Drug Medi-Cal Organized Delivery System - the Northern California Regional Model Partnership

Briefing Paper from the DMC-ODS Waiver Forum held on December 7, 2017

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Introduction

The DMC-ODS Waiver Forum funded by Blue Shield of California Foundation hosted a panel presentation and discussion of the Northern California Regional Model Partnership in December 2017. After two years of collaboration and negotiations with the Partnership HealthPlan of California (PHC), seven of the northern most counties in the state and Solano County hammered out an innovative regional approach which allowed them to opt into participation in the Drug Medi-Cal Organized Delivery System 1115 Waiver. The Implementation Application for the Regional Model Partnership was submitted to DHCS in the fall of 2017 and was approved the State Department of Health Care Services (DHCS) and the Center for Medicare and Medicaid Services (CMS). While much work has been done on the administrative and service delivery structures of this unique cross-county specialty managed care plan, as of December the Fiscal Plan remains in negotiations with DHCS. The go live date for the DMC-ODS in all eight counties is tentatively July 2018.

The December Forum was planned in collaboration with Margaret Kisliuk, Behavioral Health Administrator and Elizabeth Leslie, Program Manager, of the Partnership HealthPlan of California. In addition to their overview of the administrative and fiscal structure of the regional model, provider network management, contracting and credentialing, the Forum included a panel of county administrators who spoke about the benefits and challenges of participating in this innovative model. The counties were represented by Anne Lagorio of Modoc County, Toby Reusze of Siskiyou County, and Andy Williamson of Solano County. The Forum was capped by a discussion of PHC's plans for negotiations with Marin, Napa, Sonoma, and Yolo counties. While these counties are not participating in the Regional Model, the Waiver requires that each county develop a memorandum of understanding for the early intervention and coordination of services for shared Medi-Cal beneficiaries. DJ Pierce of Marin County spoke on behalf of the administrators.

As described in the Centers for Medicare and Medicaid Services Waiver Special Terms and Conditions the *"Drug Medi-Cal Organized Delivery System (DMC-ODS) is a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with substance use disorder (SUD). The DMC-ODS is a five-year pilot project intended to demonstrate how an organized substance use disorder system using a specialty managed care model of administration and delivery will increases the success of DMC beneficiaries while decreasing other system health care costs."*[1]

The DMC-ODS Waiver is a component of the larger Medi-Cal 2020 Waiver approved by CMS in 2015. Consistent with the Healthcare Triple Aim[2], it is intended to improve the patient experience, improve

[1] http://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCs12-22-17.pdf

[2] http://www.ihi.org/engage/initiatives/TripleAim/Pages/default.aspx

patient outcomes and to reduce overall health system costs. As reported in other Waiver Forum Briefing Papers[3] it is clear that the transformation of the current county alcohol and drug administrations to specialty managed care plans for Medi-Cal beneficiaries is a daunting challenge for counties. The new administrative and financial functions the Waiver designation as a Prepaid Inpatient Health Plan (PIHP), are significantly different than that of the current structure administrating and managing grant funded services. It is particularly challenging to small or rural counties with minimum base funding, as well as program and workforce gaps.

The Special Terms and Conditions of the Waiver, allows *"participating counties with the approval from the State [to] develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design."* Most importantly, the Waiver allows "*Counties [to] act jointly to deliver these services."* This flexibility for a regional model allowed the eight counties and PHC to envision and design a system for its shared beneficiaries using a whole person care model. Another of the unique elements of the Waiver is the requirement for coordination with other systems of care, specifically the healthcare system. This is new territory for most AOD agencies given the interface between the health care system and the alcohol and drug provider network has been largely undefined and underdeveloped.

Starting in 2015, seven of the northern most counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Trinity) and later Solano County (bay area medium sized county) started collaborating with the Partnership HealthPlan of California (PHC) to develop the Northern California Regional Model for DMC-ODS. The collaboration will allow access to screening, assessment, early intervention and a continuum of SUD treatment across the eight counties meeting the levels of care stipulated in the Waiver Special Terms and Conditions. Importantly, the Medicaid Final Rule 42.C.F.R. Part 438 applies to all managed care plans as well as the county Behavioral Health Services Departments who opt to participate in the waiver.

Participation in the DMC-ODS will bring significant federal financial resources to these eight communities. The new partnership will increase access to an organized continuum of SUD services directly linked to primary care. As noted by the county panel, this increase in access would be unachievable without this partnership. For PHC, the partnership is consistent with its vision and mission and the goals of the initiatives articulated in its 2016-2017 Annual Report[4].

The Partners

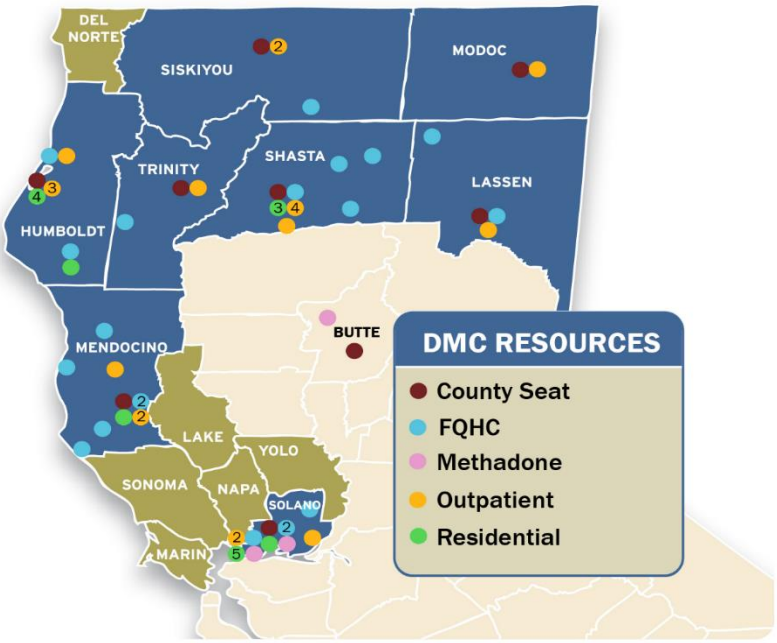
The initial seven counties range significantly in size, structure and resources. Modoc, the smallest participating county with a population of 8,700 sits in a rural area on the eastern Sierra foothills. Shasta, the largest of California's "small counties" has a population of 179,600, Recognizing the benefits of outsourcing the PIHP management, Solano County, a medium-sized suburban hub, with a population close to 450,000 in the bay area, signed on to the evolving partnership in the Spring of 2017.

Partnership HealthPlan of California operates in fourteen counties and it is the sole managed care plan in the eight participating counties. Of the close to 1 million individuals living in the diverse communities of

[3] https://www.cibhs.org/dmc-ods-waiver-forum

[4] http://www.partnershiphp.org/About/Documents/AnnualReport.pdf

the eight counties, including cities, suburbs, rural, and remote areas of the state, the Northern California Regional Model will cover coordinated services for physical, mental health and substance use disorders for approximately 285,000 Medi-cal beneficiaries. The beneficiaries are culturally diverse speaking 26 different languages with the most common languages spoken being English, Spanish, Russian, and Tagalog. The eight counties in the Regional Model share a variety of characteristics and needs including high rates of poverty and of substance use; poor health outcomes; rural geography; and many current challenges in the access to care.[5] The county governments are all part of the County Medical Services Program (CMSP) and the C-IV eligibility systems network.



Early on PHC recognized the value in collaborating with local, regional and state partners to advance its mission both in policy and service delivery. By assuming the financial risk, PHC envisions Increasing the access to services for its beneficiaries and ultimately generating cost savings for the delivery of appropriate up stream care vs. emergency care. The 2016-2017 PHC Annual Report prioritizes the work with counties and states the *"Regional Model for the Drug Medi-Cal Organized Delivery System, a program where members have access to a full continuum of substance use disorder services that includes withdrawal management, medication assisted treatment, short-term residential, case management, and care coordination with medical care, mental health, and recovery support services."*

Of the remaining six counties in which PHC administers the Medi-Cal benefit, only four have opted into the DMC-ODS Waiver (Marin, Yolo, Sonoma, and Napa). Negotiations to meet the Waiver Special Terms and Conditions requirement that "screening, brief intervention and referral to treatment (SBIRT) services are provided by non-DMC providers to beneficiaries at risk of developing a substance use disorder [health care providers] have started between PHC and these four counties." These referrals by managed care providers or plans to treatment in the DMC-ODS will be governed by the Memorandum of Understanding (MOU) held between the participating counties and managed care plans. The Northern Regional Model will provide "no wrong door" access for individuals or providers to either call a central assessment line for

[5] http://www.partnershiphp.org/Providers/HealthServices/Documents/Drug%20Medi-Cal/ODSWaiverImplementationPlan062017.pdf#search=DMC%2DODS%20IMplementation%20Plan

intake and entry into the appropriate level of care and/or allow for individual providers to assess clients and refer them to the appropriate level of care.

Overview of Northern Regional DMC-ODS Model

A key feature of the Regional Model is the coordination of a full range of physical health care, mental health and substance use disorder treatment services. The SAMHSA Center for Integrated Care recognizes that integration and/or coordination of services delivered in multiple configurations has been proven to improve health outcomes by providing comprehensive, patient-centered care to the safety net population. [6] In addition to developing the substance use service delivery model prescribed by the Waiver, the regional model will go further in facilitating the critical interactions and care coordination that is key to the effective treatment of the complex and chronic conditions often associated with substance abuse.

The Partnership HealthPlan of California will be responsible for the administrative, financial and quality assurance management, while the county behavioral health services division will provide implementation management, direct services, and specialty policy and practice expertise. The Counties will continue to be responsible for the administration of the Substance Abuse Prevention and Treatment Block Grant and other funding currently allocated from the DHCS, such as Public Safety Realignment (AB 109) and DUI funds.

For all counties opting into the DMC-ODS, the managed care administrative functions must adhere to the Medicaid Final Rule Standards. PHC will provide all compliance oversight and related management functions including the DHCS Readiness Assessment. This will allow the county Behavioral Health Services Departments to focus on the delivery of services, workforce development and supervision, evidence based-practice fidelity, and the improvement of client outcomes. A collaborative process has been established in developing the details of the model which will continue in the management and delivery of all future services.

The Agreement Vehicles

By opting in to participate in the DMC-ODS each county executes a State/County Agreement [Contract] with the DHCS to act as a Prepaid Inpatient Health Plan (PIHP), stipulating that the county agrees to comply with the 1115 Special Terms and Conditions, as well as the CMS Medicaid Final Rule. Each county will in turn sign an Agreement with PHC for the defined components of administrative and fiscal management. The structure and cost efficiency of a centralized management model for these eight counties allowed the participation in the DMC-ODS Waiver. This model also allows for greater flexibility in the development of the provider network serving the region.

The role of PHC in the DMC-ODS will include the following managed care plan functions:

Enrollment-Related Functions, including outreach, Access Line, Compliance officer responsible for fraud prevention.

[6] https://www.integration.samhsa.gov/about-us/what-is-integrated-care

Member Services, including a Member handbook in all languages, and a Provider Directory. All the information will be available to consumers on the PHC web site.

Administration and Management, including utilization review, prior authorizations for residential and recovery housing services,

Credentialing, including record keeping of all DMC individual providers and compliance audits

Solicitation and Management of provider contracts. It will be PHC that will execute all agreements with all providers integrating uniform administrative elements and practice requirements.

Network Adequacy including monitoring compliance with federal access requirements including access for individuals with disabilities and cultural and linguistic access

Beneficiary Management including the mandated Grievance, Appeal, and Fair Hearing Processes and the UCLA Treatment Perception Survey

Quality Assurance including the collection of data and multiple responses to the DHCS Readiness Reviews, development of the Quality Management Plan, collection and submission of the External Quality Review Outcome Data and development of Performance Improvement Plans. All done in collaboration with the eight Behavioral Health Services Departments

Coordinated Staff Development and Training including ASAM assessment and clinical decision making, motivational interviewing, cognitive behavioral treatments, and other evidenced based not only for SUD staff but also health and mental health practitioners. All practitioners will be trained in the principles, practices and workflows of care coordination.

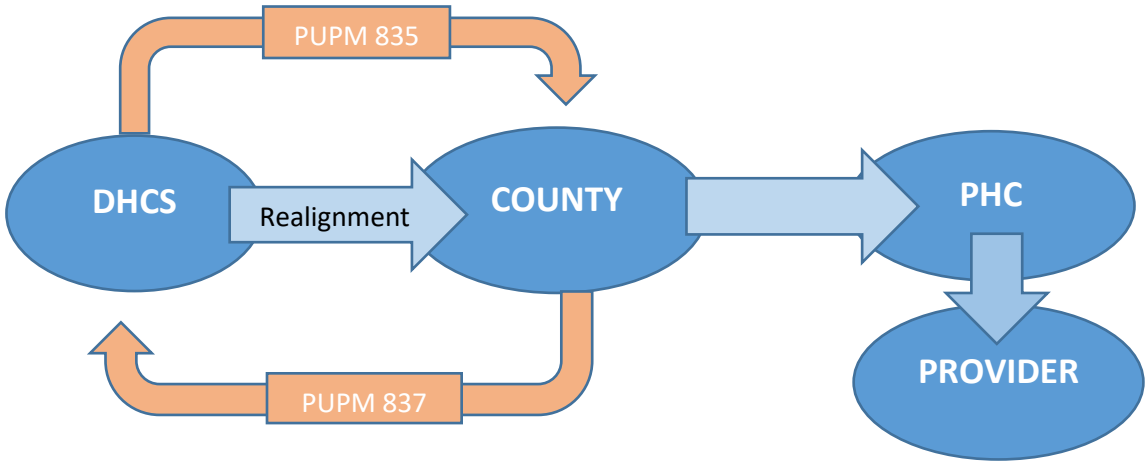
Regional Model Infrastructure Management, including billing and payment systems, collection of encounter data and analytics, annual rate setting, population management analytics

Care Coordination for substance use disorder, mental health and physical health including facilitating successful transitions between levels of care; assigning care managers to complex cases Facilitate access to mental health and physical health services. Most importantly collaborate with BHS Departments to engage in multi-party bi-directional communication using uniform Release of Information policies and procedures

Financial Structure of the Northern Regional DMC-ODS Model With clear management and delivery goals and objectives, the collaborative had to construct a financial plan to support this new business model. Negotiations with DHCS are in process. As stated each county will execute the State/County Intergovernmental Agreement in which the county will designate PHC as the legal entity responsible for or all managed care functions. This new arrangement will not only require the DHCS to develop a Model Specific Agreement but also a Modified Certified Public Expenditures Protocol. This CPA requires approval by CMS for the regional model.

Rather than a fee for service rate as in all other participating counties, a per utilizer per month rate (PUPM) has been proposed by the participating counties in the Fiscal Plan. This PUPM structure aligns with fiscal structures currently used by DHCS for the financing of other managed care plan programs and services. Each participating county has calculated and will contribute an appropriate share of its realignment funds and associated federal matching funds to support the utilization model under contract with PHC.

In developing the Fiscal Plan, rates for services were established across service modalities in the eight counties. These rates are provisional for the first year of operation. In its administrative role, PHC will negotiate contracts and rates with each county direct service unit and community-based provider in the network using these uniform rates. For Narcotic Treatment Providers the DHCS established rates will be will be used.



Northern Regional Model: Flow of Funds

Negotiations with DHCS and CMS are ongoing over Interim Cost Settlement and Final Cost Settlement structures. Consistent with other managed care plan contracts, the Fiscal Plan submitted proposes that there will be no cost settlement. The "risk" for the costs of care will be borne by Partnership HealthPlan. Simply put, if the costs exceed estimates, the Plan will absorb the loss. Consistent with its historical commitments to the community, PHC awarded $2 million in grants in 2017 to ten organizations that will be part of the Regional Drug Medi-Cal model, to increase service delivery capacity and improve services.

Benefits and Challenges

The administrator panel outlined the benefits and the challenges of the evolving partnership. What appeared very threatening with insurmountable risks initially developed into a positive solution- oriented collaboration. Much of the cross system and bidirectional communication was new and with time and persistence the path forward emerged gaining momentum as each challenge was faced. First and foremost, the administrators recognized that PHC offers a management team knowledgeable and experienced in the functions and operation of a managed care organization. Additionally, PHC's existing administrative and fiscal operations can be adapted and tailored to include the DMC-ODS requirements, meeting quality assurance, utilization review, reporting and compliance requirements. Building this infrastructure is both complex and costly under any circumstances. Efficiencies of scale and volume were significant and the fiscal and administrative barriers for small counties are mitigated.

The fact that the provider network will be managed across county boundaries, allows clients to receive services outside their county of residency. An issue that has not been fully streamlined in other counties. PHC can also affect other parts of the health care system including medical primary care and specialty providers. Telemedicine is widely used by PHC and services are frequently provided by community clinics

providing established protocols to expand capacity and access. This partnership will allow the organized coordination of all aspects of healthcare – physical health, mental health, and substance use disorder. While PHC's investment in the system will, overall, be greater than the expected savings, expected benefits of the model include reduced emergency room and hospital costs and, more importantly, improved quality of care and outcomes for Medi-Cal beneficiaries.

Challenges

There have been and will continue to be many challenges as the DMC-ODS is implemented. Many of these challenges are faced by all counties moving to the DMC-ODS; however, the solutions are quite different for very small, small, and medium counties than larger counties. On the service delivery level, the SUD has been a loose federation of providers, many practicing in the tradition of a social model approach, with non-licensed staff providing services. Evidence based practices have not been required and many providers do not have electronic health records.

While PHC brings the MCO experience to the table for the Northern Regional Partnership, PHC is not a county entity and so is not a participant in venues where DMC-ODS decisions are developed and crafted. PHC is not necessarily in the communication flow that has historically existed between Counties and the State. The small counties note that DMC is not the only administrative or funding component of AOD system. Other components which remain with the Counties create added coordination requirements (SAPT, EPSDT, Prevention and Youth set asides, DUI, Public Safety Realignment). There has been no alignment by DHCS of the of the DMC-ODS Agreement with the historical State/County Contract that provides administrative and financial management structures. This is understandable given the uncertainty of future federal priorities, all other funding will continue to be managed through a discrete State/County Contract.

Hammering out the details of an alternative payment methodology with the DHCS has proven difficult. Complicating the effort, each relationship State/County; County/PHC; PHC/Provider must be developed and finalized in contract. Emerging concerns included the interface with the new hub and spoke clinics which are not administered through the counties; gaps in workforce and the on-going engagement and development of the existing workforce across all disciplines and sectors in the new model. The new model will impact the current criminal justice relationships and referral pathways significantly and access for the re-entry population throughout the region.

Closing Summary

Once the fiscal plan is approved the development of the components of the partnership will continue to be incremental. There are many factors outside of county control or plan control that will shape the future. However, the issues surrounding access to care and health care costs will remain a critical issue. The impact of chronic disease on these costs if untreated will continue. The principles of the Triple Aim, Whole Person Care and Coordinated Care are foundational in developing and improving health care and provide a framework for system innovations. There will be much to learn and consider as best practice for future policy consideration from the Northern Regional Partnership Model once implemented.