>
<td>The county operates a single managed care plan, with which DHCS contracts directly.</td>
<td>2,190,182</td>
</tr>
<tr>
<td>Geographic Managed Care (GMC)</td>
<td>DHCS contracts with several commercial plans. Only Sacramento and San Diego counties are designated GMC counties.</td>
<td>1,102,804</td>
</tr>
<tr>
<td>Regional Model</td>
<td>The Regional Model is a slightly modified version of the Two-Plan approach created for the rural expansion, in which the state contracts with two commercial plans over a geographic region.</td>
<td>294,341</td>
</tr>
<tr>
<td>Imperial Model</td>
<td>Two commercial plans contract with DHCS.</td>
<td>72,513</td>
</tr>
<tr>
<td>San Benito Model</td>
<td>One commercial plan contracts with the state. In this model, beneficiaries can opt out of managed care.</td>
<td>7,400</td>
</tr>
</tbody>
</table>

*Sources: Medi-Cal Managed Care Program Fact Sheet, DHCS; On the Frontier: Medi-Cal Brings Managed Care to California’s Rural Counties, CHCF, March 2015; Medi-Cal Managed Care, CHCF, March 2000; Medi-Cal Managed Care Enrollment*
Managed Care Program Models, by County

Source: Medi-Cal Managed Care County Map, DHCS; Medi-Cal Managed Care Enrollment Report, DHCS, November 2015.

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<tr>
<td>Two-Plan</td>
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<tr>
<td>TOTAL*</td>
<td>10,207,600</td>
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* Total does not include 849 individuals enrolled in Primary Care Management (PCM) models in San Francisco and Los Angeles counties.

Note: All striped counties were included in the rural expansion of managed care that began in late 2013.
Managed Care Plan Possible Collaboration

- Sharing information on ER high-utilizers to target interventions such as intensive case management
- Same day referrals for SUD treatment
- Coordinate electronic health records with Confidentiality guidelines SUD, Physical Health and Mental Health
- Agree on the data to be utilized, share the data and utilize the same HEDIS (Healthcare Effectiveness Data and Information Set) measures.
- Leverage and support provider collaboration and partnership and create health care provider incentives
- Consider alternative reimbursement strategies and pilots for providers, such as member-centered performance-based payments
The Elephant in the Room – Sharing Protected Patient Information

Need to create and establish data and information sharing guidelines and mechanisms, consistent with state and federal data privacy and security laws, to provide for timely sharing of beneficiary data, assessment, and treatment information.
Importance of Data Sharing to Support Integration of Substance Use Treatment

- Center for Health Care Strategies

- Effective coordination of health care services is critical to delivery system reform efforts taking place across the country

- The success of this demonstration rests in part on the ability of counties and their participating plans and providers to manage, share, and coordinate data on behalf of their patients and populations.


Helpful Resources

California Department of Health Care Services

SAMHSA
https://www.samhsa.gov/health-care-health-systems-integration

Case Western Reserve University Center for Evidenced Based Practices
https://www.centerforebp.case.edu/

Los Angeles County Substance Abuse, Prevention and Control Division
http://publichealth.lacounty.gov/sapc/HealthCare/HealthCareReform.htm

California Institute for Behavioral Health Solutions
http://www.cibhs.org
Care 1st HealthPlan

Theresa M. Stanley, Vice President of Medical Services, Care 1st HealthPlan
Open Minds
Management Best Practices Institute

The Addiction Treatment Landscape: The California Transformation
Roles and Strategic Implications for Managed Care Health Plans

August 16, 2017

Terrie M Stanley RN
VP Medical Affairs

Care 1st HealthPlan - a Division of Blue Shield of California
AGENDA

- Managed Care
  - Model of Care Delivery
- Population Covered
  - Evolution of Change
- Enrollment Trends
- Spending Trends
- Carve Out Services
- Behavioral Health Coverage in Managed Care Plans
- What Plans Can (and Can’t) do
- Regulations and Quality
Benefits of Managed Care Plan

• Health Plan
  ✓ Generic term referring to a specific benefit package offered by an insurer, HMO, or self-funded employer group.
  ✓ A network is a group of physicians/professional providers, hospitals and other medical care professionals that a health plan contracts with to deliver services to its members.

• Managed Care Plans
  ✓ Manage costs and encourage innovation in health care delivery
  ✓ Improve the health of a community
  ✓ Designed to improve quality and control costs by encouraging competition among providers
The Past 10 Years

- Enrollment: Medi-Cal enrollment *greatly* increased over the past decade, program now covers 1 in 3 Californians vs Nationally
  - One in five Americans gets their health care through Medicaid and includes people from all walks of life-
    - middle-class individuals who have suffered a catastrophic illness,
    - seniors living in long term care (70 percent of all nursing home residents)
    - newborns and children

- Spending: Medi-Cal costs have grown nearly threefold over the last 10 years and today total $92 billion in total annual expenditures

- Managed Care: The Medi-Cal program overwhelmingly relies on the managed care delivery system, with over 80% of all beneficiaries enrolled in managed care; certain services, such as behavioral health services for individuals with severe conditions, are carved out of managed care.
Medi-Cal Managed Care in CA

Four main models of managed care operate throughout the state. In many areas, the county or plans subcontract to other plans and the plans (the primary plan and/or the subcontracted plan) delegate risk to independent physician associations (IPAs), medical groups, and/or hospitals.

- County Organized Health System (COHS)
- Two Plan
  - Commercial
  - Local Initiative
- Geographic Managed Care (GMC)
Managed Care: Delegation Confusion

Medi-Cal managed care plans may choose to delegate and subcontract to other plans, IPAs/medical groups, and hospitals. Plans vary in the degree to which they choose to delegate the delivery of care.
Managed Care Delegation EXAMPLES

Some managed care plans delegate risk and care to multiple plans, IPAs/medical groups, and hospitals, while others choose to directly contract with providers.

CenCal Health serves Santa Barbara and San Luis Obispo counties and does not delegate any plan responsibilities to other plans, IPAs or medical groups, choosing instead to directly contract with providers.

Health Plan of San Mateo (HPSM) delegates care for a small population of its patients, but otherwise only directly contracts with providers.

L.A. Care has three plan partners (Anthem, Care1st, and Kaiser), some of which may sub-delegate. L.A. Care itself also delegates to more than 30 participating physician groups and to specialty health plan vendors.

Molina serves Riverside, San Bernardino, Imperial, Sacramento, and San Diego counties and uses a delegated model.
Characteristics of the CA Medi-Cal Population

- By definition, low-income
- Approximately 60% self-identify as Latino
- 50% report not speaking English well or at all

SOURCE: Medi-Cal Landscape Assessment-ManattHealth – June 2016
THE ACA

- Expanded Medicaid programs to include adults ages 19-64 without dependent children,

- Mandated coverage for specific subpopulations. For example, this included extending coverage for youths who were receiving Medicaid benefits while in the state’s foster care system on their 18th birthday, allowing them to retain (or regain, if they had aged out) coverage until age 26

- Required states to extend family income limits through which children ages 0-18 qualify for coverage.
...while at the same time

- CalFresh - California’s Supplemental Nutrition Assistance Program (SNAP) - provides financial assistance in meeting the nutritional needs of low-income families.

- Income and residency requirements for CalFresh are similar to Medi-Cal’s.

- CalFresh beneficiaries under 65 years of age were given the option to enroll in Medi-Cal without filling out a separate Medi-Cal application. As of December 2014, approximately 185,000 individuals were enrolled in Medi-Cal under transitional CalFresh aid codes. Upon eligibility redeterminations that occurred throughout 2015, eligible individuals were placed into non-transitional Medi-Cal aid codes.
Managed Care Plan Enrollment and Growth

In 2014, 1.7 million new enrollees joined the program due to expanded eligibility under the ACA. Now, 2 out of every 3 managed care beneficiaries are enrolled in a county-based health plan. Many of these plans subcontract with other health plans, IPAs, medical groups, and/or hospitals.

### Medi-Cal Managed Care Enrollment (2013-2015)

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Dec-13</th>
<th>Dec-14</th>
<th>Dec-15</th>
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<tbody>
<tr>
<td>LA Care</td>
<td>454</td>
<td></td>
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<tr>
<td>Health Net</td>
<td>343</td>
<td>340</td>
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<tr>
<td>Inland Empire Health Plan</td>
<td>267</td>
<td>261</td>
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<td>CalOptima</td>
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<td>Anthem Blue Cross</td>
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<td>Partnership Health Plan of CA</td>
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<td>Molina Healthcare</td>
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<td>Central California Alliance for Health</td>
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<tr>
<td>CalViva Health</td>
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<td>Heath Plan of San Joaquin</td>
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<tr>
<td>Community Health Group</td>
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<td>Alameda Alliance for Health</td>
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<td>Santa Clara Family Health</td>
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<td>Kern Family Health</td>
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<td>Gold Coast Health Plan</td>
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<td>CA Health &amp; Wellness</td>
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<td>Contra Costa Health Plan</td>
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<td>CenCal</td>
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<td>San Francisco Health Plan</td>
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<td>Health Plan of San Mateo</td>
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<td>Other*</td>
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**Total Managed Care Enrollment**
- **2013:** 6 Million
- **2014:** 8.9 Million
- **2015:** 10.2 Million

**Notes:**
- “Other” includes all plans with less than 100,000 enrollees as of December 2015: Care 1st, AIDS Healthcare Foundation, and Family Mosaic.
- “Kaiser” includes Kaiser and Kaiser Foundation

Sources: California Health Insurers: Brink of Change, CHCF, Feb. 2015; Medi-Cal Managed Care Enrollment Reports, DHCS.
Participation in Medi-Cal Managed Care is on the Rise

- December 2012-64% of Medi-Cal’s overall population participated in managed care
- December 2014, 74% participated in managed care
- The driven by the state’s expansion of managed care in formerly FFS-only counties
- Direction of newly enrolled individuals into managed care delivery systems (SPD’s Duals with MLTSS)
Spending-on who?

Seniors and non-elderly adults with disabilities (includes Mental Health) - 22% of total population-account for a majority of the Medi-Cal Program Spending - 61%
Behavioral Health

Mental health and serious mental illness are some of the most commonly treated conditions among the entire Medi-Cal population, particularly for the most costly cohort.

Source: Understanding Medi-Cal’s High-Cost Populations, DHCS, March 2015.
Carve-out services

- Certain populations and services are carved out of managed care (remain in the FFS system)
  - Mental health services for individuals with serious mental health conditions (Behavioral health services for individuals with mild to moderate needs are provided through Medi-Cal managed care plans, which may choose to subcontract with a separate plan to provide these services)
Managed Care Carve-outs: Behavioral Health Services

Medi-Cal beneficiaries enrolled in managed care with serious mental health needs must navigate two separate health care delivery systems: the county mental health plan and the Medi-Cal managed care plan. In 2012, passage of Proposition 30 added language to the State’s Constitution codifying the counties’ role in the delivery of mental health services. Barring a change to the State’s Constitution, counties will continue to have a role in the delivery of mental health services.

**County Mental Health Plans**

**Services:** Range of interventions to assist beneficiaries with serious emotional and behavioral challenges, including acute psychiatric inpatient care, treatment from psychiatrists and psychologists, and a host of rehabilitation services.

**Medi-Cal Managed Care**

**Services:** Beginning in January 2014, interventions to assist beneficiaries with mild to moderate needs, including psychotherapy, psychological testing when clinically indicated, psychiatric consultation, substance use screening and brief intervention for adults.

**Funding:** Medi-Cal spending on mental health services was estimated to be $3.3 billion in FY 2012-13 from federal, state, and county funding sources.

**Memorandums of Understanding (MOUs):** In each county, the mental health plan and Medi-Cal managed care plan(s) are required by their respective contracts with the state to have an MOU specifying roles and responsibilities for coordinating the delivery of mental health services.

Sources: A Complex Case: Public Mental Health Delivery and Financing in California, CHCF, July 2013; Proposition 30 Text of Proposed Law, California Secretary of State, 2012; Behavioral Health Services Transition to Medi-Cal Managed
MH Benefits: Managed Care Plans

Effective January 1, 2014, eligible Medi-Cal beneficiaries began to receive select mental health benefits through Medi-Cal Managed Care Plans (MCPs). These services continue to be offered as Fee For Service benefits for eligible beneficiaries that are not enrolled in an MCP.
MCP Responsibilities

- Mental health services when provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license:
  - Individual and group mental health evaluation and treatment (psychotherapy)
  - Psychological testing when clinically indicated to evaluate a mental health condition
  - Outpatient services for the purposes of monitoring medication therapy
  - Outpatient laboratory, medications, supplies, and supplements
  - Psychiatric consultation
  - Screening and Briefing Intervention (SBI) - 18 or older
MCP Responsibilities-Summary

• Continue to ensure mental health screening of all beneficiaries by network PCPs. Beneficiaries with positive screening results may be treated by a network PCP within the PCP’s scope of practice.

• Refer the beneficiary to a mental health provider within the MCP network for a mental health assessment when the condition is beyond the PCP’s scope of practice.

• Use a mutually agreed upon assessment tool with the MHP to assess the beneficiary’s disorder, level of impairment, and appropriate care needed.
ALL PLAN LETTERS-Alcohol and SA

- APL15-008 PROFESSIONAL FEES FOR OFFICE VISITS ASSOCIATED WITH ALCOHOL AND SUBSTANCE USE DISORDER TREATMENT SERVICES

- Outlines requirements of Medi-Cal managed care health plans (MCPs) to reimburse providers for professional fees for office visits associated with alcohol and substance use disorder (SUD) treatment services when provided by a network provider acting within the provider’s scope of practice.
APL’s – Inpatient Detox

- APL14-005 VOLUNTARY INPATIENT DETOX
  
  [Link to document](http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-005.pdf)

- New fee-for-service (FFS) Medi-Cal benefit available to Medi-Cal beneficiaries. Beneficiaries who meet medical necessity criteria may receive voluntary inpatient detoxification (VID) services in a general acute care hospital,

- Managed Care Plan must refer member to a VID provider in a general acute care hospital.

- The VID provider facility must not be a Chemical Dependency Treatment Facility or Institution for Mental Disease.

- The VID provider must submit a Treatment Authorization Request (TAR) to local field offices for approval.

- MCP must provide care coordination with the VID provider as needed.
Recommendations

- Sharing info on ER high-utilizers to target interventions such as intensive case management
- Same day referrals for treatment
- Utilizing one coordinated EHRs with SUD, Physical Health and Mental Health
- Agree on the data to be utilized, share the data and utilize the same HEDIS (Healthcare Effectiveness Data and Information Set) measures.
- Leverage and support provider collaboration and partnership
- Provider incentives
- Alternative reimbursement strategies for providers, such as member-centered performance-based payments
The Elephant in the Room

- Establishment of data and information sharing guidelines and/or mechanisms, consistent with applicable state and federal data privacy and security laws, to provide for timely sharing of beneficiary data, assessment, and treatment information.
Barriers

- Early Identification - providers feel hindered by where to refer if identify issue

- Shortage of appropriately trained professionals

- Complexities of navigating the system

- Language - Lack of professionals who speak more than one language magnifies the treatment problem

- Stigma - Social stigma surrounding treatment
What Health Plans Do (or Can’t)

- Provide Primary Care Practitioners assist in identification and education on how to use
- Educate all providers about services and resources
- Provide information/education
- Partner with community organizations
- Treatment needs to be multi-level but plan not always able to provide services to the entire support system for the individual
Oversight, Access, and Quality

- Two state agencies oversee California’s Medi-Cal program, the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC).

- California has explicit network adequacy standards and reporting requirements, but a June 2015 State Auditor’s report concluded that DHCS did not perform adequate oversight of Medi-Cal managed care plans. DHCS is actively working to address these issues.

- While managed care organization (MCO) members are generally satisfied with their personal doctor, their overall rating of their health plan and their ability to get care quickly was below national benchmarks.
Oversight, Access, and Quality (Continued)

- California requires full-scope managed care plans to publicly report on a number of different quality measures and performance varies greatly. Quality reports show that MCOs have highly variable performance on quality of care indicators, with many performing below the minimum performance benchmark and national averages.
Partnering - the MUST HAVE’s

- Access to service
- Member engagement
- Documented Outcomes
  - Evidence-based practices
  - Clinical effectiveness
  - Process efficiency
  - Reduced inpatient utilization - including READMISSION REDUCTION
  - HEDIS and/or other national measures
- Deliver on contractual and clinical expectations - bring metrics sooner rather than later and frequently
- Data Integrity
- Operational excellence via national accreditation/licensing
QUESTIONS?
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