CalAIM: California Advancing and Innovating Medi-Cal

Presentation to the Behavioral Health Stakeholder Advisory Committee

January 6, 2020

Welcome and Introductions

Name, Title, and Organization

Overview of Agenda

- CalAIM Behavioral Health Proposals
  - County Inmate Pre-Release Application Process
  - Behavioral Health Payment Reform
  - Institutions for Mental Disease (IMD) Expenditure Waiver
  - Medical Necessity Criteria for Specialty Mental Health and Substance Use Disorder Services
  - Administrative Integration of Specialty Mental and Substance Use Disorder Services
  - Substance Use Disorder Managed Care Program Renewal and Policy Improvements
  - Behavioral Health Regional Contracting
  - Full Integration Plans
- Public Comment
- BH-SAC Member Input on Future Meeting Topics
- Review Proposed Agenda Topics and Final Comments, Adjourn

CalAIM Overview & Goals

CalAIM Overview

- DHCS has developed a comprehensive and ambitious framework for the upcoming waiver renewals that encompasses a broader delivery system, and program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal.

- Includes initiatives and reforms for:
  - Medi-Cal Managed Care
  - Behavioral Health
  - Dental
  - Other County Programs and Services

- CalAIM advances several key priorities of the Newsom Administration by leveraging Medi-Cal as a tool to help address many of the complex challenges facing California's most vulnerable residents.

CalAIM Overview

- The CalAIM package presented here is an initial set of proposals intended to drive discussion and consideration through stakeholder workgroups and meetings, as well as the legislative process.

- Funding for CalAIM will be determined through the budget process which will affect which reforms proceed as well as the timeline and scope of such reforms.

CalAIM Goals

CalAIM has three primary goals:

- Identify and manage member risk and need through Whole Person Care approaches and addressing social determinants of health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

County Inmate Pre-Release Application Process

County Inmate Pre-Release Application Process

- To ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2022. This would also include juvenile facilities.

- Additionally, DHCS is proposing to mandate that all counties implement warm-handoffs from county jail release to county behavioral health departments when the inmate was receiving behavioral health services while incarcerated, to allow for continued behavioral health treatment in the community.

- The goal is to ensure timely and seamless access to Medi-Cal services for individuals transitioning from incarceration, and to streamline pre-release application processes across counties.

County Inmate Pre-Release Application Process

Proposed timeline:

- March 1, 2020: Establish workgroup with County Welfare Directors Association, County Behavioral Health Directors Association (CBHDA), County Behavioral Health Departments, and Counties, including local correctional representation, to develop and vet implementation plan
- July 1, 2020: All county guidance development
- October 1, 2020: County and stakeholder feedback process, and Behavioral Health Information Notice
- January 1, 2021: Publish All County Welfare Directors Letter
- January – December 2021: County implementation planning and technical assistance
- January 1, 2022: Implementation of county inmate pre-release application process

Questions and Discussion for BH-SAC Members

1. To ensure a seamless transition of the inmates into the community, what type of agreement/contracts are necessary with the County Sheriffs or a third-party entity?
2. What are the data sharing issues that need to be considered?
3. What roles and responsibilities would allow for effective coordination among all parties?
4. Due to the unpredictable release dates of the population, should there be a minimum time period to allow for the pre-release application to start?
5. It has been noted that access to care remains a critical issue in the pre-release process. What steps/guidance can DHCS take to coordinate with health plans to facilitate a seamless eligibility and enrollment end-to-end process?
6. What coordination would be necessary with courts and judges to effectuate this program?
7. What are some best practices that counties can leverage for a successful pre-release program?

Behavioral Health Payment Reform

Behavioral Health Payment Reform

- As a part of CalAIM, DHCS proposes to reformat the Medi-Cal behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives.

- The first step in payment reform would be to shift away from the cost-based Certified Public Expenditure-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county non-federal share.

- A change is required in order to allow for the possibility to incentivize outcomes and quality as well as potential to increase reimbursement.

Behavioral Health Payment Reform

DHCS proposes to implement the shift in methodology in two initial phases:

- In order to establish appropriate payment rates and bring into compliance with federal requirements, DHCS proposes to transition specialty mental health and substance use disorder services from existing Healthcare Common Procedure Coding Systems (HCPCS) Level II coding to Level I coding (where appropriate); and

- DHCS will establish reimbursement rates, as well as an ongoing methodology for updating rates, for the updated codes with non-federal share being provided via intergovernmental transfer instead of Certified Public Expenditures, eliminating the need for reconciliation to actual costs.

Behavioral Health Payment Reform

The shift from Certified Public Expenditure to other methodologies will allow DHCS, in collaboration with county partners, to:

- Establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services;
- Create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal managed care plans and counties, without limiting financial benefits for the county; and
- Reduce State and county administrative burdens and allow counties to close their accounting records closer to the end of a fiscal year by eliminating the lengthy and labor-intensive cost-reconciliation process.

Behavioral Health Payment Reform

- The shift from HCPCS Level II coding to HCPCS Level I coding (where appropriate) will allow for more granular claiming and reporting of services provided, creating the opportunity for more accurate reimbursement to counties/providers.

- This will also allow counties and DHCS to better report performance outcomes and measures.

- In turn, the increased reporting will provide counties and DHCS with more accurate, useful information on health care quality to inform policy decisions.

Questions and Discussion for BH-SAC Members

1. How would set rates for services best be established? What geographic groupings might be appropriate, and how many should there be? Would there be a need to differentiate payment rate by provider type (e.g., county owned vs private provider; clinic vs individual provider)?

2. In addition to payments for services, what flexibilities would counties want in order to allow for value-based payments or quality payments?

3. Should DHCS transition all three delivery systems on the same schedule or should the systems be transitioned via a phase-in schedule?

4. Counties and providers are in different states of readiness for transition to HCPCS Level I Coding submission to DHCS. What steps should DHCS take to ensure counties are prepared for transition?

Medical Necessity Criteria for Specialty Mental Health and Substance Use Disorder Services

Revisions to Behavioral Health Medical Necessity

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.

Revisions to Behavioral Health Medical Necessity

- Identify existing or develop a new statewide, standardized level of care assessment tools – one for beneficiaries 21 and under and one for beneficiaries over 21 – that would be used by all entities to determine a beneficiary's need for mental health services and which delivery system is most appropriate to cover and provide treatment.

- 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 (note: the exception is for beneficiaries under the age of 21 as each delivery system must provide mental health services according to the broader EPSDT guidelines).

- Align with federal requirements by allowing a physician's certification/recertification to document a beneficiary's need for acute psychiatric hospital services.

Revisions to Behavioral Health Medical Necessity

- 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.

- 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.

- 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.

Revisions to Behavioral Health Medical Necessity

- DHCS is also proposing a “no wrong door” approach with children under the age of 21.
  - Regardless of the delivery system in which a child first presents, that system will be responsible for providing services, doing an assessment and either providing ongoing treatment or referring the child to the appropriate delivery system.
  - Both the Medi-Cal managed care plan and mental health managed care plan would be reimbursed for all medically appropriate services provided to a child, even if the child ultimately moves to the other delivery system.

Questions and Discussion for BH-SAC Members

1. Does DHCS' proposal to amend medical necessity criteria for outpatient and inpatient specialty mental health services effectively improve access, eliminate barriers to care, reduce variability across delivery systems, and otherwise align with the goals of CalAIM? If not, what changes are needed to address identified gaps? What else should DHCS consider?

2. Does DHCS' proposal to amend medical necessity criteria for substance use disorder services effectively improve access, eliminate barriers to care, reduce variability across delivery systems, and otherwise align with the goals of CalAIM? If not, what changes are needed to address identified gaps? What else should DHCS consider?

3. How should DHCS operationalize the "no wrong door" approach for children/youth for accessing mental health services?

4. What are your recommendations to strengthen care coordination between the counties and Medi-Cal managed care plans?

Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

- DHCS is proposing administrative integration of specialty mental health and substance use disorder services into one behavioral health managed care program.
- 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.

Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

- The result would be, by 2026, a single prepaid inpatient health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder treatment services for all Medi-Cal beneficiaries in that county or region.

- Substance use disorder fee-for-service 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.

Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

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

Questions and Discussion for BH-SAC Members

1. What are the benefits for counties and beneficiaries?

2. What elements are not included in the proposal that should be considered?

3. What advice do you have about timelines and phasing for implementation?

4. What would integration look like in counties not participating in DMC-ODS?

SMI/SED IMD 1115 Demonstration Waiver

SMI/SED IMD 1115 Demonstration Waiver

- On November 13, 2018, CMS issued a State Medicaid director letter that outlines opportunities for states to design innovative service delivery systems to improve care for adults with serious mental illness and children with serious emotional disturbance who are enrolled in Medicaid.

- Allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease (IMD).

- Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries.

SMI/SED IMD 1115 Demonstration Waiver

- DHCS would like to collaboratively assess through the stakeholder process whether California should pursue this serious mental illness/serious emotional disturbance Section 1115 demonstration.

- Similar to the State's existing 1115 demonstration to provide residential and other substance use disorder treatment services under Medi-Cal, county participation would be on an opt-in basis.

- For additional information about the demonstration goals and milestones, federal application requirements, and other demonstration requirements, please refer to Appendix E of the CalAIM proposal.

Questions and Discussion for BH-SAC Members

1. Depending on county interest, what is a realistic timeframe in which to apply to CMS, particularly given the extensive application requirements?
2. What are we trying to achieve through this waiver that will strengthen the public mental health delivery system (other than increased federal funding)?
3. What should be the parameters or expectations for counties to participate?
4. What protections should DHCS include in this demonstration to ensure that care is being appropriately delivered along the lower level of the continuum in order to prevent inappropriate use of IMDs?
5. How do we leverage all aspects of CalAIM to build the expectation for the waiver (e.g., Enhanced Care Management, In Lieu of Services, jail diversion)?

Substance Use Disorder Managed Care Program Renewal and Policy Improvements

Substance Use Disorder Managed Care Program Renewal and Policy Improvements

- The 30 counties that have implemented the substance use disorder managed care program (also known as DMC-ODS) have made tremendous strides in improving the continuum of care for Medi-Cal beneficiaries with substance use disorder treatment needs.

- Implementation has yielded lessons learned and opportunities to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency.

- However, for many counties, the substance use disorder managed care model of care is still very new or hasn't been able to be implemented.

Substance Use Disorder Managed Care Program Renewal and Policy Improvements

DHCS would like input from stakeholders on the following proposed policy clarifications and changes, which have been thoughtfully constructed to balance system improvements while minimizing disruptions at the local level:

- Residential treatment length-of-stay requirements
- Residential treatment definition
- Recovery services
- Additional medication assisted treatment
- Physician consultation services
- Evidence-based practice requirements
- Provider appeals process
- Tribal services
- Treatment after incarceration
- Billing for services prior to diagnosis

Questions and Discussion for BH-SAC Members

1. Given that this proposal will be discussed in greater detail during the February BH SAC, what topics/components do members most want to focus on?

2. Do these proposed clarifications align with county priorities based on implementation experience?

3. What would incentivize/encourage non-ODS counties to participate?

Behavioral Health Regional Contracting

Behavioral Health Regional Contracting

DHCS recognizes that some counties have resource limitations and encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries.

- There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region.

- Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership.

Behavioral Health Regional Contracting

- DHCS is interested in discussing how counties not currently seeking substance use disorder managed care participation may be more interested in doing so through a regional approach and/or how services provided under substance use disorder fee-for-service might also be provided through a regional approach.

- DHCS is committed to working with counties to offer technical assistance and support to help develop regional contracts and establish innovative partnerships.

Questions and Discussion for BH-SAC Members

1. What prevents counties from doing regional contracting now? What are the challenges?

2. Are there any lessons learned from the current regional contracts that should be considered?

3. In the proposal, DHCS mentioned several strategies for establishing regional contracts (a Joint Powers Authority, an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program). Are there any other recommended strategies that should be considered when seeking to establish regional contracts or any advice regarding the opportunities/challenges with those identified by DHCS?

Full Integration Plans

Full Integration Plans

- DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity.

- Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around:
  - Eligibility criteria for entities,
  - Administrative requirements across delivery systems,
  - Provider network requirements,
  - Quality and reporting requirements, and
  - Complex financial considerations including current sources of non-federal share, county/state financing and realignment/Prop 30.

- Workgroup meetings will kick-off in January 2020.

- Given the complexity of this proposal, DHCS assumes the selected plans would not go live until 2024.

Questions and Discussion for BH-SAC Members

1. What policy discussions/decisions need to occur before moving forward with a fully integrated delivery system?

2. What topics/discussion items would be helpful to tackle during the workgroup process?

3. What advice do you have about timelines for implementation?

Public Comment

BH-SAC Member Input on Future Meeting Topics

Recommended:

February:
Review proposed changes to SUD Managed Care (DMC-ODS)

Questions?

Email us at: CalAIM@dhcs.ca.gov

CalAIM Webpage: https://www.dhcs.ca.gov/calaim