Medi-Cal
Healthier California for All

Full Integration Plan(s)

1/31/2020

Welcome and Introductions

Agenda

10:00 – 10:15	Welcome, Introductions and Agenda Review
10:15 – 12:00	Background & Overview / Workgroup Discussion
12:00 – 12:45	Lunch
12:45 – 1: 45	Key Policy Decision Points
1:45 – 2:30	Key Criteria for Contractor Selection, Accountability & Fiscal Considerations
2:30 – 2:45	Next Steps
2:45 – 2:55	Public Comment
2:55 – 3:00	Closing

Medi-Cal
Healthier California for All
Key Goals

To achieve such principles, we have three primary goals:

1. Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;

2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and

3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

Meeting Objectives

- The objectives of the Full Integration Plan workgroup meetings are as follows:

  - Identify challenges and opportunities regarding one entity overseeing all physical health, behavioral health, and oral health benefits;
  - Help identify eligibility criteria for selecting candidates to participate in the full integration plan;
  - Help identify requirements related to administrating the full integration plan, such as utilization management, provider networks, quality and reporting;
  - Identify challenges and opportunities of blending existing separate and complex funding steams (e.g. realignment and Prop 30); and
  - Offer feedback on the implementation timeline for Full Integration Plans.

Workgroup
Expected Deliverables

- Provide recommendations outlining the parameters of a Full Integration Plan.
  a) Identify key policy decision points
  b) Outline key criteria for contractor selection
  c) Develop key issues need to determine readiness
  d) Specify funding considerations and questions
  e) Other considerations

- Workgroup input will culminate in a summary document outlining recommendations to DHCS to inform policy development on the development of the Full Integration Plans.

Full Integration Plan Background & Overview

Workgroup Discussion

Current Delivery System: Medi-Cal Fee-for-Service & Medi-Cal Managed Care

- In the Fee-for-Service (FFS) system, beneficiaries can see any provider who accepts Medi-Cal, and providers are reimbursed for each individual service or visit.
- In Medi-Cal Managed Care, health care is provided through managed care delivery systems known as Managed Care Plans (MCP's).
- MCPs provide health care to approximately 10.8 million Medi-Cal beneficiaries in all 58 California counties.
- Medi-Cal providers who want to provide services to managed care enrollees must contract with the MCP.
- MCPs must ensure appropriate access by meeting network adequacy and timely access requirements.

Current Delivery System: Behavioral Health

- 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 substance use disorder (SUD) treatment services to beneficiaries.
  - SMHS program is a statewide benefit administered by 56 mental health managed care plans, including two joint arrangements in Sutter/Yuba and Placer/Sierra.
  - SUDS managed care program (i.e., Drug Medi-Cal Organized Delivery System or 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.

Current Delivery System: Dental

- Today, dental services are provided to eligible Medi-Cal beneficiaries through two delivery systems:
  - Dental Fee-For-Service (FFS) and Dental Managed Care (DMC).
- Dental FFS was the exclusive and original delivery system offered in California's 58 counties.
- The dental managed care delivery model currently operates in two of the state's 58 counties, Sacramento and Los Angeles. DHCS has proposed to discontinue dental managed care effective January 1, 2021.

Current Delivery System Challenges

- Today, Medi-Cal beneficiaries must navigate multiple complex managed care and fee-for-service delivery systems in order to meet all of their health care needs.

- Beneficiaries enrolled in Medi-Cal managed care plans receive:
  - physical health care and treatment for mild-to-moderate mental health from their Medi-Cal managed care plan,
  - care for serious mental illness/serious emotional disturbance and substance use disorders from the county delivery system,
  - and dental care from a separate fee-for-service delivery system or a dental managed care plan.

- This fragmentation can lead to gaps in care and disruptions in treatment, cost inefficiencies, and generally fails to be patient-centered and convenient for most beneficiaries.

Proposal

- DHCS is proposing an integrated delivery system where DHCS would contract with an entity(ies) that would provide the following Medi-Cal services under a single contract:
  - Services provide through Medi-Cal managed care,
  - Specialty mental health
  - Substance use disorder
  - Dental

Proposal (continued)

- Under a Full Integration Plan, one entity would be accountable for all aspects of beneficiary health care including, but not limited to:
  - services and health outcomes
  - leveraging integrated data to improving care coordination
  - monitoring and improving beneficiary experience by reducing complexity and the need to navigate multiple delivery systems
  - aligning funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals across physical, mental, substance use, developmental and oral health
  - using savings from preventable, high-acuity care to allow investments in prevention
  - More appropriately align incentives to better ensure the most appropriate care is being provided in the most appropriate place and the right time
- One accountable entity makes it easier to tie payments to outcomes that matter to beneficiaries.

Full Integration Plan Timeline and Key Points

- Full Integration Plan implementation is targeted for 2024.
- Full Integration Plan(s) will be implemented in a limited number of counties (i.e., it will not be statewide).
- DHCS would solicit for interested entities to participate, however, such entities would require support by the County Behavioral Health Department to be considered.
  - Not all entities interested would automatically move forward, there will be a thorough evaluation and assessment process
- Full Integration Plan(s) entail both clinical and administrative responsibilities.

Alignment with Managed Care Plan Procurement

- Full Integration Plan implementation is in alignment with the Medi-Cal Managed Care Plan procurement targeted for January 2024. This allows for concurrent plan readiness processes to occur.

	Managed Care Plan Procurement	Full Integration Plan
Policy Development	N/A	2020
Build Contract / Application Process	2020	2021
Readiness Process	2022-2023	2022-2023
Implementation	January 2024	January 2024

Alignment with Behavioral Health Integration

- Behavioral Health Integration planning, targeted for full implementation in January 2026, will occur in parallel with, and will serve to prepare systems for, Full Integration Plan implementation.

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

Workgroup Questions

1. Does DHCS' proposal to fully integrate physical health, specialty mental health, substance use disorder and dental services effectively improve access, eliminate barriers to care, reduce variability across delivery systems, and otherwise align with the goals of Medi-Cal Healthier California for All? If not, what changes are needed to address identified gaps? What else should DHCS consider?

2. What concerns, if any, do you have about integrating these service delivery systems? How can DHCS best address your concerns?

Workgroup Questions

3. What are the opportunities and challenges to building an fully integrated delivery system? What are potential solutions to overcome the challenges?

4. What are your recommendations about timelines for implementation, and how many Full Integration Plans should be implemented?

Key Policy Decision Points

Discussion: Full Integration Plan Policy Considerations

- How would full integration plans work in relation to existing Medi-Cal managed care?
  - Should it only occur if full integration is done fully in place of existing Medi-Cal managed care (i.e., one or multiple plans all have to be full integration in a county)?
  - Should it be considered that full integration would be an option in a county, but the current system of Medi-Cal managed care/county systems also exist for those that choosing to enroll in full integration? If it co-exists, what challenges/considerations for remaining Medi-Cal managed care plans and county behavioral health systems would exist?

Discussion: Full Integration Plan Policy Considerations

- What considerations/requirements would be appropriate to include with respect to contracting with existing providers in either the Medi-Cal managed care plan, county behavioral health and dental provider networks?

Key Criteria for Contractor Selection, Accountability & Fiscal Considerations

Discussion: Full Integration Plan Contractor Selection Considerations

- What criteria would an entity need to meet in order to operate as a Full Integration Plan?
  - Licensure requirements?
  - Historical experience in Medi-Cal?
  - Historical quality performance?
  - Formal local/provider support?

Discussion: Full Integration Plan Contractor Selection Considerations

- What requirements would need to be considered related to administering a Full Integration Plan?
  - Provider network requirements?
  - Quality and reporting requirements?
  - Data collection and sharing capabilities?
  - Others?

Discussion: Full Integration Plan Accountability Considerations

- How should Full Integration Plans be held accountable for building fully integrated delivery systems (or be incentivized to do so)?

Discussion: Full Integration Plan Fiscal Considerations

Today, the vast majority of the non-federal share for county mental health and substance use services is provided by the individual counties through the use of certified public expenditures. This would need to change under full integration and be combined with the current non-federal share for Medi-Cal managed care.

- How would the county contribution to the full integration plan payment rates be calculated?
  - Per member per month based on historical spending? Trending?
  - Percentage of the overall rate paid for the full integration plans?
  - Total historical spend? Trending?
  - Based on actual expenditures on specialty mental health and substance use disorder services that the full integration plan experienced?
  - Other options that address the changing population numbers over time and the proportion of the population that would have otherwise been county obligation if the full integration did not exist?
- How would the appropriateness of the county funding be evaluated on a go-forward basis?

Discussion: Full Integration Plan Fiscal Considerations

The intention of full integration would be to have the payment to the plan be a risk-based capitation payment that includes all of the services. (Note: any directed payments happening in Medi-Cal managed care at the time of full integration go-live would also need to occur within these plans)

- What benefits or concerns exist with the concept of risk-based capitation?
- What types of risk mitigation might need to be included?
- What considerations should be included in developing the rate group categories that may be unique or different from existing rate groupings used in Medi-Cal managed care?

Discussion: Full Integration Plan

- Are there any more parameters to consider on how to optimally structure the Full Integration Plans that has not yet been discussed today?

Continued Collaboration

- Future agenda topics for discussion
  - Readiness
  - Funding considerations
  - Presentation on current integration at the local level (Plan/County)
  - Other recommendations
- Workgroup recommendations on meeting frequency after February 28th meeting

Public Comment

Please limit comments to 2 minutes

Closing and Next Steps

- Next Full Integration Plan Workgroup Meeting: **February 28, 2020**

- Any comments on the materials presented today can be submitted to CalAIM@dhcs.ca.gov by **February 7, 2020**

- Questions? CalAIM@dhcs.ca.gov