Medi-Cal Healthier California for All Update and Discussion

Afternoon Session

- Brief Update on Initiative Changes
- Follow-up on Items from the January 28, 2020 meeting
  - Obstacles or barriers to Initiative Implementation
  - Review responses to written questions received regarding the Initiative
- Drug Medi-Cal Organized Delivery System Update
  - Information Notice
- Specialty Mental Health

Medi-Cal Healthier California for All (CalAIM) Updates

Jacey Cooper, Chief Deputy Director
State Medicaid Director

Changes to the CalAIM Proposals

- **Annual Health Plan Open Enrollment**. Based on the robust stakeholder feedback received, the state has decided not to continue to pursue the Annual Health Plan Open Enrollment proposal.
- **Phased Approach for Enhanced Care Management Transition**. Managed care plans without Whole Person Care and Health Homes Programs experience will have until July 1, 2021 to implement the enhanced care management benefit.
- **Population Health Management**. DHCS has determined that managed care plans should have additional time to design and implement their Population Health Management Strategies – delaying the effective date to January 1, 2022.

Changes to the CalAIM Proposals

- **Targeted Case Management.** While DHCS will no longer pursue the discontinuation of the TCM benefit for managed care enrollees, the state will be asking managed care plans to take steps to ensure that enrollees do not simultaneously receive TCM and ECM services.
- **Foster Care Youth.** DHCS and DSS will convene a Foster Care Model of Care workgroup in 2020. DHCS and DSS will solicit for workgroup members in March 2020 and convene the first workgroup meeting in April.
- **Updated Dual Eligible Special Needs Plans (D-SNP) Policy Proposal.** CalAIM webpage has been updated with the revised "Expanding Access to Integrated Care for Dual Eligible Californians" policy memo, which outlines the Department's transition plan for dual eligibles and the Coordinated Care Initiative.

Enhanced Care Management/ In Lieu of Services

- Enhanced Care Management Target Population Descriptions
- Enhanced Care Management/In Lieu of Services Coding Options
- Updated In Lieu of Services Descriptions
- Whole Person Care, Health Homes Program and Targeted Case Management Transition Plan Template for Managed Care Plans

CalAIM Proposal Timeline

- DHCS is finalizing the CalAIM proposals and developing a summary to be publicly available in April 2020.
- DHCS to host Tribal and Designees of Indian Health programs meeting on April 28, 2020 in Sacramento.
- Public comment and public hearings will take place in May 2020.
- DHCS intends to submit its Medi-Cal 1115 waiver renewal request, as well as a consolidated 1915(b) waiver proposal, to CMS in June 2020.

Discussion of Obstacles or Barriers to Initiative Implementation

Review Responses to Written Questions Received Regarding the Initiative

Drug Medi-Cal Organized Delivery System Updates

Brenda Grealish, Chief
Medi-Cal Behavioral Health Division

Background

1115 Waiver & 1915(b) Waiver

- ODS under current 1115 waiver
  - Approved by CMS August 2015
  - First county ODS approved Feb 2017
    - 30 counties currently in operation; 8 more counties in process through a regional model with Partnership Health Plan.
  - Tribal
    - Tribal stakeholder planning support through CMS IAP Jan – Sept 2016
    - Draft Att BB to stakeholders, CMS summer 2017
    - Tribal Phase 5 implementation Sept 2017 – current
- Waiver renewal inclusive of ODS
    - DHCS is working to incorporate the DMC-ODS into a comprehensive Section 1915(b) waiver that would include the Medi-Cal managed care plans, mental health plans, and DMC-ODS.
    - The expenditure authority for residential treatment provided in an IMD will continue to be authorized through a Section 1115 demonstration authority.

Recap of Thinking to Date

- Stakeholder input from early development phase
  - Principles
    - Tribal “owned/operated”
    - Accountability
    - Maximize/leverage current tribal competencies
    - Transparent selection process for contractors/subcontractors
    - Advisory process inclusive of an array of tribal representatives
    - “Right size” to match users/service costs to administrative size
  - Administrative entity options
    - Tribal organization
    - Managed Care Organization
    - Hybrid or joint venture—preferred

Recap of Thinking to Date (cont'd.)

- Working model—single statewide administrative entity for Tribal ODS
- 1115 Waiver Attachment BB - August 2017
  - To Tribal stakeholders for input
  - To CMS for informal feedback
- Estimated number of potential members
  - 8,000 – 27,000 AI/AN members
    - Range from Cal OMS (low) to census/other public data points (high)
- Early expressions of interest solicited (May 2017)
  - Received responses from CRIHB, Maximus, United BH
- Working with DHCS leadership and CMS to address issues/obstacles

Tribal ODS Options

Tribal ODS Options

- #1-Tribal Administrative Entity (AE)
- #2-Use County ODS Infrastructures for Tribal SUD services
- #3-New Proposal

Tribal ODS Options

DHCS Priorities:

- Highest priority is how to get AI/AN beneficiaries SUD services
- Offer culturally responsive services

Option #1: Tribal AE

- DHCS has tried to figure out how to make a Tribal AE work; however, DHCS has come across multiple issues.
- DHCS is still open to this option for the next waiver, if needed.
- For this option to work, Tribal Partners would need to present DHCS with their choice of an AE that resolves the identified issues.

Option #1: Tribal AE

Feasibility Issues

- Lack of fully representative statewide Tribal council or governing structure for leadership.
- Lack of lead Tribal entity with comprehensive core competencies to meet Administrative Entity requirements.
- Claims adjudication and payment process needs to be established.

Option #1: Tribal AE

- Statewide network sufficiency/access requirements concerns.
- Lack of cash flow supports.
  - Start-up funds needed for AE from selection to “go-live” (hiring/training staff, IT configuration, space/equipment and other start-up costs).
  - Ongoing operations—cash flow to bridge time from incurring expenses to receipt of state general funds and FMAP.
    - Service and administrative costs reimbursement on different timelines.
    - Depends on payment arrangements between DHCS and administrative entity.
    - County ODS have state funds available to support operations prior to claiming.

Option #1: Tribal AE

- Potential high level of administrative costs.
  - In proportion to total program costs.
  - Need economies of scale to support cost effective administrative functions (claims, other IT, etc.).
  - No financial analysis completed due to model uncertainty.
- Source of funds for portion of admin costs not covered by CMS or State (25-50% funding gap).
- Options for Certified Public Entity (CPE) structure.
  - Needs to be developed by AE to replace County role for existing ODS.

Option #2: County ODS for Tribal SUD

- Benefits—addresses feasibility gaps for Option #1.
  - Claims adjudication/payment
  - Counties pay Non-federal match for Urbans
  - No cash flow gaps
  - Network sufficiency/access
  - Administrative costs for Tribal services are manageable within county structures
  - CPE structures in place
  - Shorter implementation timeline
  - Counties required to include Tribal facilities

Option #2: County ODS for Tribal SUD

Gaps

- AI/AN individuals residing in non-ODS counties services limited to State Plan SUD services.
- DHCS has heard various concerns from Tribal providers using county systems.
  - Are existing Tribal/Urban providers participating in ODS now?
  - If so, what has been their perspective?

Option #2: County ODS for Tribal SUD

- DHCS can offer:
  - Specific requirements to counties for serving AI/AN members
  - Outreach to specific Tribes
  - Special training for Tribal providers
  - Implementation support for Tribal providers
  - Coordination support to link counties and Tribes

CalAIM & Option #2 for Tribal Services

Proposed Policy Change

- DHCS will continue its engagement and consultation with Tribal representatives to work through and develop these policies.
- DHCS will seek an allowance for specific cultural practices for Tribal 638 and Urban clinics, reimbursement for the workforce of traditional healers and natural helpers, and culturally specific evidence-based practices.
- DHCS will provide clarification regarding policies to increase access to SUD treatment services for American Indians and Alaska Natives by issuing an Information Notice to counties to provide guidance regarding their current obligations, pursuant to existing contractual requirements, towards Indian Health Care Providers for Tribal and Urban Health Clinics as established in Title 42, Code of Federal Regulations, Section 438.14.

Overview of the DRAFT DHCS Information Notice to Counties

- Reminds DMC-ODS counties of their obligations to reimburse Indian Health Care Providers for the provision of DMC-ODS services.

- Provides guidance concerning the required reimbursement rates for Urban Indian Organizations and Tribal 638 providers.
  - Tribal 638 providers must be reimbursed at the all-inclusive rate for the delivery of DMC-ODS services.
  - DHCS is still researching how Urban Indian Providers will be reimbursed.

- DMC-ODS counties must contract with a sufficient number of IHCPs to ensure that AI/AN beneficiaries in the county can access DMC-ODS services at an IHCP for reimbursement purposes.

Services that Can be Provided are Dependent on the Beneficiary's County of Residence

- If the out-of-county beneficiary resides in a DMC-ODS county, the IHCP can provide the out-of-county beneficiary all DMC-ODS services available under their county of residence's DMC-ODS intergovernmental agreement with the State (the county of residence is responsible for reimbursement).

- If the beneficiary resides in a non-DMC-ODS county, the IHCP may only provide services authorized by California's Medicaid State Plan (the IHCP must contract with either the beneficiary's county of residence or the State to receive reimbursement for the provision of State Plan services).

DMC-ODS County Obligations for IHCP Reimbursement (cont'd.)

Tribal 638 Providers

- The California Medicaid State Plan sets forth specific criteria governing the reimbursement rate to which Tribal 638 Providers are entitled. Two possible rates:
  - The all-inclusive rate published in the Federal Register if services are provided by one of the health professionals identified in the California Medicaid State Plan and if the service does not exceed the three daily visit limit set forth in Supplement 6 OR
  - The same rate as for an Urban Indian Organization for services that do not meet the requirements of Supplement 6.

- Rate may differ from the rate paid to Urban Indian Organizations.

DMC-ODS County Obligations for IHCP Reimbursement (cont'd.)

- The rates that a DMC-ODS county must pay to either an Urban Indian Organization or a Tribal 638 will vary if the beneficiary has Medicare, Part B.

- The draft Information Notice also provides information related processing and payment of IHCP Claims.

Next Steps

Next Steps

- Feedback on the draft Information Notice is requested from Tribal and Designees of Indian Health Programs within two weeks of release for comment.
- DHCS to disseminate the draft Information Notice to DMC-ODS Counties for feedback, as well.

Option #3: New Proposal

- DHCS is still open to new thoughtful proposals from Tribal partners/entities for future waivers.
- Proposal needs to be something providers support.

Behavioral Health Services Update

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Medi-Cal Behavioral Health Division

Payment Reform

Behavioral Health Payment Reform Goals

- Transition from a cost-based reimbursement methodology to a fee schedule.
- Transition from a Certified Public Expenditure (CPE) methodology to utilizing Intergovernmental Transfers (IGTs) to fund the county non-federal share.
- Transition from broad Healthcare Common Procedure Coding System (HCPCS) Level II codes to more specific Level I codes, known as Common Procedure Terminology (CPT) codes, when available, for claiming and reimbursement.
- Administratively integrate the Drug Medi-Cal (DMC) Organized Delivery System (ODS) program and Specialty Mental Health Services (SMHS) program.
- Reimburse a county the same rate for the same service provided in the DMC-ODS program and the SMHS program.
- Eventually, use the more detailed claims data to explore/support a potential future transition to a risk-based reimbursement methodology.

Potential Benefits/ Risks to Counties

- Reduced administrative burden for the State and counties
  - Counties will no longer need to complete and submit an annual cost report and reconcile interim payments to that cost report.
  - Counties will no longer need to crosswalk procedure codes submitted to DHCS (HCPCS) to procedure codes submitted to all other payers.
- Counties will have more flexibility to develop and implement alternative payment methodologies to improve quality.
- Counties will have financial risk if the cost to provide a service is different than the rate DHCS sets in the fee schedule.

Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

Current Delivery System

- For the specialty mental health and substance use disorder managed care plans, DHCS contracts with counties to act as prepaid inpatient health plans to provide, or arrange for the provision of, specialty mental health services (SMHS) and SUD treatment services to beneficiaries.
  - The SMHS program is a statewide benefit administered by 56 mental health managed care plans, including two joint arrangements in Sutter/Yuba and Placer/Sierra.
  - The DMC-ODS is only covered in counties that have “opted-in” and are approved to participate by DHCS and CMS. 30 counties administer the SUD managed care program, covering 93 percent of the Medi-Cal population.
  - The remaining 28 counties provide outpatient SUD treatment services through the fee-for-service delivery system.
    - Eight of these counties are working with a local Medi-Cal managed care plan to implement an alternative regional model for substance use disorder managed care.

Proposal

- DHCS is proposing administrative integration of SMHS and SUD services into one behavioral health managed care program by 2026.
- The result would be a single prepaid inpatient health plan in each county or region responsible for providing, or arranging for the provision of, SMHS and DMC-ODS treatment services for all Medi-Cal beneficiaries in that county or region.
- State Plan DMC counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-for-service verses prepaid inpatient health plans.

Benefits of an Integrated Delivery System

- The goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care.
- An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the State.
- Participating counties would benefit from streamlined state requirements and the elimination of redundancy.
- Consolidating operations and resources into one behavioral health managed care plan would allow counties to successfully meet state and federal requirements and significantly decrease their administrative burden.

Integration Priorities

Clinical Integration	Administrative Functions	DHCS Oversight Functions
• Access Line • Intake, Screening and Referrals • Assessment • Treatment Planning • Beneficiary Informing Materials	• Contract • Data Sharing/Privacy Concerns • Electronic Health Record Integration • Cultural Competence Plans	• Quality Improvement • External Quality Review Organization • Compliance Reviews • Network Adequacy • Licensing and Certification

Medical Necessity Criteria

Framing the Issue

- The medical necessity criteria for specialty mental health and substance use disorder services, as currently defined, is outdated, lacks clarity, and should be re-evaluated.
- Existing medical necessity determinations are driven by diagnostic determinations and documentation of functional impairments.
- Responsibility for mental health services is shared between counties and Medi-Cal managed care plans.
  - This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services.

Medical Necessity Proposal Goals

To ensure beneficiary behavioral health needs are being addressed and guided to the most appropriate delivery system as well as provide appropriate reimbursement to counties for providing behavioral health services, DHCS is proposing to:

- Separate the concept of eligibility for receiving specialty mental health or substance use disorder services from the county and medical necessity for behavioral health services.
- Allow counties to provide and be paid for services to meet a beneficiary's mental health and substance use disorder needs prior to the mental health or substance use disorder provider determining whether the beneficiary has a covered diagnosis.

Medical Necessity Proposal Goals

- Identify an existing or develop a statewide, standardized screening tool, one for beneficiaries 21 and under and one for beneficiaries over 21, that would be used to by counties, Medi-Cal managed care plans, and providers to determine a beneficiary's need for mental health services (i.e., level of care needed), if any, and which delivery system (Managed Care Plan or Mental Health Plan) is most appropriate to cover and provide treatment.
- Each delivery system should then provide services in accordance with an individualized beneficiary plan, as recommended by a physician or other licensed mental health professional.
- Develop a universal transition process to facilitate transitions between MCP and MHP delivery systems.

Medical Necessity Proposal Goals

- Revise the existing intervention criteria to clarify that specialty mental health services are to be provided to beneficiaries who meet the eligibility criteria for specialty mental health and that services are reimbursable when they are medically necessary and provided in accordance with the Medi-Cal State Plan instead of the existing state service criteria.
- DHCS is proposing that eligibility criteria, being largely driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, should be the driving factor for determining the delivery system in which someone should receive services.
- Prior authorization would be required for higher levels of care.

Medical Necessity Proposal Goals

- Align with federal requirements; allowing a physician's certification/recertification to document a beneficiary's need for acute psychiatric hospital services.
- Make other technical corrections to address outdated references to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM)-4 rather than the more current DSM-5, and reflect federal diagnostic coding requirements related to use of International Classification of Diseases (ICD) code sets.

Mandatory Medi-Cal Application Process Upon Release from Jail

Mandatory Medi-Cal Application Process Upon Release from Jail

- DHCS is proposing to mandate all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2022, which would include juvenile facilities.

- The mandated county inmate pre-release application process will standardize policy, procedures, and collaboration between California's county jails, county sheriff's departments, juvenile facilities, county behavioral health and other health and human services entities.

Mandatory Medi-Cal Application Process upon Release from Jail Behavioral Health Warm-Handoff

- The goal of the proposal is to ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment, receive timely access to Medi-Cal services upon release from incarceration.

- DHCS proposes to mandate warm-handoffs from county jail release to county behavioral health departments for inmates receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.