Trends in Behavioral Health

Webinar Series

One in Three Californians is a Medi-Cal Beneficiary. Is Your Organization Ready for the Next Steps in Drug Medi-Cal's ODS Waiver?

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presented by

BHAP
BEHAVIORAL HEALTH ASSOCIATION OF PROVIDERS

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Agenda

1. Background
2. Federal and National Landscape
3. DMC-ODS Waiver Authority
4. Core Elements
    i. Benefits
    ii. Beneficiary Eligibility
5. County, State, and Provider Responsibilities
6. Interim results and next steps

Background

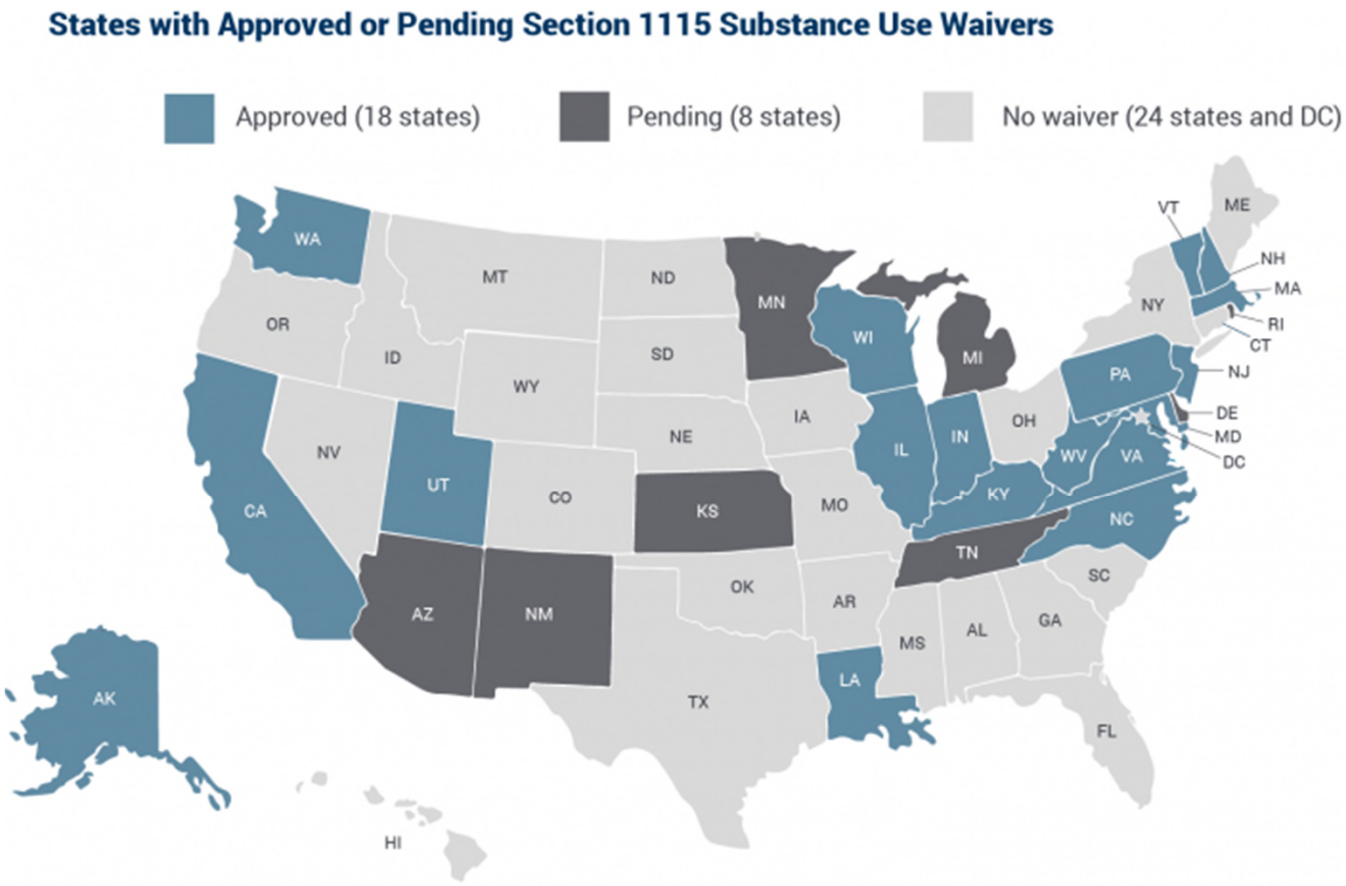
- Medicaid is playing an increasingly important role as a payer for services provided to individuals with SUD in the United States.
- An estimated 12 percent of adult Medicaid beneficiaries ages 18-64 have an SUD* and the federal government is strongly prioritizing SUD treatment as a focus of the Medicaid program.
- According to CMS:
  - Nearly 12 percent of Medicaid beneficiaries over 18 have a SUD, and on average, 105 people die every day as result of a drug overdose.
  - 6,748 individuals across the country seek treatment every day in the emergency department for misuse or abuse of drugs
  - Drug overdose is the leading cause of injury death and has caused more deaths than motor vehicle accidents among individuals 25-64 years old.
  - The monetary costs and associated collateral impact to society due to SUDs are very high.

*Substance Abuse and Mental Health Services Administration. Behavioral Health Treatment Needs Assessment Toolkit for States [online]. 2013. Retrieved from: http://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf, p.10.

Federal Landscape

- On July 27, 2015, the federal Centers for Medicare and Medicaid Services ("CMS") announced a new opportunity to submit 1,115 demonstration projects for individuals with Substance Use Disorder (SUD).
- Largely in response to pressure from California
- The initiative allowed states, starting with California, to cover residential SUD treatment services that had previously excluded from coverage under federal Medicaid due to their classification as Institutions for Mental Diseases (IMD).
- In return, states are required to develop a comprehensive re-design of their SUD coverage and treatment system to ensure that a continuum of care is available to individuals with SUD and that the continuum is based on an independent, evidence based standard.

National Landscape



Note: This map reflects states with approved or pending Section 1115 substance use disorder demonstrations as of November, 2018.
Source: MACPAC, 2018, analysis of Section 1115 substance use disorder Medicaid demonstrations (CMS 2018).

DMC-ODS Waiver Authority

- Organized Delivery System (ODS): Pilot program to demonstrate how organized SUD care increases beneficiary success while decreasing other health system costs
  - Continuum of care based on ASAM
  - Increased local control and accountability
  - Utilization controls to improve care and efficiency
  - Increased program oversight and integrity
  - More intensive services for criminal justice population
  - Evidence based practices requirements
  - Increased coordination with other systems of care
- Authorized and financed under the authority of the state's Medi-Cal 2020 Waiver
- The DMC-ODS Pilot Program will be elective for 5 years at the county level, then mandatory.

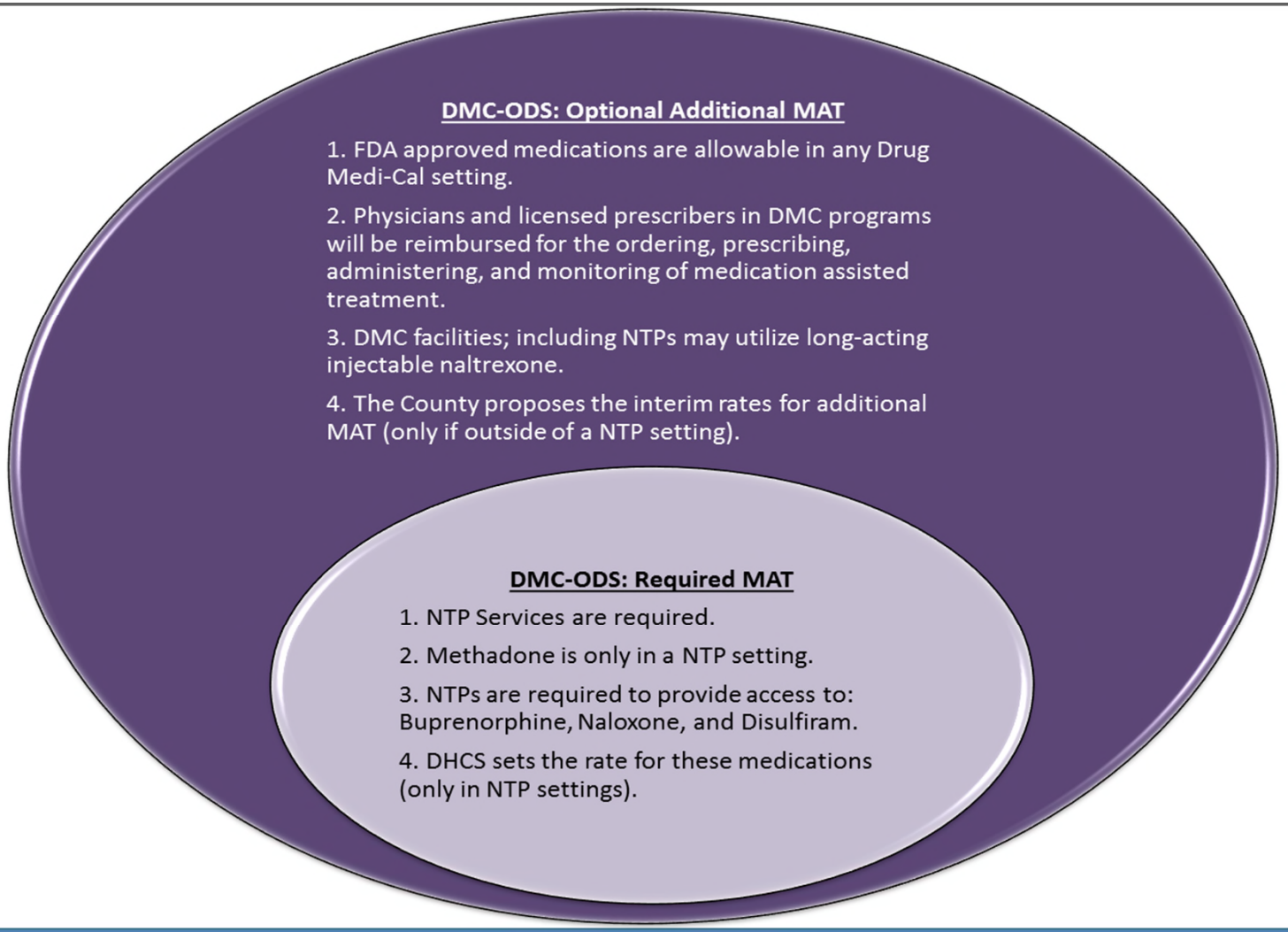
Core Elements of the DMC-ODS - Benefits

Standard DMC Benefits (available to beneficiaries in all counties)	Pilot Benefits (only available to beneficiaries in pilot counties)
Outpatient Drug Free Treatment	Outpatient Services
Intensive Outpatient Treatment	Intensive Outpatient Services
Naltrexone Treatment (oral for opioid dependence or with TAR for other)	Naltrexone Treatment (oral for opioid dependence or with TAR for other)
Narcotic Treatment Program (methadone)	Narcotic Treatment Program (methadone + additional medications)
Perinatal Residential SUD Services (limited by IMD exclusion)	Residential Services (not restricted by IMD exclusion or limited to perinatal)
Detoxification in a Hospital (with a TAR)	Withdrawal Management (at least one level)
	Recovery Services
	Case Management
	Physician Consultation
	Partial Hospitalization (optional)
	Additional Medication Assisted Treatment (optional)

Core Elements of the DMC-ODS - Benefits

Standard Residential (non-ODS)	Residential Under DMC-ODS Pilot
State plan currently limits residential SUD services to perinatal beneficiaries only	Services are provided to non-perinatal and perinatal beneficiaries (all eligible adults and adolescents).
Federal matching funds are only available for services provided in facilities not considered IMDs (i.e. 16 bed max).	No bed capacity limit (i.e. 16 bed IMD exclusion does not apply)
	Providers must be designated by DHCS to meet ASAM treatment criteria
	Counties must provide prior authorization for residential services within 24 hours of submission of the request.

Core Elements of the DMC-ODS - Benefits



Core Elements of the DMC-ODS - Eligibility

- **No age restrictions**
- **Eligibility:**
  - Enrolled in Medi-Cal
  - Reside in Participating County
  - Meet Medical Necessity Criteria:
    - Adults: One DSM Diagnosis for substance-related and addictive disorders (with the exception of tobacco); meet ASAM criteria definition of medical necessity for services
    - Children: Be assessed to be at risk for developing a SUD and meet the ASAM adolescent treatment criteria (if applicable)

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County Responsibilities

County Responsibilities – Managed Care

- Under managed care, beneficiaries receive part, or all, of their Medicaid services from providers who are paid by an organization (i.e. county) that is under contract with the State.
- Counties participating in the DMC-ODS Pilot Program are considered managed care plans.
  - **Prepaid Inpatient Health Plan.** The State has entered into an intergovernmental agreement with counties to provide or arrange for the provision of DMC-ODS pilot services through a "Prepaid Inpatient Health Plan" (PIHP), as defined in federal law.
  - **Federal Managed Care Requirements.** Accordingly, DMC-ODS Pilot PIHPs must comply with federal managed care requirements (with some exceptions).
- This is a new responsibility for counties and includes network adequacy, quality assurance and performance improvement, beneficiary rights and protections, and program integrity.

County Responsibilities – Requirements

- Use a benefit design modeled after the American Society for Addiction Medicine (ASAM) criteria, covering a broad continuum of SUD treatment and support services
- Specify standards for quality and access
- Require providers to deliver evidence-based care
- Coordinate with physical and mental health services
- Act as a managed care plan for SUD treatment services

County Responsibilities – Access

- **Accessible Services.** Each county must ensure that all required services are available and accessible to enrollees.
- **Out of Network Coverage.** If the county is unable to provide services, the county must adequately and timely cover these services out-of-network for as long as the county is unable to provide them.
- **Appropriate and Adequate Network.** The county shall maintain and monitor a network of appropriate providers that is supported by contracts with subcontractors, and sufficient to provide adequate access.
- **Provider Selection.** Access cannot be limited in any way when counties select providers.
- **Timely Access.** Hours of operation are no less than those offered to commercial enrollees or comparable Medi-Cal FFS, if the provider only services Medi-Cal. Includes 24/7 access, when medically necessary.
- **Cultural Considerations.** Pilot county participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including LEP and diverse cultural / ethnic backgrounds.
- **Monitoring.** Monitor providers regularly to determine compliance and take corrective action if there is a failure to comply.

County Responsibilities – Network Adequacy

In establishing and monitoring a network, pilot counties must consider:

- **Timely Access Standards.** Ability of providers to meet Department standards for timely access to care and services as specified in the county implementation plan and contract.
- **Emergency and Crisis Care.** Ability to assure that medical attention for emergency and crisis medical conditions be provided immediately.
- **Number of Eligibles.** The anticipated number of Medi-Cal eligible clients.
- **Utilization.** The expected utilization of services, taking into account the characteristics and SUD needs of beneficiaries.
- **Number / Type of Providers.** The expected utilization of services, taking into account the characteristics and SUD needs of beneficiaries.
- **Providers Not Accepting New Patients.** The number of network providers who are not accepting new beneficiaries.
- **Geography.** The geographic location of providers and their accessibility to beneficiaries, considering:
  - Distance
  - Travel Time
  - Means of Transportation Ordinarily Used by Medi-Cal Beneficiaries
  - Physical Access for Disabled Beneficiaries

County Responsibilities – Selection Criteria

- **Policies and Procedures.** County should have written policy and procedures for selection and retention of providers that are applied equally
- **Criteria.** Counties will only select providers that have:
  - A license and/or certification in good standing
  - Enrolled / revalidated enrollment with DHCS as a DMC provider and have been screened as a "high" categorical risk
  - A medical director who has enrolled with DHCS, has been screened as a "limited" categorical risk within a year prior, and has a signed Medicaid provider agreement with DHCS
- **Contracting.** Counties must enter into contracts with selected providers including:
  - **Cultural Competency.** Provide culturally competent services, including translation services, as needed.
  - **Coordination**. Procedures for coordination of care for enrollees receiving Medication Assisted Treatment (MAT) services.
  - **EBPs.** Implement at least two (2) of the following Evidence Based Practices (EBPs):
    - Motivational Interviewing
    - Cognitive-Behavioral Therapy
    - Relapse Prevention
    - Trauma-Informed Treatment
    - Psycho-Education

County Responsibilities – Contract Appeals

- **Written Notification of Denial.** County must serve providers that are not selected with a written decision and have a protest procedure for providers that are not selected.
- **Local Protest Procedure.** Providers may challenge the denial to DHCS only after the local protest procedure has been exhausted; must also have reason to believe that the county has an inadequate network
- **State Appeal.** Following submission of appeal and county response, DHCS will set a date for parties to discuss with a DHCS representative with subject matter knowledge.
- **Final Determination.** DHCS will make a final determination, which may result in no further action or a county corrective action plan (CAP).

State Responsibilities

Monitoring Plan (EQRO, Program Integrity)

Triennial Review

Reporting of Activity

ASAM Designation for Residential

Provider Appeals Process

State Responsibilities

- **Certified Public Expenditure.** Counties will certify the total allowable expenditures incurred in providing DMC-ODS pilot services through county-operated or contracted providers.
- **County-Specific Rates.** Counties will develop proposed county-specific interim rates for each covered service (except for NTP) subject to state approval.
- **2011 Realignment Provisions / BH Subaccount.** 2011 Realignment requirements related to the BH Subaccount will remain in place and the state will continue to assess and monitor county expenditures for the realigned programs.
- **Federal Financial Participation (FFP).** FFP will be available to contracting pilot counties who certify the total allowable expenditures incurred in delivering covered services.
- **County-Operated Providers.** County-operated providers will be reimbursed based on actual costs.
- **Subcontracted Providers.** Subcontracted fee-for-service providers will be reimbursed based on actual expenditures.
- **CPE Protocol.** Approved by CMS to allow FFP under the Pilot. Includes provisions related to:
  - Inflation Factor
  - Lower of Cost or Charge
  - Cost Report

State Responsibilities – Rates

- **Annual Fiscal Plan.** Counties are required to complete and submit an Annual County Fiscal Plan following DHCS guidance.
- **DHCS Review and Approval.** DHCS will review and approve the plan annually.
- **Interim Rates.** Proposed interim rates must be developed for each required and selected optional service specified in the waiver.
- **Supporting Information**. Counties must provide supporting information consistent with state and federal guidance for each proposed rate.
- **Sources.** Appropriate sources of information include filed cost reports, approved medical inflation factors, detailed provider direct and indirect service cost estimates, and verified charges made to other third party payers for similar programs.
- **Residential Rates.** Proposed residential rates must include clear differentiation between treatment and non-treatment room and board costs.
- **Outpatient Rates.** Proposed outpatient treatment rates should include all assessment, treatment planning and treatment provision direct and indirect costs consistent with coverage and program requirements outlined in state and federal guidance.
- **Admin, QI, UR, etc.** County administrative, quality improvement, authorization, and utilization review activities may be claimed separately consistent with state and federal guidance.

Overview of California's DMC-ODS Pilot Programs

- In California, 8.5% of residents age 12 and older (2.7 million people) met the criteria for having a SUD in the past year.
- Only 1 in 10 received treatment
- The goal of the DMC-ODS pilot program is to treat more people more effectively by reorganizing the delivery system for SUD treatment in Medi-Cal.

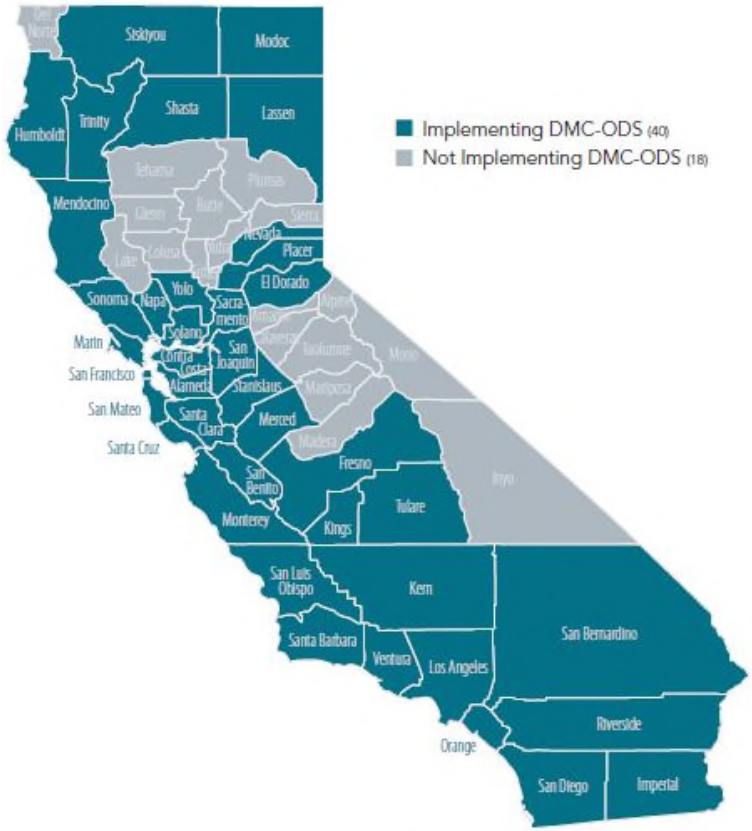
*Source: California Health Care Foundation, Issue Brief, August 2018

Overview of California's DMC-ODS Pilot Programs

- Forty California counties are taking part in the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot program under California's Medicaid Section 1115 waiver, which was approved in 2015 and will run through 2020 (see Figure 1).
- As of July 2018, 19 counties were providing services under the pilot and represent approximately 75% of the State's Medi-Cal population.*

*Source: California Health Care Foundation, Issue Brief, August 2018

Figure 1. California Counties Implementing DMC-ODS



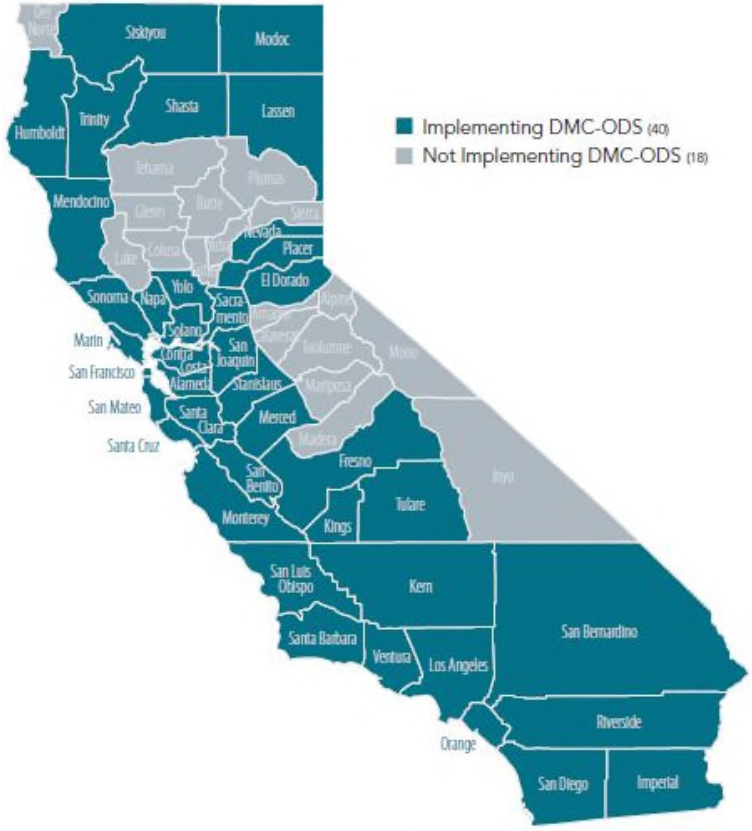
Source: California Department of Health Care Services, www.dhcs.ca.gov.

Overview of California's DMC-ODS Pilot Programs

- When the remaining 21 counties that have submitted implementation plans begin services, over 97% of Medi-Cal enrollees will have access to DMC-ODS pilot programs
- The Tribal and Urban Indian Health Programs are scheduled to begin implementation in the summer of 2019

*Source: California Health Care Foundation, Issue Brief, August 2018

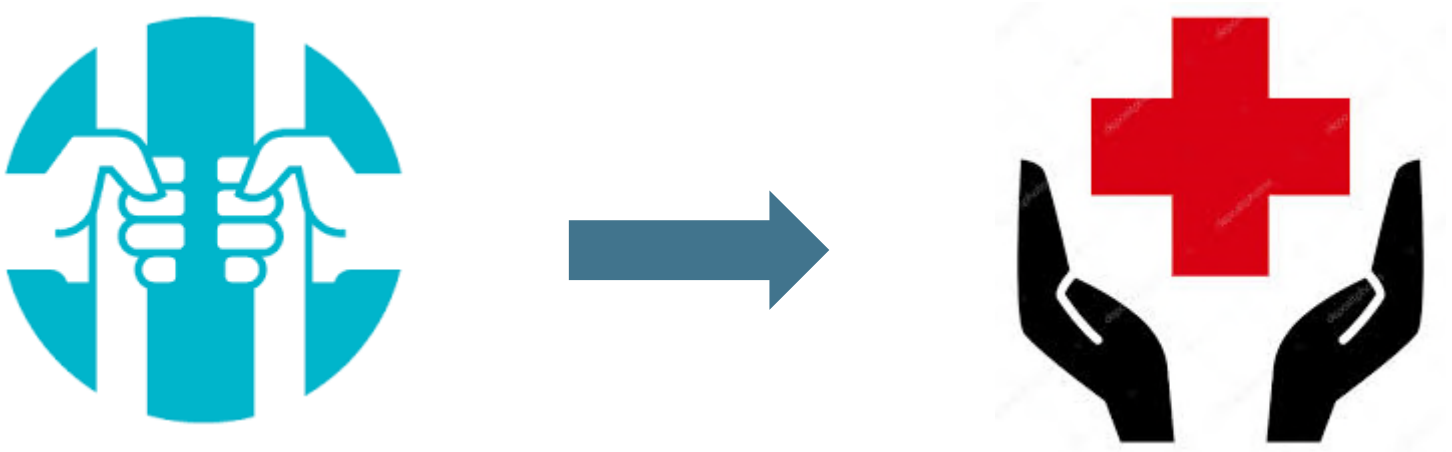
Figure 1. California Counties Implementing DMC-ODS



Source: California Department of Health Care Services, www.dhcs.ca.gov.

Reframing of SUD Treatment

- Historically, SUD treatment has been associated more with criminal justice than healthcare.
- Under the DMC-ODS pilot program, SUD treatment has been brought into the larger health care landscape and addiction is being reframed as a chronic disease, which is a fundamental shift.



*Source: California Health Care Foundation, Issue Brief, August 2018

Standard Drug Medi-Cal vs. DMC-ODS

Table 1. Drug Medi-Cal Program vs. the Drug Medi-Cal Organized Delivery System Pilot Program

DRUG MEDI-CAL (STANDARD PROGRAM)	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (PILOT PROGRAM)
Providers contract with: Counties or state	**Providers contract with:** Counties
Services: ▸ Outpatient drug-free treatment ▸ Intensive outpatient treatment ▸ Residential SUD services for perinatal women only (limited to facilities with 16 beds or fewer) ▸ Naltrexone treatment ▸ Narcotic treatment programs (methadone only) ▸ Detoxification in a hospital	**Services:** All services provided in the standard Drug Medi-Cal program, plus: ▸ Multiple levels of residential SUD treatment (not limited to perinatal women or to facilities with 16 beds or fewer) ▸ Case management ▸ Narcotic treatment programs expanded to include buprenorphine, disulfiram, and naloxone ▸ Withdrawal management (at least one ASAM level) ▸ Recovery services ▸ Case management ▸ Physician consultation ▸ Partial hospitalization (optional) ▸ Additional medication-assisted treatment (optional)

*Source: California Health Care Foundation, Issue Brief, August 2018

Keys to Success

- Provider Engagement
- Communications Plan
- Partnerships

*Source: California Health Care Foundation, Issue Brief, August 2018

Challenges – Stigma

- Misconceptions about SUD and its treatment
- Some believe SUD is not a medical condition
- Public attitudes are evolving

*Source: California Health Care Foundation, Issue Brief, August 2018

Challenges – Criminal Justice System

- Embedded patters have been disrupted
- Each individual has unique treatment needs
- Court-ordered treatment may not meet medical necessity criteria

*Source: California Health Care Foundation, Issue Brief, August 2018

Challenges – Administrative Infrastructure

- Increased requirements for documentation, training, and coordination of care
- Expenses for new staff, technology, facility improvements, and training

*Source: California Health Care Foundation, Issue Brief, August 2018

Challenges – High Demand, Low Supply

- Need a sufficient supply of qualified providers for high demand
- More residential providers needed
- More providers who serve the youth population needed

*Source: California Health Care Foundation, Issue Brief, August 2018

Challenges – Predicting Costs

- Budgetary planning needed
- Increased demand for services

*Source: California Health Care Foundation, Issue Brief, August 2018

Generational Opportunity to Advance SUD Treatment

"This is a generational opportunity to advance SUD treatment," "Everyone — providers, patients, and plans — should realize how important this is. It's a watershed moment for Medi-Cal."

- John Connolly, PhD, who is leading the implementation of the Los Angeles County DMC-ODS pilot program.

*Source: California Health Care Foundation, Issue Brief, August 2018

Questions?

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