County Behavioral Health Landscape

DHCS Care Coordination Advisory Committee

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COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

October 2018

Presentation Outline

I. County Behavioral Health Care Services Today

II. Our Role in the Future of Medi-Cal

III. Strategies for Improving Care & Preparing for the Future

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	Medi-Cal Managed Care Plans and Fee-For-Service Providers	County Medi-Cal Specialty Mental Health Plans	County Mental Health Safety Net Services
Primary Fund Sources	• Federal Medicaid Funds • State General Funds	• Federal Medicaid Funds • State Tax Revenues vehicle license fees, sales tax, personal income tax	• State Tax Revenues vehicle license fees, sales tax, personal income tax • County funds
People Served	Medi-Cal enrollees of all ages	Medi-Cal enrollees of all ages (adults must have a moderate to severe mental health condition)	Uninsured, to the extent resources are available
Services Provided	Individual and group psychology services; psychological testing; medication monitoring; outpatient labs, supplies, supplements; psychiatric consultation	EPSDT mental health services for youth under age 21; inpatient hospitalization and post-stabilization; targeted case management; and rehabilitative services (e.g., individual, group, or family-based care; day treatment; residential treatment; psychiatric health facility services)	Community-based mental health services, crisis response

Medi-Cal Specialty Mental Health

- In 1995, CA received a federal Section 1915(b) "Freedom of Choice" waiver to provide "Specialty Mental Health Services" (SMHS)
  - Current waiver renewal (July 1, 2015 - June 30, 2020) is the 9th waiver.
- DHCS operates and oversees the SMHS program, and all counties have a contract to provide SMHS.
- Counties are "Mental Health Plans" (MHPs)
  - Managed care model.
  - Must provide/arrange for specialty mental health services for any full scope Medi-Cal beneficiary who meets medical necessity criteria.
  - MOUs with Medi-Cal Managed Care Plans require care coordination.

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Standard Drug Medi-Cal (DMC) Program

- State-County contracts with DHCS.
- Counties may subcontract with state-certified providers.
- DHCS may enter into direct provider contracts for the provision of DMC services with certified DMC providers when a county chooses not to enter into a contract for services.
- The state sets the rates for covered services.

DMC-Organized Delivery System (ODS) Pilot

- Pilot authorized by CMS in 2015 under California's Medicaid Section 1115 waiver, and expires in 2020.
  - National standards as specified in the American Society of Addiction Medicine (ASAM) Criteria.
  - Selective provider contracting.
  - Counties propose interim payment rates; except for Opioid Treatment Program (OTP) services. These continue to be set by the state.
  - Increased coordination with other systems of care, including physical and mental health.
  - Increased state and local oversight and accountability.
  - Create structures to promote quality improvement and quality assurance.

Substance Use Disorder (SUD) Organized Delivery System

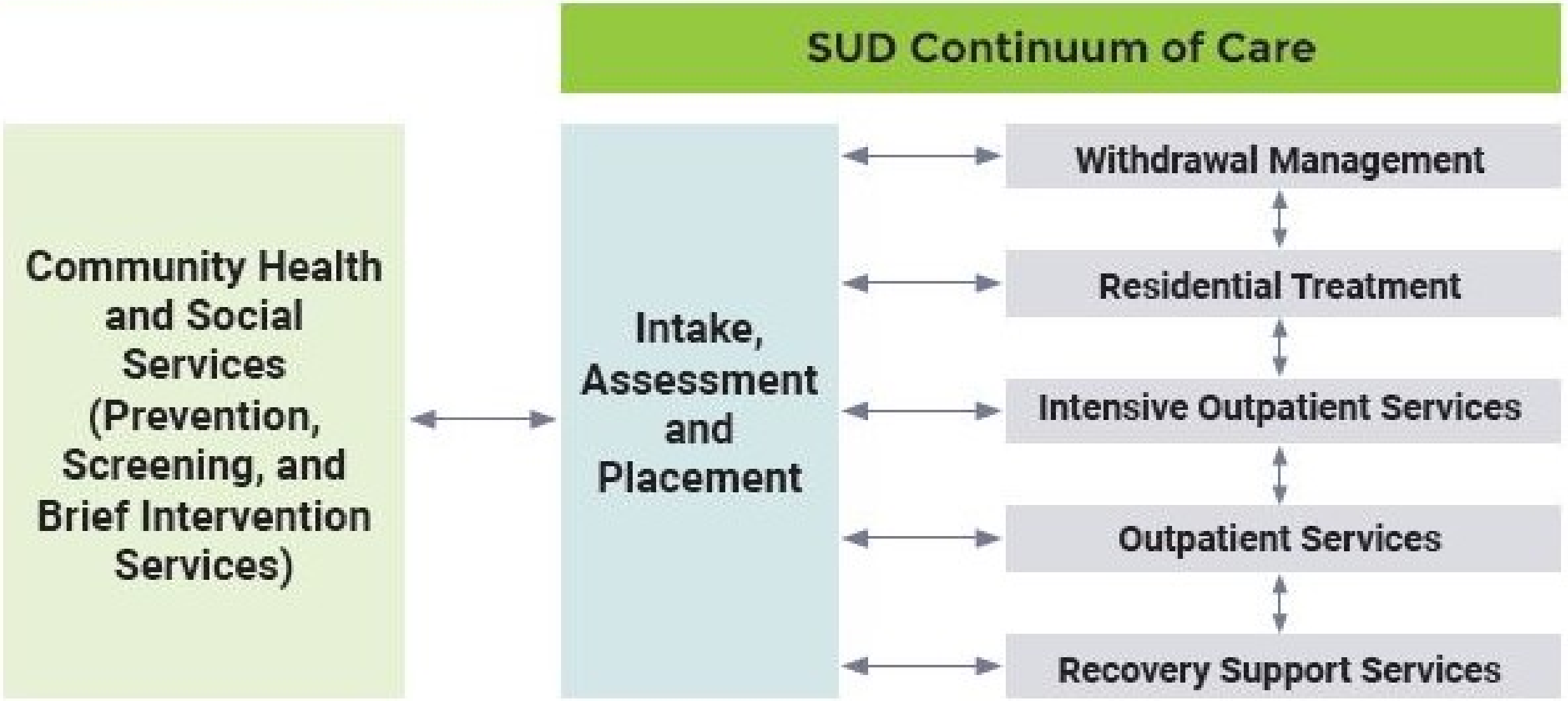

Diagram adapted from UCLA Integrated Substance Abuse Programs 2015 Evaluation Training and Technical Assistance for Substance Use Disorder Services Integration (ETTA) Report (Appendix 2, p 118)

Comparison of Benefits

Standard DMC Program:

- Outpatient Drug Free Treatment
- Intensive Outpatient Treatment
- Naltrexone Treatment (oral for opioid dependence or with TAR for other)
- Narcotic Treatment Program
- Perinatal Residential SUD Services (limited by IMD exclusion)

DMC-ODS Pilot Program:

- Outpatient Services
- Intensive Outpatient Services
- Naltrexone Treatment (oral for opioid dependence or with TAR for other)
- Narcotic Treatment Program
- Residential Services (not restricted by IMD exclusion or limited to perinatal)
- Withdrawal Management (at least one ASAM level)
- Recovery Services
- Case Management
- Physician Consultation
- Partial Hospitalization (Optional)
- Additional Medication Assisted Treatment (Optional)

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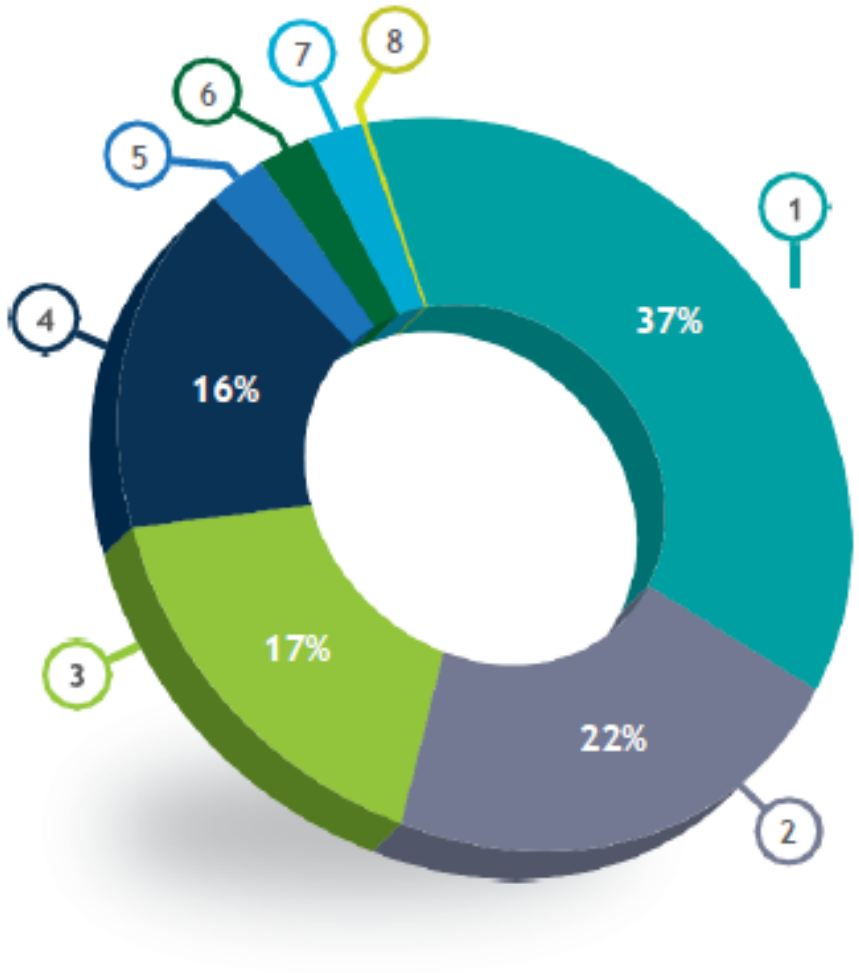
California County Behavioral Health Funding

California counties receive over $8 billion in funds annually for behavioral health. The money comes from a variety of sources.*



1	Federal Mental Health Medicaid Matching Funds	$3.04 billion
2	Mental Health Services Act	$1.77 billion
3	2011 Realignment	$1.39 billion
4	1991 MH Realignment	$1.31 billion
5	Federal SAPT Block Grant	$225.6 million
6	Other (MH Block Grant, County MOE, County GF)	$212.8 million
7	Federal SUD Medicaid Matching Funds	$190.5 million
8	State General Fund	$14.7 million

**Amounts based on FY16/17 Estimated Behavioral Health Funding.*

Does not reflect projected increases in federal matching funds and state general fund spending on SUD services under the DMC-ODS (lines 7 and 8).

County Financial Responsibility

- Unlike other services that are carved out of Medi-Cal managed care (e.g., dental services, high cost pharmaceuticals) Medi-Cal specialty mental health services and substance use disorder services are **realigned** programs under current law and the State Constitution
- Counties bear **full** financial responsibility for the non-federal share of costs.
  - Receive federal financial participation
  - Rely upon tax revenues, which perform based on the health of the state's economy
  - Revenues decline as Medi-Cal enrollment trends increase during downturns
- State General Funds are only provided for new mandates

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IMPROVING CARE & PREPARING FOR THE FUTURE

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Our Role in Medi-Cal's Future

- 2011 Realignment solidified the transition of full risk for the non-federal share of cost and responsibility to counties for Drug Medi-Cal and Specialty MH for all Medi-Cal beneficiaries.
  - Counties are *mandated* to provide care through contract, state law, regulations, and with State Constitutional funding protections.
- Rehabilitation Medicaid State Plan, Proposition 63 funds, and creation of a more robust substance use disorder benefit
  - Care not limited to clinic sites – can be provided in schools, homes, streets.
  - Funds available for housing and other non-Medicaid supports.
  - Many of health plans' most costly beneficiaries have behavioral health needs.

Some Current Challenges to Address

- Each county manages these behavioral health benefits
  - Administrative infrastructure and economy of scale inefficiencies
  - Population density, rural areas or counties, and other unique demographics
- Inefficient, Fee-For-Service Reimbursement Structure
  - Arduous documentation requirements (diagnosis, treatment plan, and progress notes all used to substantiate medical necessity)
  - Not designed to truly “managed care”
- Cross-System Care Coordination
  - High cost beneficiaries driving physical health care costs
  - Reduced lifespan due to comorbid physical illness
  - Information-sharing between providers and plans

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Four Key Strategies for Achieving Better Health Outcomes as We Plan for the Future

1. Promote regional approaches
2. Increase financial efficiency & effectiveness
3. Promote care coordination
4. Support integration of mental health and substance use disorder services

1: Promote Regional Approaches

- Explore options for regional planning, administration, and delivery of behavioral health services
  - Reduce variance among individual counties and regions of the state.
  - Increase efficiency through collective efforts.
  - Consider each county's Medi-Cal managed care model.
  - Examine whether multi-county options would improve beneficiary care and administrative efficiency.

2: Improve Fiscal Efficiency, Effectiveness

- Transition from volume-based, fee-for-service reimbursement
  - Reimbursement currently based on units of service delivered.
- Focus on beneficiary outcomes and managing risk
  - Move toward national health care reimbursement trends of payment for value.

3: Promote Care Coordination

- Focus on the beneficiary outcomes that would be improved with better coordinated care for all beneficiaries.
- Ensure bi-directional access to physical health care and behavioral health care for people with multiple chronic conditions.
- Reduce beneficiaries' barriers to care, including reevaluating the organization of the mild/moderate mental health benefit.
- Build on the goals and early lessons of Whole Person Care and Health Homes.

4. Support Integration of Mental Health & Substance Use Disorder Services

- Nearly every county has merged the administration of mental health and substance use disorder services into Behavioral Health systems.
- Reimbursement, state-county contracts, documentation and reporting, and oversight are still very much siloed.
- Many beneficiaries have co-morbid behavioral health conditions affecting their recovery and wellness.

Questions & Discussion