Developing the Infrastructure to Transition to an SUD Managed Care System

Briefing Paper from the DMC-ODS Waiver Forum held on September 29, 2016

Elizabeth Stanley-Salazar, M.P.H.

With the support of the Blue Shield of California Foundation, the CIBHS DMC-ODS WAIVER FORUM creates a collaborative think tank to support county behavioral health and substance use disorder leaders in the planning and implementation of the Drug Medi-Cal Organized Delivery System. Working with the CBHDA SAPT Committee, the first FORUM was held in September 2016 and focused on the transition from the current county alcohol and drug services administration to a specialty managed care organization.

Background - The Opportunity

The administrators in attendance recognized that the Waiver offers a substantial opportunity to use federal funds to transform the current limited alcohol and drug service delivery network in California. The Waiver improves and expands consumer access to treatment services reimbursable under the Drug Medi-Cal program. It standardizes service delivery using evidenced based practices and a chronic disease model of care. It strengthens the county oversight of network capacity and financing. It initiates first steps to coordination and integration across public delivery systems. For the first time, Medi-Cal beneficiaries will have access to a continuum of care defined by the America Society of Addiction Medicine Criteria in counties that opt into the Waiver (TABLE I). These services will generate significant federal financial support. The Waiver requires changes in the delivery of services and clinical practice, in addition to a restructuring of the county administration and operational functions.

Table I: DMC-ODS Continuum of Care Elements

- Early Intervention (through Managed Care Plans)
- Outpatient Services and Intensive Outpatient
- Residential (*not restricted by IMD exclusion*)
  (ASAM Designation required)
- Narcotic Treatment Program
- Withdrawal Management (at least one level)
- Recovery Services
- Case Management
- Physician Consultation
- Medication Assisted Treatment
- Optional: Partial Hospitalization

The Components of a Managed Care Organization

Today, the public mental health services for the seriously mentally ill are already organized as a discrete county Specialty Managed Care Organization, and services for the mild to moderately impaired are delivered by the Managed Care Plans. At the practice level, limited integrated services for co-occurring conditions can be found. All administration, payment, and accountability functions flow through discretely managed, regulated and procedural systems housed at the Department of Health Care Services in multiple divisions. The Waiver designates the county as a Specialty Managed Care Organization for substance use

disorder treatment called a Prepaid Inpatient Hospital Plan (PIHP). The SUD delivery system will remain a carve-out.

Managed care models operate using centralized screening, assessment, and utilization management that are designed to contain costs by reducing unnecessary and inappropriate care and improving quality. Ultimately, managed care utilizes financial incentives and management controls intended to direct individuals to efficient providers who are responsible for giving appropriate care in cost-effective and clinically proven settings. The "tools of the trade" are benefit design, utilization management, quality assurance and quality improvement protocols, information system capacity, and alternative payment mechanisms. There is concern about the impact of cost containment on quality care. The inherent danger with cost containment is undertreatment and un-duly limited access to necessary care. As a result, there is an increasing focus on the development of policies and procedures for assuring adequate quality through an External Quality Review Organization (EQRO). New requirements are spelled out in the DHCS-County Waiver Agreement for these quality assurance and utilization review systems.

Current alcohol and drug services in California have been developed, administered, and funded largely as capped county allocations under the Substance Abuse Prevention and Treatment Block Grant. The requisite DMC-ODS centralization of access and uniform delivery standards are only in place in a few counties and only to a limited extent in others. Historically, this has resulted in an autonomous collection of mission driven, community based organizations. In this under-resourced collection of services, the community based provider network is limited both by program design and in the numbers of a qualified workforce to meet the program standards and regulations required of a Medi-Cal provider in the ODS.

Fifteen counties have submitted their implementation plans to date. With the introduction of non-Medi-Cal funds, local general fund, and criminal justice realignment funds, these medium to large counties have incrementally invested in uniform client assessment, matching to level of care, utilization management and local program innovations and partnerships allowing them to pivot to DMC-ODS.

Our Presenters

Ron Kercheval of Advocates for Human Potential (AHP), Inc kicked off the Forum with an overview of the elements of an effective Managed Care Organization. He outlined the functional administration and the operating environment for a public agency as a manager of benefits, payment, and quality control.

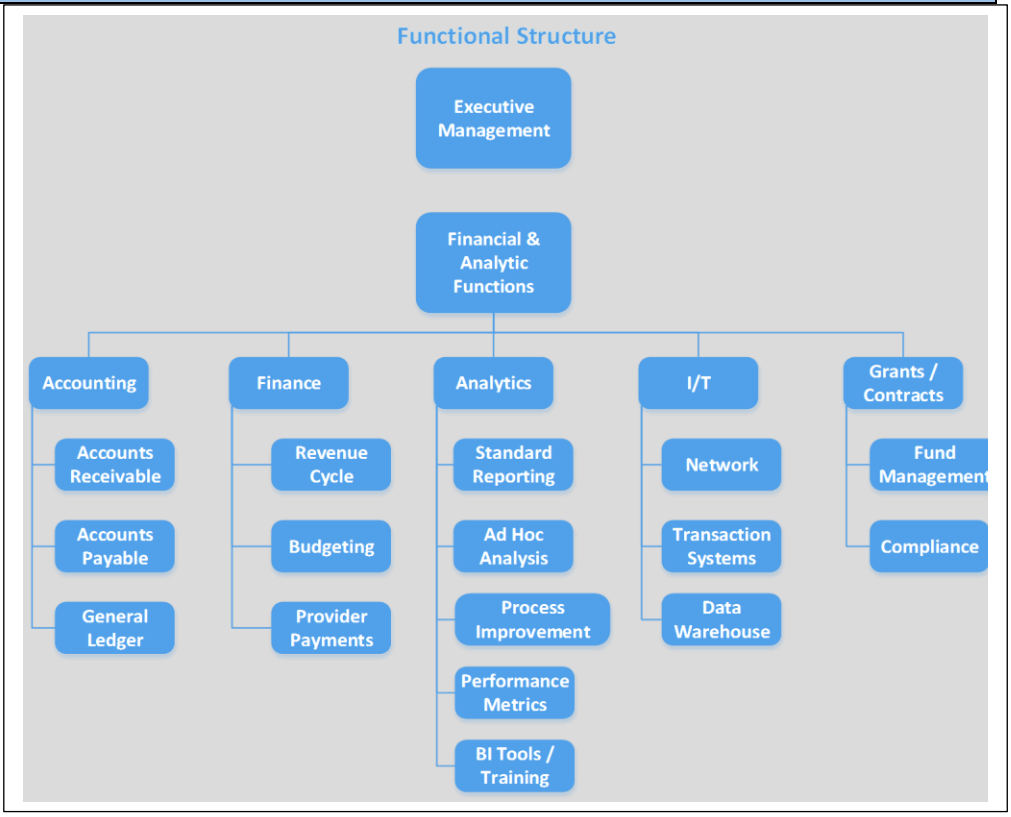
Rama Kahlsa, Ph.D. of Behavioral Health Concepts, Inc. (the Department of Health Care Services' EQRO subcontractor for the DMC-ODS Waiver) presented an overview of the administrative components of quality improvement and the role of the local administrator in improvement vs. compliance management.

Mr. Kercheval pointed out that the risk bearing nature of the Waiver for the counties requires reconstructing many of the system functions currently in use, including: network development with call center, centralize utilization management; selective contracting; compliance; data solutions; care

coordination; and new service design. He suggested an operational structure for the county management of these functions (Table II).

Some of the most significant changes in function that were discussed are in the areas of claims management and processing, as opposed to pass through administrative functions. This will require information technology redesign and solutions with interoperability. Ultimately, incentivized alternative payment mechanisms that consider the high utilizers of service and their complex needs are needed for the success of the managed care model. The Waiver will create the uniform implementation of a fee-for-service payment mechanism. This payment mechanism in and of itself is only a first step to the implementation of managed care goals.

TABLE II: Financial and Analytic Functions (*chart created by AHP, Inc)*



In summary, Mr. Kercheval, pointed out that data analytic functions are closely related to financial functions and utilization management. Managed care is simply impossible without meaningful data systems, sophisticated analytics and the ability to share this data with necessary internal and external partners. He emphasized the difficulty of a small free standing operation taking on these operations, and supported the idea of shared functions across counties and /or partner agencies and regional models of operation. He noted that there is a cost-effective tipping point related to volume of services that must be achieved in financial and risk management. It is important to note that in opting into the DMC ODS, each

county will use Drug Medi-Cal (DMC) as the primary payor for beneficiaries. Other funding sources including the Substance Abuse Prevention and Treatment Block Grant will be used to cover services not reimbursable by DMC and for those seeking services who are not eligible for Medi-Cal enrollment.

Dr. Khalsa focused on the role of the PIHP administrator in the new county - beneficiary relationship, as defined in the new DMC-ODS DHCS-County Agreement. Ownership by the administrator of the quality mission, message, and improvement initiatives is the key to a positive consumer experience and outcome. Dr. Khalsa outlined the core quality values as including individualized treatment, timely access, active treatment engagement to optimize recovery, coordination of care within and across systems, and recovery supports to acknowledge the needs of the individual for sustained recovery. BHC is working with counties to integrate the ASAM standards and knowledge into the delivery system, the data system, and into planning. Dr. Khalsa and members of the EQR County Clinical Committee offered specific metrics and their current use in decision making. She recommended that there are core elements in the mental health system infrastructure that can be leveraged to implement and be successful with performance improvement plans and quality goals

County-to-County Collaboration

The participants broke into to small groups facilitated by county leaders who have been successful in the submission and negotiation of their county implementation plans. The following is a summary of the dialogue and key recommendations that emerged in these discussions.

The participants were assigned to one of five groups based on size and geography – two small county groups; two medium sized county groups; and one large county group. Overall, the participants resonated to the concepts presented and proceeded to engage in collaborative deep dive discussions to answer the following questions:

Given the new functions, skills, and resources needed to administer a Prepaid Inpatient Hospital Plan, how have you considered transitioning from the current structure (allocated grant management) to a managed care organization?

What are the county system assets and most significant challenges that exist for quality improvement?

What are the key tipping points that would turn the corner towards implementation?

What are options for internal and external support?

The questions were intentionally open-ended and each group approached the discussion from a slightly different perspective. The starting point or baseline for each county as they consider the implementation of an organized delivery system is very different. The diversity of county size, geography, population characteristics, funding streams, historical AOD delivery framework, existing community based providers, public system partners, and stakeholder support the concept of local control for service delivery. This

diversity also has inherent challenges and barriers to the statewide DMC-ODS implementation. Size, resources and foundation matter.

Table III: Strengths of the Current Opt-In Counties

- robust funding from non-DMC sources
- support from other county funding sources
- an incrementally developed infrastructure
- high and predictable DMC utilization
- existing call center or centralized access
- strong providers reflecting all levels of care
- utilization of medication assisted treatment
- diverse, experienced and recovery oriented workforce
- credentialed providers in SUD workforce
- providers using electronic records
- strong county-provider relationships
- partnerships with health plans
- collaboration with BHS in QA/QI efforts
- data collection with analytic capacity

The counties identified strengths that exist in the current opt in counties to one degree or another. Those counties that have opted into the Waiver have built the ODS Implementation Plan using these strengths. The summary of the county discussions that follows sheds light onto the challenges, barriers and the possible enhancements needed for success.

Infrastructure, Up Front Costs and Risk

The PIHP administrators will manage access and utilization vs. the distribution of scarce block grant resources. Budgeting, rate setting, and billing structures based on costs or volume of transactions will be changed, initially to fee-for service and case rates and in the future to value based performance contracts. The county will be responsible for a beneficiary access hotline; authorization for residential services; care coordination with Primary Health Managed Care Plans and the Specialty Mental Health Systems; quality improvement activities; and all utilization management including authorization for residential services. Counties opting in are required to build a county administrative and operational infrastructure that supports the Terms and Conditions of the Waiver as contracted in the new state county agreement. There is uncertain financial risk to the county as well as uncovered costs.

The administrators agree that the opportunity to negotiate new interim payment rates (county specific) is a chance to reverse a long history of low and inadequate reimbursement for services and establish parity for mental health and substance use disorder treatment services. The fact that there is little historical data and little experience related to DMC record keeping, billing, and data systems creates much uncertainty for both counties and providers. Additionally, it was noted that setting rates will be difficult due to the historical funding of “social model” programming. The medical necessity based on assessment and diagnosis practice mandate changes the California AOD paradigm to a “clinical model” increasing workforce specialization and expenses considerably. Additionally, many counties have had very low utilization of drug Medi-Cal and some none. There is insufficient data to forecast utilization and expenditures.

Many counties have experience with fee for service contracts with providers; however, the payment mechanisms within the DHCS-County Waiver Agreement are new. The counties must maintain the structure of the block grant financial management while instituting discrete DMC-ODS Waiver Agreement terms and conditions. Counties report that the limited administrative overhead payments currently available through DMC will not cover the future infrastructure. The pressing questions raised by everyone

are (1) how do we move from fee for service to alternative payment and accounting mechanisms including capitation? and (2) how quickly do we do it?

The lead counties noted that existing county structures, workflows, job descriptions, and current county AOD workforce must be reconsidered in this transformation. Current system components can be leveraged to build a new administrative foundation. However, this will not address the immediate and overall need for enhanced data systems designed for utilization management and population management. Larger counties can leverage existing internal resources and pivot to this transition. Those counties that have some level of a coordinated system of care; those that have existing partnerships with other key county stakeholder agencies, such as health or managed care plans; and those that have been able to leverage these partnerships are moving ahead.

Network Adequacy

All counties agree that meeting network adequacy requirements and maintaining access to the continuum of care in accordance with the Final Medicaid Rule will be one of the most challenging transformations of the current system. This will include expanding residential services and medication assisted treatment; expanding withdrawal management services working with health care system and medical providers; and recruiting and integrating Licensed Practitioners of the Healing Arts into the ODS. With few exceptions, the ASAM standards which define modalities, setting, and staffing have not been widely used.

The administrators recognize that the "passion and resolve" of those who work in the field at very low wages over many years has subsidized the services to individuals suffering from SUD. As noted earlier, much of the work is performed in autonomous, loosely connected community based agencies. These agencies have knowledge of their communities, the social determinants of health, and the ability to provide culturally responsive services. These agencies work also with high risk clients with complex needs that others in the health care delivery systems do not. Within the current system there is a strong focus on recovery and a commitment to personal responsibility. On the negative side there remain gaps in the use of evidence based practices and in the understanding of the episodic chronic nature of relapse. There are of course notable exceptions and best practices in counties that have incrementally built systems of care.

The operational challenges for community based substance use disorder treatment providers are many. The costs of retooling internal systems and of startups are significant. There are no startup or ramp up funds associated with this initiative. In theory, the costs will be "covered" in rates once client utilization and volume is at capacity. Counties noted that MHSA for example included innovation, technical assistance, ramp up and startup costs. There was strong agreement that strategic consideration and planning for overcoming the barriers to network adequacy needs to be addressed at a state level by DHCS and not only at a county level. There are soft costs such as licensing, certification, training and workforce development, technical assistance and telehealth. There are hard costs associated with siting new facilities, expanding programs, and IT equipment and systems costs.

All programs will require the integration of Licensed Practitioners of the Healing Arts, including a Medical Director, in each program. Currently the trained and qualified workforce does not exist in the numbers needed. Workforce development is just one the issues that will require a strategic and coordinated approach by a myriad of state, county, provider and academic agencies.

Regional Innovation

Participating counties with the approval from the State may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. With this flexibility in mind, eight of the small northern counties have been working for two years with Partnership Health Plan (PHP) to form a regional partnership for the administration of the organized delivery system while maintaining individual county integrity. In this model, PHP will provide administrative oversight, quality and utilization management, data management, analytics, and financial functions including selected contracting. Outcome measures will be established collaboratively and measured uniformly. The Behavioral Health Services Division of each county will continue to be the primary provider for all non-residential services. The BHS units deliver both substance use disorder services and mental health services in their respective counties. This partnership permits access to medication assisted treatment through primary care physicians as well as narcotic treatment programs under contract. PHP and the counties are proposing a capitated rate (per member/per month) to DHCS and CMS. There are many efficiencies that will be achieved in this model, including provider regional contracts. Training for both medical personal as well as SUD personnel can be managed efficiently and coherently. PHP is investing in the upfront costs and taking on the risk. Housing remains a key challenge; however, options for support may be feasible to a collaborative that are not county by county.

Other small and frontier counties have few options for several reasons. Regionalization has been viewed as a partnership with managed care plans and many of the managed care plans have yet to see the business case for these partnerships. The counties have not yet explored sharing administrative functions across county lines or sharing a centralized call center and/or financial management subcontractor. There remain too many uncertainties for under-resourced counties to opt into the Waiver.

Data Management, Analytics and Sharing

The success of the DMC-ODS rests on collecting, tracking, monitoring, managing, sharing and analyzing beneficiary data from first beneficiary contact throughout the continuum of care. Shared data is essential to managing access, establishing utilization controls both through available service data banks and treatment authorizations. Dr. Kahlsa emphasized that measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making lead to improvement. Measurement for improvement should not be confused with measurement for research. Working with the counties, Behavioral Health Concepts has formed a County Clinical Committee that is developing uniform performance measures.

As noted by Mr. Kercheval, data analytic functions are closely related to financial functions, the revenue cycle and to utilization management. The current “data warehouse” i.e. CalOMS is not designed for these

functions and is currently embedded in many county data systems. Compounding the implementation of the ODS, many providers throughout the state have not initiated the use of electronic client records. The lead counties are actively engaged in retooling their data systems. However, state level strategic planning and action to address these macro data issues is critical.

Two immediate challenges to the organized system will be local centralized screening and the matching of clients to appropriate levels are care. Knowledge of capacity and service availability is necessary for a 24/7 access function. Once an individual accesses the system, the coordination between appropriate levels of care will be required. Data necessary for these functions is shared between the management system and the providers. Data sharing is not limited to the internal workings of the organized delivery system. Care coordination amongst other treatment systems presents its own set of challenges not the least of which is confidentiality and privacy rules. Counties are developing uniform consent based tools for the sharing of information.

These electronic record, IT system design, and interoperability costs are uncertain and for a large part uncovered costs. The interoperability challenges are enormous. The administrators are keenly aware that the current IT capacity and specialist workforce is not embedded in their operations. They are thinking of the economies of scale, shared backroom functions and analytic specialists. Administrators shared their perceived strengths and plans for the next steps for their counties.

In San Francisco, the capacity to measure and monitor data about access to SUD services and transitions exists. Collecting mental health episodes, claim data and the tracking of medication use is strong. The current challenges for San Francisco are monitoring medication assisted treatment and exchange of client primary care information.

In Alameda, the initiation and engagement measures are under development as well as the tracking of the services delivered to meet program and access standards and follow up. Tracking the levels of care and how many transitions occur between levels are challenges. The federal and state data sets currently open and close each episode and do not recognize a continuum of care. The rules governing all documentation are based on these discrete episodes vs diagnoses.

Counties like Fresno, with client electronic systems, are working with IT vendors to enhance the systems to reflect integration of systems and using managed care models for metric development. Administrators expect that the Whole Person Projects in their counties (where they are awarded) will accelerate solutions to these many IT challenges. All agree, population health management is not possible without the sharing of client data.

Care Coordination and Partnerships with Other Systems of Care

Care coordination has been identified by the Institute of Medicine as a key practice strategy for improvement of effectiveness, safety, and efficiency of the health care system. It also has the potential to improve outcomes for those served. Currently the average client receiving SUD treatment is not accessing the full continuum of care required by the Waiver. In many counties, the ASAM levels of care simply do

not exist. The pathways and workflows to support care coordination between providers, agencies and systems also do not exist. Most clients today are referred and admitted to community based providers for an episode of treatment and when completed referred to "aftercare" within the same agency.

Coordination through a centralized access point will require tracking pre-admission activity and movement of all clients in the system. Most counties submitting plans have described "no wrong door" procedures and have strengthened provider roles in screening, assessment and case management. The promising practices outlined by counties strengthen the centralized county role in Quality Assurance and Utilization Management including pre-authorization for residential services and complex case management.

Each opt in county has submitted a description of a seamless transition of care for beneficiaries between levels of SUD care without disruptions to services. The Waiver not only requires this care coordination of client services within the organized system of services; but also, the coordination of care with primary care. To accomplish this requirement, each county is required to enter a memorandum of understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS.

As noted earlier, the sharing of information is the foundation of care coordination. This can conflict with current patient confidentiality rules and practices for each specialty arena. The administrators emphasized new state and federal rules and guidelines for consents for release of information and data exchange are needed. The current practices are deeply embedded in the service systems as well as county legal departments.

New partnerships must be forged with the health care system. The role of health care is defined at the front end of the continuum of care and at the backend. Health Plans are responsible for early intervention using screening and withdrawal management that requires hospitalization. The communication pathways, role definition of practitioners, and workflows are to be developed and implemented. One of the greatest needs for successful implementation is cross functional training of the workforce both on the SUD and primary care side of the landscape.

The administrators noted the treatment modality that will require the most dramatic change is withdrawal management, commonly known as detoxification. Adherence to the ASAM structure, creating levels of care for assessment and management of safe withdrawal will require coordinated clinical practice using six ASAM levels of withdrawal management. At the most severe, medically managed withdrawal management will require streamlined pathways to hospital based services. The structural changes to diagnostic and billing codes need immediate attention to ensure participation of the health care plans and medical providers in the continuum.

As with all other aspects of this new continuum of care, counties have developed unique local configurations of services, innovative projects, and partnerships with these agencies. Care Coordination is one of the key concepts of providing comprehensive "whole person care." Counties have successfully

used the co-location of mental health services as a common tool in emergency departments, county jails, and courts. While there are SUD co-location projects, such as drug court, these are limited in scope and practice. The Waiver accelerates the momentum for the integration of SUD and health care services.

The Substance Abuse and Mental Health Services (SAMHSA) – Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions has provided grant funding for the integration of primary care and behavioral health services. These new projects have been limited but as the DHCS pursues system reform and beneficiary access expands, new partnership models will emerge.

As with network adequacy, one of the greatest challenges to integration is at the practice or service level. Because the mental health and substance use treatment systems have existed in two distinct silos, the workforce has not developed the requisite integrated clinical practice competencies, protocols, and guidelines to treat co-occurring conditions routinely. Whole Person Care initiatives will begin to change the delivery landscape. However, leadership and workforce investment is needed to enhance SUD treatment knowledge and cross train the MH and SUD practitioners. Many more Licensed Practitioners of the Healing Arts with the training and competencies to work in an integrated practice environment are needed.

Summary

In summary, the feedback received from this collaborative meeting identified the challenges ahead and lessons learned by counties that have submitted and negotiated Implementation Plans. These challenges in some counties may become insurmountable barriers to participation. There was recognition that many of these challenges cannot be resolved on a county by county basis and without a statewide framework for policy and procedural solutions.

All counties agree there are costs associated with this major restructuring that require the full attention and support of local and state funders and administrators. There has been very limited state investment in this initiative to balance the local investment required for implementation. Despite these challenges, the commitment and willingness to meet the intention of the Waiver and to increase access is held by all administrators.

The business case for support from the county health authority, the board of supervisors, the health care system, community based providers and the criminal justice system to opt must be made strengthened and made transparent. Marketing of this business case for access to substance abuse disorder treatment services remains one of many priorities. The day ended with each administrator recognizing that strong leadership, partnerships, and communication is necessary and will provide tipping points for change.

Key Strategies Going Forward

A consensus emerged from the day on the key strategies for counties going forward:

- ☐ Educate local government agencies, partners, and providers about the Organized Delivery System, the ASAM Treatment Model and managed care paradigm
- ☐ Make the business case for the expansion of a continuum of care for beneficiaries for health care savings
- ☐ Create a consumer education and engagement campaign
- ☐ Strengthen regional partnerships and other functional sharing models
- ☐ Define statewide uniform outcome metrics utilizing ASAM as foundation
- ☐ Develop data /analytics training for county staff working in the ODS
- ☐ Strengthen care coordination innovations to manage transitions and achieve outcomes
- ☐ Maximize county MAA claiming to support resource needs
- ☐ Explore all legal possibilities for sharing data and merging with other systems
- ☐ Use mental health system claiming experience and structures such as QA claiming for SUD on cost report like MH
- ☐ Develop partnerships outside of current provider network
- ☐ Build political capacity through partnerships with mental health and health care service agencies
- ☐ Merge call centers across all county or regional services (example Mendocino 911 for health and all other services)
- ☐ Develop, fund and ramp up new services (residential and NTP) including regional services though innovation projects Increase cross- county collaboration and share county procedures and business agreements

There was also a consensus on the need for intergovernmental collaboration and strategic planning in the following areas:

- ☐ Explore alternative payment mechanism pilots and funding incentives with DHCS and CMS
- ☐ Simplify and integrate the SAPTBG administrative and cost reporting requirements
- ☐ Work with foundations to fund educational and communication campaigns, implementation components, and infrastructure development
- ☐ Develop a statewide workforce initiative working with educational institutions and certifying bodies needed including career path development and LPHA educational and cross-functional training
- ☐ Fund data system, analytics and interoperability capacity in a managed care paradigm