

Federal Budget/Policy Update
FY 2016–17 Block Grant Application

- Continues to allow states to submit an application for both MH & SUD services.
- Reflects the ACA's emphasis on coordinated and integrated care.
- Block Grant funds should be directed toward 4 purposes:
 - To fund priority treatment and support services for individuals without health insurance or for whom coverage is terminated for short periods of time.
 - To fund priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals, and that demonstrate success in improving outcomes and/or supporting recovery.

Federal Budget/Policy Update (cont.)

- For SAPT funds, 20% is set aside to fund primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
- To collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.
- There is some indication that SAMHSA will approve the use of a certain percentage of SAPTBG funds to pay for transitional housing for individuals in recovery.
- In addition to the targeted/required populations and/or services required in statute, states are encouraged to consider the following populations:

Federal Budget/Policy Update (cont.)

- Individuals with mental and/or substance use disorders who are homeless or involved with criminal justice systems.
- Individuals with mental and/or substance use disorders who live in rural areas.
- Underserved racial and ethnic minority and LGBT populations.
- Persons with disabilities.
- Community populations for environmental prevention activities.
- Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities.

Drug Medi-Cal Organized Delivery System (ODS) Benefits

Service	Required	Optional
Outpatient Services	ODF & IOT	Partial Hospitalization
Residential Services	At Least 1 Level of Service	Additional ASAM Levels
Withdrawal Management	At Least 1 Level of Service	Additional ASAM Levels
Medication Assisted Tx	Yes	
Recovery Services	Yes	
Case Management	Yes	
Physician Consultation		Yes

Cost Summary for Enhanced DMC Benefits* (includes historic & expansion populations)

Service Type	2015-16 Estimated Total Annual Cost
Intensive Outpatient	\$24,255,618
Residential	\$131,905,990
Recovery Support	\$24,767,372
Opioid Detoxification	\$13,636,383
Alcohol Detoxification	\$10,462,196
Total	\$205,027,559
Estimated Federal Share	\$122,408,216
Estimated non-Federal Share	\$ 82,619,343

* From DHCS Fiscal Forecasting Branch

County Responsibilities

Selective Contracting

- However, must maintain client access to services.
- Must provide a continuum of care with the required services.
- Must have policies & procedures for selection, retention, credentialing and re-credentialing.

County Responsibilities

- Authorization of Residential Services
- State-County contract with further detailed requirements for access, monitoring, appeals, etc.
- Beneficiary access number
- Coordination - MOU - with managed care plans.

County Responsibilities

County Implementation Plan

- County implementation plans must ensure that providers are appropriately certified for the services contracted, implementing *at least two evidence based practices*, trained in ASAM Criteria, and *participating in efforts to promote culturally competent service delivery*.

County Responsibilities

Coordination with DMC-ODS Providers

- Culturally competent services
- Medication Assisted Treatment
- Evidence based practices
 - Evidence based programs - Matrix, Seeking Safety
 - Evidence based counseling methods and techniques - CBT, MI, etc.

Fiscal Provisions for DMC-ODS Waiver

Sharing Ratio

Guiding Principles:

- The cost of all DMC Waiver services will be shared among the federal government, state government, and the counties.
- The federal government will continue to pay FFP for the existing population at the 50% rate (including residential services).
- The federal government will pay FFP for the expansion population at the applicable enhanced rate (including residential), currently 100%.

Fiscal Provisions (cont.)

- Quality Assurance Activities will be reimbursed at 75% FFP.
- The non-federal share will be split between the State/County based on a county-specific sharing ratio.
- The sharing ratio will apply to outpatient, intensive outpatient, narcotic treatment programs (including buprenorphine, disulfiram and naloxone), recovery services, case management, physician consultation, residential, quality assurance activities, and county administrative services.

Fiscal Provisions (cont.)

Calculating the Sharing Ratio:

- The county expenditures are based on FY 2012-13 approved DMC claims, and funded through the Behavioral Health Realignment subaccount.
- The state expenditures include the intensive outpatient and residential services, and are contained in the November 2014 Medi-Cal Estimate. The estimates use actual DMC billing data, the existing perinatal residential reimbursement rate, and caseload projections that were based on 36 months of the most recent complete caseload data. The estimate was calculated at the county level.

Fiscal Provisions (cont.)

- Buprenorphine, Disulfiram and Naloxone expenditures are also the responsibility of the State, and are calculated in a State Plan Amendment.

Example of Calculating the Sharing Ratio:

1. County A's total FY 2012-13 approved DMC claims were \$330.
2. County A's total Nov. 2014 Medi-Cal estimate was \$270.
3. The total available to calculate the State/County sharing ratio is \$600 (non-FFP).
4. County A's sharing ratio would be 55% county/45% State.

Fiscal Provisions (cont.)

Rates

- Rates are set at the State rates; however, counties can propose coming in higher or lower, except for NTP services.
- If counties propose a rate different than the current rate, there can be a geographic variation in the proposed rate.
- Counties will need to explain in their implementation plans why the proposed rate is higher or lower than the State rate.
- The State will negotiate the proposed rates with the counties and will have final approval.

Fiscal Provisions (cont.)

Possible Use of SAPT Funds for DMC-ODS Waiver

- Residential room and board.
- Recovery residences.
- Training.
- County % of sharing ratio costs if expenditures exceed projections.

What Does All This Mean?

- ▶ An expanded and more directive role for counties in provider oversight.
 - Medical, fiscal, utilization, QI
- ▶ An expanded and more directive role for counties in client access to and movement through the treatment system.

What Does All This Mean?

- ▶ More data to collect, report and analyze
 - For the evaluation
 - To monitor access
 - Assess the impact of cultural competence measures.
 - Support QI process
 - Monitor provider performance and client outcomes to support selective contracting process.

What Does All This Mean?

- ▶ More/different staff at county and provider levels
 - Physicians or other LPHAs
 - Licensed staff for youth treatment (e.g., MFT)
 - Clinical supervisors
 - Billing clerks
 - Data analysts
- ▶ Moving from volume-based to value-based reimbursement.

In the Next 120 Days . . .

- ▶ Develop selective contracting standards.
- ▶ Recruit providers.
- ▶ Issue RFPs.
- ▶ Financial analysis – Where is the risk?
- ▶ Gap analyses
 - Data needs and associated technology.
 - Type and quality of contractor cost data.

In the Next 120 Days . . .

- ▶ Project the necessary regional service coverage that –
 - provides client choice,
 - is culturally competent, and
 - will meet county performance and quality standards.
- ▶ Develop key system baseline measures.

In the Next 120 Days . . .

- ▶ Develop Rehab model service provision rules.
- ▶ Forecast utilization and cost by modality.
- ▶ Gap analysis for network adequacy.
- ▶ Draw the network map.
