MEDI-CAL HEALTHIER CALIFORNIA FOR ALL (FORMERLY CALAIM)
1. The states proposal to change the federal waiver or contract we have with the federal government
Population Health Management and Annual Health Plan Open Enrollment

NCQA Accreditation

Enhanced Care Management (ECM) and In-Lieu-Of-Services (ILOS)

Behavioral Health

Full Integration Plans

Long-Term Plan for Foster Care (TBD)
BEHAVIORAL HEALTH PROPOSALS

- Payment Reform
- Behavioral Health Integration
- Full Integration Pilots
- Long-Term Plan for Foster Care
- Medical Necessity
- Enhanced Care Management/In Lieu of Services
- SED/SMI IMD Waiver
PAYMENT REFORM - PROBLEMS

- **Value**: Counties’ limitation to *payment for costs*
  - Limits ability to invest over cost
  - Requires extensive documentation of costs

- **Streamlining & Simplicity**: Detailed documentation requirements lead to:
  - Risk for audit disallowances (non-payment for services rendered)
  - Inefficiencies and workforce burnout
  - Misalignment with other parts of health care delivery

- **Partnership**: Unique features of payment limit ability to partner and contract with health plans

- **Investment & Transparency**: Lengthy and slow cost-settlement process
  - Carry over financial risk year to year over up to a decade or more
Payment drives decisions

To realize reforms at level of clients and providers, need to reform how we are paid and the rules for who we can serve
PAYMENT REFORM

- Replaces cost-based reimbursement with:
  - Set fee-for-service rates
  - Medical coding aligned with health care requirements
- Changes how counties use dedicated tax revenues
  - Shift from “Certified Public Expenditures” (CPEs) to “Intergovernmental Transfers” (IGTs)
MEDICAL NECESSITY PROBLEMS

**Gatekeeping:** Sets rules about who can be served by Specialty Mental Health and Substance Use Disorder Plans – grounded in diagnosis, which limits accessibility.

**Inflexible:** Currently requires documentable diagnosis and services which align to up-front determination and treatment plan.

**Financial Risk:** If eligibility and services are not properly documented, counties face additional audit/financial risk.

**Inefficient:** Because certain populations may not meet criteria, they are being served without federal Medicaid matching funds.
Remove diagnosis as the determining criteria to access Specialty Mental Health and SUD services
  • Allows for services pre-diagnosis
  • Avoids stigma associated with diagnosis
  • Acknowledges that diagnoses may change

Focus instead on:
  • Increasing access, particularly for children, to specialty mental health services
  • Functional impairment
  • Evolving/dynamic problem list
  • No Wrong Door approaches
  • Client continuity of care
BEHAVIORAL HEALTH INTEGRATION

- **Duplication** – Counties must operate two entirely different plans/systems with different rules, processes, which creates unnecessary duplication and inefficiencies.

- **Compliance vs Client Centered** – Clients must go through separate assessment processes, which means they must tell their story twice.

- **Clinical integration not supported** – Separate administrative structures works against clinical integration and whole person care concepts vital to addressing individuals with co-occurring conditions.

- **Solution**: Administrative Integration of Mental Health and Substance Use Disorders
  - One county plan by 2026
### BEHAVIORAL HEALTH INTEGRATION

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KEY QUESTIONS: BEHAVIORAL HEALTH INTEGRATION

- Can we get DHCS/state to provide guidance to counties regarding how to achieve integrated care models in light of 42CFR?
  - Strategy: Make this request with County Counsels Association.

- Can we develop a new approach to clinical documentation that is client-centered, less complex, and aligned across SMH and DMC/DMC-ODS?

- What, if any, other complications do you foresee in merging Mental Health, and Substance Use Disorder plans?
• **DHCS Goals:**
  • Replacement strategy for:
    • Whole Person Care Pilots
    • Health Homes
  • Pay for social determinants of health, e.g. housing supports/services
  • Reduce complexity for clients navigating multiple delivery systems:
    • Physical Health
    • Mental Health
    • Substance Use Disorders
    • Long-Term Care Services & Supports
    • Dental
  • Emphasis on high risk populations
    • Must be cost effective & medically appropriate
ENHANCED CARE MANAGEMENT/IN LIEU OF SERVICES

Enhanced Care Management (ECM)

Required benefit
Target populations (e.g. Seriously Mentally Ill with other risk factors, reentry population, homeless, “high utilizers”)
Possibility of contracting with counties or providers
Coordinating across delivery systems and in-person/high touch

In Lieu of Services (ILOS)

Optional benefit for plans and beneficiaries
Established under federal law for capitated plans only
Pay for services otherwise not covered by Medi-Cal
ENHANCED CARE MANAGEMENT/IN LIEU OF SERVICES

- **Questions/Concerns:**
  - Tied to Medi-Cal Managed Care Plan Population Health Management Strategy
  - Coordination with counties optional
  - Reinforces variation across Medi-Cal
  - Need for specialized case management
  - Health plans lack experience with Whole Person Care pilots
INFRASTRUCTURE BUDGET PROPOSALS

• January Budget Includes $695 million ($348 million General Fund), growing to $1.4 billion ($695 million General Fund) in 2021-22 and 2022-23 for:
  1. Enhanced care management and in lieu of services;
  2. Necessary infrastructure to expand whole person care approaches statewide; and
  3. Build upon existing dental initiatives

• January Budget Proposes Placeholder $40 million ($20 million GF) for state operations to implement
January Budget includes $45.1 million General Fund in 2020-21 and $42 million General Fund in 2021-22 for the DHCS to implement a Behavioral Health Quality Improvement Program funding to county-operated community mental health and substance use disorder systems to:

- Incentivize system changes and process improvements that will help counties prepare for opportunities through the Medi-Cal Healthier California for All

Envisioned improvements include:

1. Enhanced data-sharing capability for care coordination; and
2. Establishing the foundational elements of value-based payment such as: data collection, performance measurement, and reporting.
INFRASTRUCTURE QUESTIONS

- Significant investment will be needed to upgrade to HCPCS Level I Coding and new Medical Necessity Criteria. Discussion has emerged about trying to get county MHPs on a single IT platform for interoperability and consistency in how the rules are applied. Is this concept feasible, and if so, where?

- For payment/claims
- Client data sharing across counties, providers, and systems
  - Clinical data
  - Treatment history
- Data sharing re: Providers
- Tracking outcomes in various programs
- Datasharing with Managed Care Plans
FULL INTEGRATION PILOTS

• **Optional demonstrations:** Test the effectiveness of the administrative integration of Medi-Cal physical health, behavioral health, and oral health services under a single health plan/entity/payer.

• **Tentative timeline - 2024:** The state would release an RFP for comprehensive coverage of all Medi-Cal services, and hopes to have these plans “go live” in 2024.

• **Structure/financing unspecified:** DHCS acknowledges that strategies for financing and administration of these plans must be developed and is not putting forward specific fiscal proposals at this time.

• **Parallels Kaiser Carve-Out:** DHCS is also proposing to carve out specialty mental health services in Sacramento and Solano where currently carved in.
Optional demonstration program: Counties could opt in to receive federal funds for services delivered in MH treatment facilities with more than 16 beds.

Requirements for community-based services: The state and participating counties would be required to demonstrate that California is simultaneously supporting and improving a robust continuum of community-based (non-IMD) alternatives for Medi-Cal beneficiaries with serious mental illness.

Length of stay restrictions: The state/counties would be expected to maintain a statewide average length of stay of 30 days or less for participating IMD facilities.

Rigorous application process: California must provide extensive data on existing MH services and develop fiscal, HIT, implementation and evaluation plans for CMS to approve.
SMI/SED DEMONSTRATION: CONSIDERATIONS
(MENTAL HEALTH IMD EXCLUSION WAIVER)

- Counties must pay for IMD services with realignment funds and no federal match
  - Reduces amount available for community-based care
- How to ensure investment in community-based infrastructure?
- What are lessons learned from Drug Medi-Cal Organized Delivery System IMD Waiver?
- What, if any, interaction with changes in LPS laws?
• The purpose of this waiver is not to increase numbers of inpatient beds.

• With extra funding possible, would counties be willing to require re-investment in the community-based continuum as a condition of applying to receive FFP?
  • What are some of the areas where additional dollars could add value? In the short term? In the long term?

• What are the unique challenges of Small/Medium/Large counties related to an IMD waiver for mental health?

• What facility types should be included in the demonstration?
LONG-TERM PLAN FOR FOSTER CARE

No proposal yet by DHCS

Intention to establish stakeholder working group in June 2020

Possible ideas:
- Automatic eligibility for specialty mental health services for foster youth
  - Considers trauma of removal from home
- A single statewide Managed Care Plan for Foster Youth
LONG-TERM PLAN FOR FOSTER CARE

- Working group date moved up to April 2020
MEDI-CAL HEALTHIER CALIFORNIA FOR ALL
TARGET POPULATIONS

High Utilizers (top 5%)
Aging population
Behavioral Health
Homeless
Children
Justice involved

Health for All
IMPLICATIONS FOR COUNTY BEHAVIORAL HEALTH

- Modernizing eligibility criteria & payment
- Need for infrastructure changes (IT systems, coding, claiming)
- Need for workforce and delivery system investment/training
- Increased collaboration/contracting between counties and Medi-Cal managed care plans
- Could make it easier to track funding
- Opportunities for investments in delivery system (especially community-based services)
- Promotion of integration concepts
- Sets stage for value-based payment
DHCS Care Coordination Working Group Fall/Winter 2018

Full proposal released October 29, 2019

Stakeholder Engagement Process November 2019–February 2020

Legislation and Budget January-August 2020

DHCS submits waiver proposals to CMS Spring 2020

State/CMS Waiver Negotiations Summer/Fall 2020

Current waivers expire December 2020