DMC-ODS
System Transformation

Presented at DHCS 2017 Annual Conference

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Objectives

- Understand managed care principles applied to DMC-ODS Waiver
- Understand the new county role as a PIHP in managing network adequacy
- New provider requirements and roles
- Care coordination & integration of services for improved client outcomes
- How two providers with a defined populations achieve care coordination
- On the ground elements of care coordination and integration of service delivery
DMC-ODS Forum, hosted by the CBHDA SAPT Committee, creates a collaborative learning environment to support county behavioral health and substance use disorder leaders in the planning and implementation of the DMC – ODS Waiver

- Four forums and three webinars
- Web site access to the white papers and other information at https://www.cibhs.org/dmc-ods-waiver-forum
- County Resource Library
- Adolescent Continuum of Care Design Forum in November
The Landscape in 2010

- Institute of Medicine publishes *Crossing the Quality Chasm: A New Health System for the 21st Century in 2001* calling for fundamental changes in service delivery and focus on coordinated care.

- In 2008, researchers at the Institute for Healthcare Improvement (IHI) proposed the Triple Aim, which became a cornerstone of the Affordable Care Act in 2010.

- Mental health and SUD services are mandated as one of ten essential health benefits covered under the ACA in 2010.

- Most state public sector delivery systems have been inadequate for the safety net population funded only by the Substance Abuse Prevention and Treatment Block Grant.

- Most state Medicaid programs have minimal services, have insufficient provider networks, and few standards for this type of care.

- In 2015, California received approval for a Waiver Demonstration Project to provide a continuum of care for SUD services.
The Patient Protection and Affordable Care Act
Accelerated Pathway to Transformation

2014 Medi-Cal Eligibility Expansion in California
New beneficiaries now include single adults without children, with income up to 138% Federal Poverty Level (FLP)

August 2015 CMS approves the DMC-ODS Waiver
Expands available levels of care, adopts ASAM criteria, supports quality assurance/utilization management

January 2016 CMS approves the Medi-Cal 2020 Waiver
Builds on the 2010 Bridge To Reform Waiver to expand access, improve quality and outcomes, and control the cost of care

April 2016 CMS issues Final Rule on Managed Care
Implements MH/SUD benefits, overrides IMD exclusion & implements MHPAEA
DMC-ODS Implementation

DMC-ODS is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program California Medi-Cal 2020 Demonstration

- Riverside, San Mateo, and Marin County started service delivery in April 2017
- Contra Costa, Los Angeles, Santa Clara, and San Francisco started in July 2017
- Fiscal Plans approved for Santa Cruz, Napa, Monterey, San Luis Obispo, Sonoma and Alameda.
- A total of 32 counties have opted to participate in the Waiver, covering 85% plus of the state Medi-Cal population
- 8 of these northern small counties are forming a regional model with Partnership Health Plan as allowed in the Special Terms & Conditions
- DHCS has started implementation discussion with Tribal & Indian Health Providers – Phase V
• Authorizes DHCS to test a new paradigm for the organized delivery of health care services for Medi-Cal eligible individuals with a substance use disorder

▪ Authorizes the implementation of a new SUD evidenced-based benefit design covering a full continuum of care, requiring providers to meet industry standards, and a strategy to coordinate and integrate across systems of care

▪ Seeks to demonstrate how organized substance use disorder care will increase the health outcomes and success of Medi-Cal beneficiaries

▪ Demonstrate how organized SUD care improves outcomes for DMC beneficiaries while decreasing other system health care costs
California Medi-Cal 2020 Bridge To Reform Waiver

- Improve health care quality and outcomes for the Medi-Cal population
- Strengthen primary care delivery and access
- Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency
- Address social determinants of health and improve health care equity
- Use CA' Medicaid Program as an incubator to test innovative approaches to whole-person care
Whole Person Care and Carve Out Funding
Behavioral Health and Health Intersection

Mental health and serious mental illness are some of the most commonly treated conditions among the entire Medi-Cal population, particularly for the most costly cohort.

Source: Understanding Medi-Cal’s High-Cost Populations, DHCS, March 2015.
Key Administrative Elements

- Use of the American Society of Addiction Medicine Criteria (ASAM) for client placement, utilization management, and transition to the appropriate level of care

- Counties have the authority to selectively contract with providers following managed care methodology to create a provider network based on network adequacy

- Counties must establish a continuum of care that will meet the need/demand for services and allow adequate and timely access

- Like Specialty Mental Health Services, Counties are required to coordinate SUD services with the Medi-Cal Managed Health Plans; however unlike SMHS there is no legislative mandate

- DHCS retains Drug Medi-Cal Provider Certification authority through the Provider Enrollment Division

- Counties retain quality assurance and utilization management through contracts with providers and prescribed Quality Assurance & Utilization Review mandates
Key Financial Elements

- Counties submit a Fiscal Plan based on volume of services projected
  - Projections for each service modality
  - Projections for each level of service
  - Rates are submitted for approval to DHCS and CMS as a component of the Implementation
  - County holds flexibility in negotiating rates with providers
- Counties can re-negotiate the financial plan/proposal annually
- Organized Delivery system is broader than just DMC-financed services defined in the Waiver
  - Fiscal Plan must calculate all funds and expenditures, both federal and matching local funds
  - Fiscal Plan must include all other funding including SAPT Block Grant, Realignment and DUI programs
Industry Reimbursement Moving from Volume Transactions to Value Based Performance
- Policies and procedures for the selection, retention credentialing and re-credentialing provider agencies
- Pre-Authorization of Residential Services
- Beneficiary Access Number and Defined Service Referral process
- Care Coordination – MOU – with Managed Care Plans
- State-County contract with detailed requirements for access, monitoring, appeals etc
- County Implementation and Fiscal Plans
- Culturally Competent Services
- Fidelity to Evidenced-Based Programs
- Billing Systems that meet managed care standards
- Compliance with Medicaid Final Rule Section 438
- Annual Review by External Quality Review Organization (EQRO)

County

Responsibilities as a Prepaid Inpatient Hospital Plan (PIHP)

42 CFR 438.2
Key Service Elements

- Each SUD clinic shall have a **licensed physician** designated as the substance use disorder medical director. *(Title 22, § 51000.70)*

- Expansion of the role of Licensed Practitioners of the Healing Arts in assessment and other SUD treatment activities consistent with their scope of practice

- Reimbursement for SUD treatment in residential programs
  - *Medi-Cal does not allow reimbursement for room and board paid using SAPTBG funds*

- Integration of Medication Assisted Treatment into all levels of care

- Permits Recovery Residences and Recovery Support Services
  - *Medi-Cal does not allow reimbursement for room and board paid using SAPTBG funds*

- Reimbursement for defined Case Management Services

- Requirement for the use of established SUD evidence-based practices
Licensed Practitioner of the Healing Arts (LPHA) and SUD Treatment Professional

*LPHA* includes physicians, nurse practitioners (NP), physician assistants (PA), registered nurses (RN), registered pharmacists (RP), licensed clinical psychologists (LCP), licensed clinical social workers (LCSW), licensed professional clinical counselors (LPCC), licensed marriage and family therapists (LMFT), and licensed-eligible practitioners, registered with Board of Behavioral Health Services and working under the supervision of licensed clinicians.

- Provides medically necessary, clinical services prescribed for beneficiaries admitted, registered, or accepted for care by the substance use disorder clinic
- LPHA must enroll in Medi-Cal Program using DHCS 6010 form

*SUD Treatment Professional* includes an intern registered with BBS or with Board of Psychology and/or an alcohol and other drug (AOD) counselor that is registered or certified pursuant to Title 9
What is this about for SUD . . .

- Expanding availability of SUD treatment by expanding the network of selected service providers
- Creating a defined and accessible continuum of evidenced-based SUD services
- Improving outcomes in the recovery management and maintenance of the gains achieved in treatment
- Adopting standards of practice with improved consistency and quality of services
- Implementing managed care administrative methodology to meet the PCACA Triple AIM Goals
- Development of a sustainable and viable financing structure and reducing costs
DMC-ODS Evaluation

University of California. Los Angeles
Integrated Substance Abuse Programs

Designed to assess four key areas of beneficiary access, outcomes, utilization, health care costs and integration and coordination of care utilizing a comparison between comparable populations in opt-in counties and others

✓ Impact of providing intensive outpatient SUD services in the community
✓ Effectiveness of drug based SUD treatments
✓ Impact of providing residential SUD services
✓ Whether the length of stay of residential services affects the impact of such services
✓ Whether residential treatment methods affect the impact of such services
## Benefits required in the DMC-ODS

<table>
<thead>
<tr>
<th>Service</th>
<th>Required</th>
<th>Optional</th>
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</thead>
<tbody>
<tr>
<td>Early Intervention 0.5</td>
<td>Provided &amp; funded by MCP</td>
<td></td>
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<tr>
<td>Outpatient Services</td>
<td>Required level 1.0</td>
<td>Partial Hospitalization 2.5</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>Required level 2.1</td>
<td></td>
</tr>
<tr>
<td>Residential</td>
<td>At least one level in year 1 Level 3.1, 3.3, 3.5, 3.7 within 3 years 4.0 provided &amp; funded through FFS or MCP</td>
<td>Additional ASAM Levels</td>
</tr>
<tr>
<td>NTP (rates set by DHCS)</td>
<td>Required County Contract</td>
<td></td>
</tr>
<tr>
<td>Withdrawal Management</td>
<td>At least one level of five service levels</td>
<td>Additional ASAM Levels</td>
</tr>
<tr>
<td>Recovery Services</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Physician Consultation</td>
<td>Required</td>
<td></td>
</tr>
</tbody>
</table>
The Provider Challenges and Complexity

- Provider Enrollment Division
- Entity Disclosures
- Clearances
- LPHA Disclosures
- 6-8 month process

- Medical Director
- Licensed/Certified
- Training Pre-requisites
- EMR /County IT

- DHCS Certification
- Use/business/permit
- Fire clearance
- Program Statement
- Hours of operation
- Staffing plan

- Specialty DMC Service Contract with County
- Network to meet demand
- Pre-Authorization
- Access Line
- Loss of autonomy

- Drug Medical Clinic Certification
- AOD Design and Certification
- Operations Workforce Technology Components
- Operations Workforce Technology Components
Pathway to Licensing, Certification and Selective Provider Contracting

Residential Programs

- AOD License & Certification MHSUDS, SUD Compliance Division
- ASAM Level Designation
- DMC Certification Provider Enrollment Division
- Incidental Medical Services Certification MHSUDS, SUD Compliance Division

Outpatient and Intensive Outpatient

- AOD Certification MHSUDS, SUD Compliance Division
- DMC Certification Provider Enrollment Division

There is no uniform pathway for those providers which are not currently licensed or certified by DHCS
Care Coordination – The Heart of Integration

- Care Coordination is the cornerstone of many healthcare redesign efforts, including primary and behavioral healthcare integration
- It involves bringing together various providers and information systems to coordinate health services, patient needs, and information to help better achieve the goals of treatment and care
- Research shows that care coordination increases efficiency and improves clinical outcomes and patient satisfaction with care.

SAMHSA – Center for Integrated Health Solutions

https://www.integration.samhsa.gov/
Care Coordination defined in the 1115 Waiver
Special Terms & Conditions

- Counties must develop a structured approach to care coordination to ensure beneficiaries transition between levels of SUD care without disruptions
- Indicate which beneficiaries will receive care coordination and who will deliver these services
- Focus on access to recovery supports and services following discharge or upon completion of an acute stay
- Goal long-term retention in SUD and behavioral health treatment
- County shall enter into a MOU with any Medi-Cal managed care plan that enrolls beneficiaries served by DMC-ODS
- Can be met through an amendment to the Specialty Mental Health MOU
SYNERGY with Managed Care Plans

- Shared Goals of the Drug Medi-Cal Organized Delivery System (DMC-ODS) and Managed Care Plans
  - Improved health outcomes for California beneficiaries with a substance use disorder (SUD)
  - Reduced costs to the Medi-Cal program
- Efforts that can support care coordination between SUD and health services, include
  - Payment for targeted case management services,
  - Physician consultation for medication assisted treatment (MAT),
  - Requirement for memorandum of understandings (MOUs) between counties and managed care plans
  - Dedicated Care Coordinator for high risk / high utilizer client
Note: Chart is for illustrative purposes only and may not include all relevant providers or funding streams serving this population. Source: LA Care Health Plan, January 2016.
Managed Care Carve-outs: Behavioral Health Services

Medi-Cal beneficiaries enrolled in managed care with serious mental health needs must navigate two separate health care delivery systems: the county mental health plan and the Medi-Cal managed care plan. In 2012, passage of Proposition 30 added language to the State’s Constitution codifying the counties’ role in the delivery of mental health services.

### County Mental Health Plans

**Services:** Range of interventions to assist beneficiaries with serious emotional and behavioral challenges, including acute psychiatric inpatient care, treatment from psychiatrists and psychologists, and a host of rehabilitation services.

### Medi-Cal Managed Care

**Services:** Beginning in January 2014, interventions to assist beneficiaries with mild to moderate needs, including psychotherapy, psychological testing when clinically indicated, psychiatric consultation, substance use screening and brief intervention for adults.

**Funding:** Medi-Cal spending on mental health services was estimated to be $3.3 billion in FY 2012-13 from federal, state, and county funding sources.

**Memorandums of Understanding (MOUs):** In each county, the mental health plan and Medi-Cal managed care plan(s) are required by their respective contracts with the state to have an MOU specifying roles and responsibilities for coordinating the delivery of mental health services.

Sources: A Complex Case: Public Mental Health Delivery and Financing in California, CHCF, July 2013; Proposition 30 Text of Proposed Law, California Secretary of State, 2012; Behavioral Health Services Transition to Medi-Cal Managed
## Managed Care Program Models

Counties operate managed care through four main models and two additional models - Imperial / San Benito.

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Enrollment (Dec. 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two-Plan</td>
<td>The Department of Health Care Services (DHCS) contracts with one county-developed plan called a Local Initiative (LI) and one commercial plan.</td>
<td>6,540,360</td>
</tr>
<tr>
<td>County Organized Health System (COHS)</td>
<td>The county operates a single managed care plan, with which DHCS contracts directly.</td>
<td>2,190,182</td>
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<tr>
<td>Geographic Managed Care (GMC)</td>
<td>DHCS contracts with several commercial plans. Only Sacramento and San Diego counties are designated GMC counties.</td>
<td>1,102,804</td>
</tr>
<tr>
<td>Regional Model</td>
<td>The Regional Model is a slightly modified version of the Two-Plan approach created for the rural expansion, in which the state contracts with two commercial plans over a geographic region.</td>
<td>294,341</td>
</tr>
<tr>
<td>Imperial Model</td>
<td>Two commercial plans contract with DHCS.</td>
<td>72,513</td>
</tr>
<tr>
<td>San Benito Model</td>
<td>One commercial plan contracts with the state. In this model, beneficiaries can opt out of managed care.</td>
<td>7,400</td>
</tr>
</tbody>
</table>

Sources: Medi-Cal Managed Care Program Fact Sheet, DHCS; On the Frontier: Medi-Cal Brings Managed Care to California’s Rural Counties, CHCF, March 2015; Medi-Cal Managed Care, CHCF, March 2000; Medi-Cal Managed Care Enrollment
Managed Care Program Models, by County

Source: Medi-Cal Managed Care County Map, DHCS; Medi-Cal Managed Care Enrollment Report, DHCS, November 2015.

* Total does not include 849 individuals enrolled in Primary Care Case Management (PCCM) models in San Francisco and Los Angeles county.

Note: All striped counties were included in the rural expansion of managed care that began in late 2013.
Managed Care Plan Possible Collaboration

- Sharing information on ER high-utilizers to target interventions such as intensive case management
- Same day referrals for SUD treatment
- Coordinate electronic health records with Confidentiality guidelines SUD, Physical Health and Mental Health
- Agree on the data to be utilized, share the data and utilize the same HEDIS (Healthcare Effectiveness Data and Information Set) measures.
- Leverage and support provider collaboration and partnership and create health care provider incentives
- Consider alternative reimbursement strategies and pilots for providers, such as member-centered performance-based payments
The Elephant in the Room – Sharing Protected Patient Information

Need to create and establish data and information sharing guidelines and mechanisms, consistent with state and federal data privacy and security laws, to provide for timely sharing of beneficiary data, assessment, and treatment information.
Helpful Resources

California Department of Health Care Services

SAMHSA
https://www.samhsa.gov/health-care-health-systems-integration

Case Western Reserve University Center for Evidenced Based Practices
https://www.centerforebp.case.edu/

Los Angeles County Substance Abuse, Prevention and Control Division
http://publichealth.lacounty.gov/sapc/HealthCare/HealthCareReform.htm

California Institute for Behavioral Health Solutions
http://www.cibhs.org

Blue Shield of California Foundation