## Appendix 2 Framework for Shared Accountability: Coordination and Alignment Strategies for Integrated Delivery of Behavioral Health Services

This section proposes a framework for shared accountability for coordinating and aligning the delivery of behavioral health services between demonstration health plans, county-administered mental health plans (MHPs) and county substance use disorder agencies. CMS and stakeholders requested greater detail on this aspect of the demonstration. Specifically, CMS requested a more detailed description of a shared accountability strategy to achieve the demonstration aims of seamless access to services and reduced cost shifting for individuals receiving county-administered specialty mental health and Drug Medi-Cal services, both of which are not proposed to be included in the capitated payments to health plans.

The framework described here recognizes the value of existing service delivery structures and aims to build on this existing infrastructure to improve coordination and meet the demonstration goals. Further details will be developed in the MOU between DHCS and CMS and in health plan contracts. Stakeholders also have an opportunity to comment during the 30-day federal comment period.

**Background**

Behavioral health conditions, including mental illness and substance use disorders, are prevalent among dual eligible beneficiaries. For Medicaid beneficiaries with common chronic conditions, health care costs are as much as 75 percent higher for those with mental illness compared to those without a mental illness[[1]](#footnote--1) and the addition of a co-occurring substance use disorder results in two- to three-fold higher health care costs.[[2]](#footnote-0) Among dual eligible beneficiaries, national estimates show that 44 percent have at least one mental health diagnosis.[[3]](#footnote-1) The prevalence of serious mental illness among dual eligible beneficiaries under age 65 is at least three times higher than for those age 65 and older.[[4]](#footnote-2) Meanwhile, substance use disorder, with and without co-occurring mental illness, is more prevalent among dual eligible individuals than among Medicare-only beneficiaries.[[5]](#footnote-3)

**California’s Behavioral Health Services Delivery Infrastructure**

Dual eligible beneficiaries in California receive mental health services through three separate funding sources: Medicare, Medi-Cal and programs funded by the Mental Health Services Act (MHSA). Medicare pays for outpatient, community-based treatment and most acute inpatient psychiatric admissions for people who are dually eligible. Medi-Cal and MHSA fund specialty mental health services for individuals with severe and disabling mental illnesses as defined in Welfare and Institutions Code Section 5600.3. These recovery-focused “specialty mental health services” have been realigned to the counties in accordance with the Mental Health Adult and Older Adult System of Care as set forth in Welfare and Institutions Code Section 5806. Dual eligible beneficiaries receive limited substance use services through Medicare and Medi-Cal. Substance use covered benefits are significantly less comprehensive than mental health benefits.

**County Specialty Mental Health Services**

Through a Section 1915 (b) “freedom of choice” waiver, all individuals who meet specified medical necessity criteria[[6]](#footnote-4) receive specialty mental health services through the County Mental Health Plans (MHPs). Under the provisions of this waiver, the county mental health plans are considered prepaid inpatient health plans (PIHP) because they are responsible for assuring 24 hour, seven day a week access to emergency, hospital and post stabilization care for the covered psychiatric conditions for Medi-Cal beneficiaries. California also has two approved state plan amendments (SPAs) that increase the scope of outpatient, crisis and residential and inpatient mental health coverage provided to Medi-Cal beneficiaries when medically necessary, by the mental health plans.

* The first, which was updated and approved by CMS in December 2010, covers targeted case management for individuals with mental illness. [[7]](#footnote-5)
* The second, which was updated and approved by CMS in October 2010, covers mental health services available under the Rehabilitation Option, broadening the range of personnel and locations that were available to provide services to eligible beneficiaries. [[8]](#footnote-6)

In June of 2006, the California Code of Regulations (CCR) (Title 9) governing the payment for and delivery of specialty mental health, emergency and psychiatric hospital services to eligible beneficiaries in California became permanent. In addition to the required contract between DHCS and the MHP, these regulations form the basis for the access, beneficiary protection and payment provisions governing operation of the MHPs. Through the process of successive 1915(b) renewal applications it was determined by CMS that the MHPs are subject to Code of Federal Regulation (CFR) Title 42, Part 438 Managed Care requirements. Among other things, these federal requirements specify additional access, beneficiary protection and quality management requirements that the MHP must conform to, many of which are specified in the contract. About 28 percent of the roughly 240,000 adults served by the county mental health plans are dual eligible beneficiaries (see Table 1 for more details).[[9]](#footnote-7)

**Table 1: Dual Eligible Clients in California’s Specialty Mental Health Services**

|  |  |
| --- | --- |
| **COUNTY** | **Dual Eligible Clients** |
| Los Angeles | 16,829 |
| Orange | 1,632 |
| San Diego | 3,276 |
| San Mateo | 1,979 |
| Alameda | 3,488 |
| Santa Clara | 3,226 |
| Riverside | 3,123 |
| San Bernardino | 2,931 |
| 8 County Total | 36,484 |
| Statewide Total | 67,776 |
| Based on Short-Doyle Approved Claims for FY 2009-10 |

Both federal and state code and regulation require a contract between the State and the MHP specifying the conditions under which the managed care program will operate. State regulation specifies the process for developing changes to the contract, and the current waiver indicates that the contracts shall be in effect for three-year periods subject to amendments, as necessary. The regulations and contract also specify requirements for the coordination of health and mental health treatment between the county and the state contracted health plans. One component of this coordination of care is the requirement that a memorandum of understanding (MOU) be in place between the county and each health plan specifying the respective responsibilities and protocols for timely referral and treatment of the beneficiary’s health and mental health conditions.[[10]](#footnote-8) Some demonstration health plans already contract directly with the county behavioral health agencies to ensure seamless care delivery, and others are working with behavioral health administrative service organizations to coordinate services across the care continuum.

**Drug Medi-Cal**

All Drug Medi-Cal (DMC) services are outpatient services. Services available through DMC include individual and group counseling, narcotic replacement medication and counseling, naltrexone services for opioid dependence, residential and day care rehabilitation treatment for women who are pregnant or within the prescribed postpartum period, and day care rehabilitation treatment for full-scope Medi-Cal beneficiaries under age 21. Although DMC services are classified as rehabilitative services, they are not provided under the “rehabilitation option,” meaning they must be delivered in a certified clinic.

In fiscal year 2010-11 there were 62,004 unique DMC admissions statewide, of which 8,381 were dual eligible beneficiaries. About 44 percent (3,679) were in Los Angeles County.

Currently, Medi-Cal beneficiaries must obtain DMC services through the county, a county-contracted provider or a direct contract provider. Although other providers may have DMC certification, if they do not have a contract with the county or the State, they cannot receive Medi-Cal reimbursement. To provide DMC services with its contracted provider network and assure full compliance with federal requirements, California is pursuing a Medicaid 1915(b) freedom of choice waiver.

Beginning in State Fiscal Year 2011-12, funding and responsibility for DMC and other alcohol and drug services were realigned to the counties. Responsibility for State administration of DMC services is being transferred from the Department of Alcohol and Drug Programs to the Department of Health Care Services. The state-level transfer will be completed by July 1, 2012.

Currently, substance use benefits are not a required benefit for Medi-Cal health plans. Medi-Cal managed care beneficiaries are able to access medically necessary services through their county alcohol and drug (AOD) program office. Formal relationships between the Medi-Cal health plans and the county alcohol and drug office that oversees the delivery of DMC services are not common.

**Framework for Shared Accountability**

While the existing delivery systems provide vitally important services, notably lacking is effective person-centered care and coordination across the service domains and alignment of financial incentives to reduce cost shifting across payers. Information sharing and coordination between the Medicare and Medi-Cal systems for dual eligible beneficiaries is especially challenging. Without this coordination, access to and the delivery of quality services cannot be assured, and additional cost is incurred to both the Medicare and Medicaid programs because of the inherent inefficiencies.

This demonstration presents an opportunity to promote person-centered care coordination and align financial incentives to drive shared accountability for improving beneficiary outcomes. Successful approaches must take into account the current complexity of financing and service delivery, notably counties’ roles in managing full risk for inpatient and long-term psychiatric care for California’s Medi-Cal beneficiaries. The county portion of Medi-Cal funding for specialty Medi-Cal mental health services will be carved out of the capitation rate, at least initially. However, the State intends for health plans and county agencies to work together to coordinate care and develop strategies for shared accountability through local contracts or MOUs. This approach avoids destabilizing the current system and recognizes the value of existing service delivery structures.

**Contracts/MOUs**

An MOU or contract will be the mechanism for the systems to operationalize and monitor the requirements for coordination. DHCS will oversee these contracts/MOUs by reviewing documentation (copies of the contracts/MOUs) and by using compliance oversight mechanisms and performance metrics to ensure that required activities are conducted. DHCS expects to see solutions that reflect unique local circumstances and vary by county in their structure and timing. Adoption of the elements is expected to be progressive over the three years of the demonstration.The MOU will include, at least, the following key elements:

1. **Roles & Responsibilities**. Clear delineation of roles and responsibilities are needed to reduce duplication, improve efficiency, and meet the demonstration goals.
2. **Coordination strategies**. DHCS will require evidence of specific coordination strategies to strengthen integration (clinical, administrative, and financial).
3. **Information Exchange Plan**. The health plans and county agencies must put into place strategies to support the flow of information, with assigned lead responsibilities and a standardized approach to patient referral and follow-up.
4. **Performance measures to track accountability**. Specific reporting metrics will measure and show evidence regarding the quality of administrative activity, clinical activity, and patient satisfaction outcomes, as well as evidence of reduced costs. They will correspond to the state and national quality and evaluation framework. In the first year(s), these measures may be process-oriented and represent tangible, measurable activities that indicate collaboration and form the foundation necessary for integrating care. Outcome measures will be developed and used in later years.
5. **Shared Financial Accountability**. DHCS will require outlines for shared financial accountability in the MOU that include specific incentives and/or penalties linked to performance metrics applied to the health plan and county mental health and substance use agencies.

**Roles & Responsibilities**

Clear delineation of roles and responsibilities in locally developed MOUs/contracts will serve as the foundation for all coordination efforts. This role delineation shall describe clear processes for referrals and payment terms. The Demonstration counties will report to the DHCS-led stakeholder work group and provide evidence of local collaboration. Additionally during the readiness review process, DHCS and CMS will ensure the establishment of MOUs/contracts with the required elements.

**Coordination Strategies**

As part of their preparation for the readiness review process, demonstration health plans will describe how they will coordinate with county agencies and other stakeholder groups, including but not limited to consumer/family members and network providers, to reduce duplication, improve efficiency, and meet the demonstration goals. Coordination activities will span clinical, administrative and financial areas. Examples of clinical integration at the point of care include but are not limited to: (1) comprehensive physical and behavioral health screening and assessment; (2) triage and assignment of beneficiaries to appropriate care manager; (3) beneficiary engagement; (4) shared development of goal-setting and care plans by the beneficiary, caregivers, and all providers; and (5) care coordination and navigation support.

**Information Exchange**

Successful coordination is dependent on the ability to collect, report and share relevant patient-level encounter data. Thus, clear data sharing/privacy guidelines need to be established to facilitate information exchange across systems. California’s counties and corresponding demonstration health plans have varying capabilities, agreements and legal interpretations related to the sharing of information. Regulatory and other legal barriers (or perceived barriers) to sharing essential information between systems should be identified and addressed as soon as possible. Detailed plans for overcoming these barriers will be necessary. It is expected that information sharing will be phased in. Achievements in this area may correspond to the process measures indicating progress toward integration.

The eventual goal should be developing capability to share accurate and timely information electronically. Such a secure electronic platform may contain: (1) a current integrated problem list; (2) a single integrated person-centered, recovery-oriented plan of care; (3) contact information for lead coordinator(s); (4) a current medication list; and (5) dates of service and servicing providers for most recent provider and service contacts within respective systems. Ideally, the system also would track appropriate patient processes of care and outcome metrics, such as HgA1c and BMI assessment for those on atypical antipsychotics; improvements in standardized scores on depression and anxiety scales, etc.

**Performance Measures**

Identified performance metrics will serve as the foundation for shared accountability for improving outcomes and reducing costs. These metrics will be subject to agreement with CMS and correspond to state and national evaluation frameworks to allow for comparisons and tracking overall performance. The measures will correspond to the overarching outcomes or goals for the two systems that include, but are not necessarily limited to:

* Delivery of person-centered, recovery-oriented care
* Delivery of care in the most appropriate setting
* Improved quality of life and support for the highest level of recovery and independence
* Reduced avoidable emergency room visits or inpatient hospitalizations
* Reduced total cost of care
* Improved or maintained health outcomes

These metrics would be phased in and reflect the unique local context and a tiered approach to joint accountability in achievement of specified measures. Examples could include:

* Year 1: Measures focus on process improvements and tangible, measurable activities that indicate collaboration. These may include common member assessments, screening, stratification, and information about treatment/medications, jointly developed care plans, and real-time notification of hospital and ED admissions, as well as psychiatric emergency and crisis services utilization.
* Year 2: Measures evolve to capture intermediate outcomes, such as reduced emergency department and psychiatric crisis use and unnecessary inpatient admissions.
* Year 3: Measures may include health outcomes achieved and/or actual calculation of savings based on changes in service and pharmacy utilization.

**Shared Financial Accountability**

A key aim of this demonstration is to reduce cost shifting across delivery systems and promote person-centered care coordination. Thus, it is expected that the demonstration health plans and county behavioral health agencies develop formal financial arrangements based on identified performance measures to improve health outcomes and reduce medical costs.

The State will continue exploring these options with stakeholders and CMS, but it is expected that a financial alignment strategy will be in place by year three of the demonstration. Further exploration of the following options will occur in cooperation with stakeholders.

* **Incentive Payments**: Health plans and Counties could enter a formal agreement for care coordination. An incentive pool could be established to award bonus payments for meeting set performance measures tied to activities that promote integration and/or outcomes that indicate successful coordination, reduced emergency and crisis services utilization and eventually good health outcomes. Alternatively, the “quality withhold” – the portion of the rates withheld pending the achievement of quality metrics – could include a behavioral health coordination and utilization metric and the health plans could be required to share some or all of this portion related to behavioral health with the county agencies.
* **Shared Savings Pools**: Health plans and Counties could agree to an arrangement that establishes mechanisms for local shared savings (between the plan and county) around benchmarks, such as reduced ED, psychiatric crisis, inpatient utilization, or pharmacological costs. Absent local shared savings agreements, DHCS could coordinate shared savings arrangements, for example, by adjusting a portion of the health plan payments for sharing between the health plan and county agencies.
* **Inclusion in the Capitation Payment**: Counties could provide an inter-governmental transfer (IGT) to the State or appropriate government entity for the portion of the capitated rate related to mental health services for dual eligible beneficiaries with serious mental illness. The IGT could be based on an analysis of the amount of funding the county would have expended through certified public expenditures (CPEs) for enrolled duals. DHCS could include those funds within the capitated rate paid to the plan. The plan could contract back with the county mental health agency for service delivery.
* **Care Coordination Services.** There could be a new benefit/service category(ies) specific to the demonstration’s goals of increasing care coordination provided by the county behavioral health agencies and reimbursable by the health plans.

As with the metrics, financial accountability is intended to be phased-in with a focus on process measures in the first year while work is underway to develop outcome and utilization/cost metrics and corresponding incentive mechanisms for future years. The development of final financial alignment strategies is dependent on negotiation with, and requirements of, CMS.

1. C. Boyd, B. Leff, C. Weiss, J. Wolff, A. Hamblin, and L. Martin, *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations* (Center for Health Care Strategies, Inc., December 2010), [http://www.chcs.org/publications3960/publications\_show.htm?doc\_id=1261201]. [↑](#footnote-ref--1)
2. Ibid [↑](#footnote-ref-0)
3. 4 J. Kasper, M. O’Malley-Watts, and B. Lyons. *Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending*. Kaiser Commission on Medicaid and the Uninsured, July 2010. Available at http://www.kff.org/medicaid/8081.cfm

. This includes 16 percent with diagnoses of Alzheirmer’s or other dementia. [↑](#footnote-ref-1)
4. Ibid [↑](#footnote-ref-2)
5. W. Lin, J. Zhang, G. Leung, and R. Clark, “Twelve-Month Diagnosed Prevalence of Behavioral Health Disorders Among Elderly Medicare and Medicaid Members,” *American Journal of Geriatric Psychiatry*. Published Ahead-of-Print November 25, 2010. [↑](#footnote-ref-3)
6. Medi-Cal beneficiaries receive specialty mental health services if they meet all of the following medical necessity criteria: 1) Diagnosis – one or more of 18 specified Diagnostic and Statistical Manual of Mental Disorders; 2) Impairment – significant impairment or probability of deterioration of an important area of life functioning, or for children a probability the child won’t progress appropriately; 3) Intervention: services must address the impairment, be expected to significantly improve the condition, and a physical health care based treatment would not work. [↑](#footnote-ref-4)
7. Available here: <http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/docs/10_012B_SPA_for_webposting.pdf> [↑](#footnote-ref-5)
8. Available here: <http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/docs/CA_SPA_10_016_for_webposting.pdf> [↑](#footnote-ref-6)
9. Department of Health Care Services. Analysis of Short-Doyle II claims data. December 2011. [↑](#footnote-ref-7)
10. For more detailed description see: Med-Cal Managed Care Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program  [PL 00-001 Rev (PDF - 4.3MB)](http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2000/MMCDPL00001REV.pdf) [↑](#footnote-ref-8)