



Voluntary Behavioral Health Integration in Medi-Cal: What Can Be Achieved Under Current Law

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Introduction

California’s Medicaid program, Medi-Cal, currently operates separate managed care delivery systems for behavioral and physical health services under federal Medicaid waiver authorities.¹ The program excludes most mental health and substance use disorder services from its contracts with Medi-Cal managed care plans² and makes those services available through county-operated mental health plans (MHPs) and Drug Medi-Cal program contracts. These separate delivery systems operate under distinct statutory and regulatory authorities, and the contractors and their network providers are subject to differential standards developed over decades in the context of separate programs. The programs are also reimbursed and financed differently, with the Medi-Cal managed care plans placed at risk for the cost of services, and the county programs reimbursed through cost-based structures.³

The separateness of the delivery systems creates challenges to achieving administrative and financial integration of physical and behavioral health services in Medi-Cal. In February 2019, the California Health Care Foundation and Well Being Trust published *Behavioral Health Integration in Medi-Cal: A Blueprint for California*,⁴ which addressed the benefits of assigning responsibility for Medi-Cal’s behavioral and physical health services to a single accountable entity, thereby creating opportunities for integration of care. To help identify potential paths forward, this article explores different contracting structures through which a county could lead efforts to create such an accountable entity.

One option is for a county to work with the state and a Medi-Cal managed care plan to have the plan designated as the local MHP or Drug Medi-Cal program contractor. State laws governing the MHPs and the Drug Medi-Cal program were designed to default contracts to counties, but in the absence of a county contract — for example, if the county terminates or declines to renew its contract — the laws also permit a contract to be awarded to a qualified nongovernmental entity. Alternatively, a county could achieve a similar result by electing to delegate its responsibilities under its MHP or Drug Medi-Cal contract to a qualified Medi-Cal managed care plan.

The integration of physical and behavioral health could also be approached from the other direction — by granting new authority for a county to opt to cover physical health services as a supplement to its existing behavioral health services contracts. For example, a county could agree to serve as a Medi-Cal “specialty health plan” responsible for comprehensive health services for a designated patient population (e.g., those currently receiving Drug Medi-Cal services or specialty mental health services through the county). This result could be achieved either by having the county enter into a new Medicaid managed care plan contract with the California Department of Health Care Services that would be in addition to other plans currently operating in the county, or by having the county enter a subcontract with one (or more) of those plans to provide coverage for a subset of the plan’s enrollees.

Each of these options potentially can be pursued consistent with existing law through the execution of voluntary contractual agreements. In most cases, in addition to having both a county that would initiate the effort and a willing Medi-Cal managed care plan, success would require the approval and participation of the state Medi-Cal agency — the California Department of Health Care Services (DHCS) — and the approval of the federal Centers for Medicare and Medicaid Services (CMS). Integration would also require a number of important decisions about what legal, financial, and operational standards apply to the accountable entity. In the sections that follow, we identify potential paths forward and highlight some key legal and operational issues.

Integrating Responsibility for Care in a Medi-Cal Managed Care Plan

One integration pathway that a county could take would be to consolidate responsibility for care in the Medi-Cal managed care plan. This section discusses several options for achieving this for both specialty mental health services and for specialty substance use disorder (SUD) services (through the Drug Medi-Cal program).

Transferring MHP Services to a Medi-Cal Managed Care Plan

Under California law, specialty mental health services are available for Medi-Cal beneficiaries through MHPs that contract with DHCS. These services are excluded from the contracts held by Medi-Cal managed care plans, although the plans do cover mental health services that do not qualify as specialty mental health services.⁵ The MHPs are subject to federal Medicaid managed care requirements and provide or contract for the provision of specialty mental health services. The unique MHP delivery system is authorized by the Social Security Act section 1915(b) specialty mental health services waiver approved by CMS.

The specialty mental health services “carve out” from Medi-Cal managed care plan contracts is made necessary largely by state law that directs DHCS to enter into contracts with MHPs for the provision of those services. Counties currently holding MHP contracts have rights to continue in this role. In addition, Medi-Cal managed care plans would not qualify as MHPs under state law unless DHCS modified their contracts to impose standards required for the MHPs. Within these parameters, we have identified two options for a county to voluntarily “transfer” responsibility for MHP services to a Medi-Cal managed care plan: (1) the county may terminate its MHP contract so as to enable DHCS to designate the Medi-Cal managed care plan as a successor MHP if it meets the applicable standards; or (2) the county may delegate some or all of its MHP obligations to a qualified Medi-Cal managed care plan via a subcontract.

Medi-Cal Managed Care Plan as the MHP

California law directs DHCS to implement managed mental health care for Medi-Cal beneficiaries through contracts with MHPs.⁶ Currently, each of the MHPs is operated by a county or by counties acting jointly. However, if a county (or joint county entity) does not serve as the MHP, DHCS must ensure that specialty mental health services are provided to Medi-Cal beneficiaries and is required to designate a new MHP for the county.⁷ The successor MHP would need to enter into a contract with DHCS that subjects it to the same duties and obligations otherwise required of a county MHP.⁸ In this circumstance, while the county would no longer

serve as the MHP, the county would continue to be obligated to provide community mental health services to the indigent to the extent it has available resources to do so.⁹ The successor MHP could elect to purchase specialty mental health services from the county and would be required to have mutually agreed-upon protocols with the county to clearly establish conditions under which beneficiaries may obtain non-Medi-Cal reimbursable services from the county.¹⁰

The current MHP statutes provide a path for the potential designation of a Medi-Cal managed care plan as an MHP. To implement this option, a county would first need to inform the state that the county is no longer willing to serve as the MHP. DHCS would then need to approve the Medi-Cal managed care plan as qualified to fulfill the obligations of an MHP.

A county's ability to terminate its role as the MHP is governed by the terms of its existing MHP contract with DHCS. The most recently published boilerplate MHP contract identifies the contract term as applicable from July 1, 2017, through June 30, 2022, but individual MHP contracts may specify a different term.¹¹ Provisions of the boilerplate contract allow for a county to terminate prior to the expiration date of an executed contract by providing written notice to DHCS, including the reason and effective date, at least 180 calendar days prior to the effective date of termination.¹² The boilerplate contract also requires a county that chooses not to renew its expiring MHP contract to provide written notice but does not specify a time frame.¹³ The county could also seek an amendment of the MHP contract end date that coincides with a planned transition of services.

Termination or nonrenewal of a contract could trigger notice provisions for beneficiaries. If the county terminates a subcontract with a provider (which could be a consequence of terminating the MHP contract), the county is required to make a good faith effort to provide notice within 15 days to beneficiaries who recently or regularly received services from the terminated provider.¹⁴ The county may also be required to make patient records and files available to DHCS, including information maintained by any subcontractor.¹⁵

Once it receives notice of a contract termination, DHCS would need to award a new MHP contract. However, DHCS is not necessarily limited to looking only to Medi-Cal managed care plans for this purpose; DHCS could also solicit interest from other counties, counties acting jointly, or other qualified governmental or nongovernmental entities.¹⁶ Before awarding a contract, DHCS would likely evaluate the chosen entity to ensure it can meet MHP standards and preserve MHP protections for beneficiaries and providers through the transition. Failure to undergo such a process could leave DHCS's contract award open to challenge.

State law does not address with specificity the standards MHPs must meet. Instead, MHPs, whether public or private, are required to be "governed by" a set of guidelines. Key requirements among these guidelines include the following:¹⁷

- ▶ A public planning process for the development of the MHP that includes a significant role for Medi-Cal beneficiaries, family members, mental health advocates, providers, and public and private contract agencies
- ▶ Appropriate standards relating to quality, access, coordination of services within a managed system of care, and costs, and opportunities for existing Medi-Cal providers that meet those standards to continue to provide services under the MHP
- ▶ Provision of covered services in the beneficiary's home community, or as close as possible to the beneficiary's home community
- ▶ Continuity of care for current recipients of services during the transition to managed mental health care

State regulations additionally provide that an MHP that is not a county would be subject to the same standards as a county MHP.¹⁸ This directive does not fully reflect the impact of contracting with a noncounty plan. The standards applicable to MHPs have been developed over decades in the context of the county systems, and currently MHPs utilize different reimbursement, claims processing, utilization review, and authorization standards from other types of Medi-Cal managed care plans. As part of the approval process for a Medi-Cal managed care

plan to serve as the MHP, DHCS would need to consider the extent to which the plan could apply the processes utilized for its Medi-Cal managed care business rather than have to develop new systems to re-create the current county-specific processes. DHCS would also need to consider the extent to which the plan would be required to contract with the existing MHP network.

Designating a Medi-Cal managed care plan as a successor MHP would have significant implications for funding the nonfederal share of mental health services. Currently, counties use public funds as certified public expenditures (CPEs) to draw down the federal Medicaid matching payments for the MHPs, which are reimbursed based on their allowable costs. Federal rules provide that only public agencies may make CPEs.¹⁹ Assuming that the Medi-Cal managed care plan serving as the successor MHP is not a public agency, a viable and compliant Medi-Cal funding and payment mechanism for drawing federal matching funds would need to be developed. The transfer of the contract to a Medi-Cal managed care plan could also prompt changes to the reimbursement methodology for specialty mental health services — for example, the development of capitation rates in lieu of the current cost-based structure. For all of these reasons, the designation of a Medi-Cal managed care plan as an MHP would represent a significant change to the delivery system.

Stakeholders should carefully consider whether further state legislative direction should be sought to facilitate an effective transition if a county wishes to initiate this option. New legislation could help to clarify the process by which a county could agree to reassign its MHP role to a Medi-Cal managed care plan, potentially eliminating a period of uncertainty after the county gives notice of its termination and before DHCS has awarded a new contract. Legislation could also establish with greater specificity the standards to which the new MHP contractor would be held, address the funding of the nonfederal share, and include protections or assurances for the transfer. Short of legislative action, a county could work with DHCS to develop a plan, potentially including temporary agreements among the county, DHCS, and the Medi-Cal managed care plan, to arrange for appropriate transitions of coverage. This approach is not expressly contemplated in current law but arguably is consistent with DHCS's authority to amend existing agreements.

Whether via new legislation or under existing authority, changes to the current MHP designations would also require modifications to the terms and conditions of the 1915(b) specialty mental health services waiver. The waiver's terms and conditions authorize the operation of the MHPs, and the authorizations would need to be modified to reflect the existence of noncounty MHP options. The terms and conditions also indicate that the MHPs are operated as non-risk-based managed care entities known as prepaid inpatient health plans (PIHPs). If the MHP contract assumed by a Medi-Cal managed care plan were to become capitated, then the waiver documents would need to be modified and the MHPs would be subject to additional requirements applicable under federal law to risk-based Medicaid managed care plans. These additional requirements would need to be incorporated into the MHP contracts and approved by CMS. Conforming changes to waiver terms and conditions applicable to the Medi-Cal managed care plans and their covered services also would be needed. In addition, as noted earlier, changes to the current cost-based reimbursement structure for MHPs may be required to reflect the new reimbursement and financing structures for a noncounty plan.

County MHP Delegation to a Medi-Cal Managed Care Plan

If a county wishes to retain its status as the MHP in an integration model, the county could explore subcontracting with a Medi-Cal managed care plan. This approach would allow the county MHP to delegate responsibility to a Medi-Cal managed care plan for the coverage of some or all specialty mental health services through the Medi-Cal managed care plan's network. Under a subcontracting approach, DHCS would not need to designate a new MHP. Rather, the county would remain designated as the MHP and ultimately responsible for the contracted plan's performance, subject to indemnification provisions or other protections negotiated between the parties. DHCS approval of the subcontract may be required.

The ability to subcontract is provided for in state and federal law and written into the MHP contracts. Federal Medicaid regulations provide that managed care plans (including the MHPs) may enter into subcontracts so long as (1) the state that contracts with the plan ensures that the plan "maintains ultimate responsibility" for

compliance with the terms and conditions of the plan contract, notwithstanding any subcontracted relationships; and (2) the subcontractual relationship includes assurances that the subcontractor will be subject to and comply with all requirements in the state's contract with the primary plan when performing the delegated activities or obligations and will be subject to applicable Medicaid requirements.²⁰

State law and regulation do not limit the ability of MHPs to enter into subcontracts,²¹ and DHCS's boilerplate MHP contract states:

Unless specifically prohibited by this contract or by federal or state law, Contractor may delegate duties and obligations of Contractor under this contract to subcontracting entities if Contractor determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this contract. The Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the Department, notwithstanding any relationship(s) that the Mental Health Plan may have with any subcontractor.²²

The MHP contract further specifies the requirements for MHP subcontracts, which track federal law.²³

Significantly, the MHP template agreement states that "the Department hereby, and until further notice, waives its right of prior approval of subcontracts and approval of existing subcontracts," providing an exception to contract provisions that would otherwise require prior approval of subcontracts for services costing more than \$5,000.²⁴ However, DHCS regulations state that an MHP must request approval from DHCS "to establish a contract with a provider ... where that provider is held financially responsible for specialty mental health services provided to beneficiaries by one or more other providers or to establish a payment arrangement with contract or non-contract providers that would not be allowed under this Chapter absent approval under this section."²⁵ This regulation suggests DHCS has a specific interest in approving risk-based subcontracts. Federal approval is not required for MHP subcontracts.

These authorities support a path forward for a county MHP to subcontract with a Medi-Cal managed care plan (or other entity) to help fulfill the MHP's obligations under its contract with DHCS. Under this scenario, a county and a Medi-Cal managed care plan could negotiate the terms of an agreement to allocate responsibilities, subject to applicable DHCS approval. Potential arrangements could run the gamut from the Medi-Cal managed care plan taking sole responsibility for developing a network for specialty mental health services and processing claims, to more limited arrangements in which the county relies on the plan to supplement its network or to perform limited administrative activities.

As with the option discussed above (Medi-Cal Managed Care Plan as the MHP), the incorporation of Medi-Cal managed care plans into the MHP delivery system raises a number of questions. For example, as described earlier, the MHPs currently claim federal financial participation pursuant to a cost-claiming protocol approved by CMS.²⁶ This protocol does not specifically address the potential for MHPs to make payments (whether on a capitated or other basis) to contractors responsible for developing their own network. Clarifying modifications to the protocol could be made to address how the county MHP can utilize CPEs to claim reimbursement for its expenditures to contractors, including its payments to the Medi-Cal managed care plan. Similarly, claims reporting and processing procedures would need to be available for providers added to the MHP network through their contract with the Medi-Cal managed care plan. A county would likely need to work closely with DHCS to ensure that the county could continue to meet all MHP requirements through such a subcontract.

Transferring Responsibility for the Drug Medi-Cal or Drug Medi-Cal Organized Delivery System Program to a Medi-Cal Managed Care Plan

While some physician-administered SUD benefits are available through traditional Medi-Cal (either fee-for-service or through Medi-Cal managed care plans), most are available only through California's Drug Medi-Cal program.²⁷ Under the Drug Medi-Cal program, counties contract with DHCS; establish assessment and referral procedures; and arrange, provide, or subcontract for

covered services in their service area.²⁸ Counties are required to provide all Drug Medi-Cal services to which beneficiaries are entitled and receive realignment funding for this purpose.²⁹

Under the Drug Medi-Cal program, counties bear some obligations similar to those of a managed care network — namely, meeting requirements for establishing assessment and referral procedures for Drug Medi-Cal services.³⁰ However, Drug Medi-Cal counties cannot restrict payment to a Drug Medi-Cal provider certified by DHCS and are required to pay the rates established by DHCS.³¹ Moreover, DHCS invoices the county for the nonfederal share of approved Drug Medi-Cal claims payments to those providers that contract directly with DHCS rather than with the county.³² Because of these limitations, counties holding Drug Medi-Cal contracts operate more as fiscal intermediaries for a fee-for-service benefit, with only modest ability to coordinate and organize care. These Drug Medi-Cal counties are not subject to federal Medicaid managed care regulations.

In part to address these limitations, California received federal approval in 2014, under Social Security Act section 1115 Medicaid demonstration authority, to expand available SUD services through the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot project.³³ Through DMC-ODS pilots, counties that elect to participate are treated as managed care entities responsible for coordinating and ensuring access to the continuum of care for SUD services, with greater flexibility than under "traditional" Drug Medi-Cal to limit the provider network and establish payment rates.³⁴ Participating counties enter into a DMC-ODS contract with DHCS. The majority of counties have opted into the DMC-ODS program.

Because of the different structures of Drug Medi-Cal and the DMC-ODS pilots, there are different options and considerations for transferring responsibility for the programs to a Medi-Cal managed care plan. Specifically, to achieve integrated contracts, a "traditional" Drug Medi-Cal county could ask DHCS to enter into a direct contract with the Medi-Cal managed care plan instead of the county, while counties operating a DMC-ODS pilot may prefer to subcontract with the Medi-Cal managed care plan in order to ensure the continued availability of the expanded SUD benefits.

Drug Medi-Cal

Drug Medi-Cal Direct Contract Model with a Medi-Cal Managed Care Plan

State law governing Drug Medi-Cal provides that DHCS “may” contract with each county for alcohol and drug use services.³⁵ While this language appears permissive in contrast to the MHP statutes discussed earlier, the statutory framework contemplates that counties would be offered such contracts by addressing the circumstances in which a county decides not to enter into a Drug Medi-Cal contract. As a practical matter, counties do currently hold these Drug Medi-Cal contracts.

Like the MHP authorities discussed in section A.1, the Drug Medi-Cal laws provide a path for a county to terminate its existing Drug Medi-Cal contract to enable DHCS to enter into a new contract with a qualified entity to ensure beneficiary access to Drug Medi-Cal services. Specifically, if a county decides not to enter a Drug Medi-Cal contract, the county must notify DHCS in writing by May 20 preceding the fiscal year in which, or at least 60 days before, the contract would have become effective.³⁶ Further, the law provides, “to the extent that a county decides not to enter into or terminates its Drug Medi-Cal Treatment Program contract with the department, the department shall contract for Drug Medi-Cal Treatment services in the county as necessary to ensure beneficiary access to these services.”³⁷ These contracts may be with certified Drug Medi-Cal providers directly or through qualifying individual counties, counties acting jointly, or county consortia, and with qualified individuals, organizations, or nongovernmental entities.³⁸ While the Drug Medi-Cal statutes do not explicitly identify Medi-Cal managed care plans as potential Drug Medi-Cal contractors, they permit DHCS to contract with “qualified individuals, organizations, or nongovernmental entities,” and to enter into contracts “for the procurement of services to assist the department in administering the Drug Medi-Cal Treatment Program.”³⁹

If DHCS were to contract with a Medi-Cal managed care plan to cover Drug Medi-Cal benefits, the plan could employ managed care principles not currently available to the county. As Medi-Cal managed care plans operating under current demonstration authority, the plan could operate a closed network and set payment rates

that differ from those under the Medicaid state plan (this authority is distinct from the waiver authorization for DMC-ODS). Modifications to the current demonstration special terms and conditions would be needed to recognize that the plan is responsible for providing Drug Medi-Cal services. While these systems would be similar in some ways to the DMC-ODS pilots, they would not have the authority to cover the expanded scope of SUD benefits available in counties opting into DMC-ODS.

To initiate this option, an interested county would approach DHCS about potentially terminating its current Drug Medi-Cal contract in favor of a Medi-Cal managed care plan. If DHCS were interested in pursuing such a change, the parties could explore a transitional agreement to keep the county’s role in place until the Medi-Cal managed care plan’s contract becomes effective, and to ensure an effective transition.

As with the MHP contracts, counties use public funds and CPEs to provide the nonfederal share of Drug Medi-Cal expenditures, a mechanism that is not available to a nonpublic entity. The termination of the county’s Drug Medi-Cal contract to facilitate a successor arrangement with a Medi-Cal managed care plan that is not a public entity would therefore impact the financing and payment of Drug Medi-Cal services, and would require the development of appropriate methods.

Drug Medi-Cal Subcontract with a Medi-Cal Managed Care Plan

In theory a county could also seek to delegate its Drug Medi-Cal obligations to a Medi-Cal managed care plan via a subcontract (similar to the model described in section A.2 for specialty mental health services). We note, however, that this option poses few advantages. Unlike services delivered through the DMC-ODS pilots, the Drug Medi-Cal program is a fee-for-service Medi-Cal benefit. While counties enter into contracts with DHCS to provide Drug Medi-Cal benefits, the counties do not benefit from the authorities available to Medicaid managed care plans and as a result have limited ability to deny claims from noncontracting providers or to vary payment rates among providers. A subcontractor to a county would also not be able to exercise these options, limiting the benefits of integrating legal authority of care

into a single entity. For these reasons, a county interested in assigning authority for Drug Medi-Cal services to a Medi-Cal managed care plan may prefer to either have DHCS directly contract with the Medi-Cal managed care plan under the state's existing managed care authorities or elect to participate in the DMC-ODS pilot, which incorporates managed care authority into the delivery of Drug Medi-Cal services.

If a county wishes to pursue a subcontracted arrangement with a Medi-Cal managed care plan without opting into DMC-ODS, the county could reach out to DHCS for clarification and approval of the potential subcontract. The specifics of those subcontracts would depend on language in the county's existing Drug Medi-Cal contract. While DHCS has not issued a boilerplate Drug Medi-Cal agreement, at least some Drug Medi-Cal contracts we have reviewed include provisions requiring prior written authorization from DHCS before a contractor enters into a subcontract of more than \$5,000. Unlike the boilerplate MHP agreement, the agreements did not indicate that DHCS has waived this requirement. In addition, clarification from DHCS would be needed regarding the limitations included in some contracts defining "subcontract" and "subcontractor" to specify that a subcontractor may not "delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/client services."⁴⁰ This definition could be construed to prevent a county from delegating to another entity responsibility for contracting with Drug Medi-Cal providers.

Drug Medi-Cal Organized Delivery System

Since 2014, the state's section 1115 demonstration project has authorized counties to implement DMC-ODS pilots and allow beneficiaries to access an expanded set of SUD benefits through such pilots.⁴¹ Counties are required to submit to DHCS an implementation plan describing how they will provide benefits; once the counties contract with DHCS they gain additional authority as managed care plans and are able to offer beneficiaries an expanded set of SUD benefits.

Because authority for the DMC-ODS pilot is currently tied to the county's participation, an amendment to the applicable special terms and conditions would be needed to allow for a DMC-ODS pilot in which the

county opts out of the DMC-ODS pilot and the state enters into a direct DMC-ODS contract with a Medi-Cal managed care plan. Such an amendment could be pursued with DHCS and CMS.

Absent such an amendment, a county could seek approval to have its DMC-ODS program integrated with a Medi-Cal managed care plan through a subcontract. The demonstration special terms and conditions applicable to the DMC-ODS authorize participating counties to "contract with a managed care plan to provide services."⁴² This authorization provides existing federal approval for a county to subcontract with a Medi-Cal managed care plan to develop the network of certified Drug Medi-Cal providers that will deliver services and potentially manage their reimbursement and utilization. To implement this approach, a county may need to modify its implementation plan for the DMC-ODS pilot and should approach DHCS about requirements related to its prior approval of the subcontract and change in network model.

In addition, the county may need to modify its DMC-ODS contract with DHCS to clarify the ability to enter into a subcontract with a plan. The boilerplate version of the DMC-ODS contract authorizes the use of subcontracts that meet federal requirements, which were described earlier in section I-A-2.⁴³ However, the contract also includes the same definitions of subcontractors we have seen in the Drug Medi-Cal contracts, requiring prior DHCS approval of subcontracts⁴⁴ and including definitions that appear to prohibit a subcontractor from further subcontracting with other providers to deliver covered services.⁴⁵ These definitions in a county's DMC-ODS contract should be reviewed with DHCS to determine whether amendments are needed to allow for subcontracting a plan that will develop and use its own network.

Based on these authorities, a county interested in delegating DMC-ODS functions to a Medi-Cal managed care plan might wish to approach DHCS about whether it would approve the arrangement and confirm any requirements for modifications to the county's current agreement or implementation plan. It is also likely that financial issues would need to be worked out, as DMC-ODS is operated as a non-risk-based managed care entity from the federal perspective (counties are at risk only for the cost of their nonfederal share). A county

that delegates responsibility to a managed care plan could potentially do so in a manner that pays the plan a capitated rate, with the county claiming federal financial participation based on its costs of making such payments, but approval for claiming those costs would need to be confirmed before committing to such an arrangement.

Integrating Responsibility for Care in a County

The second general approach to achieving administrative and financial integration of care in Medi-Cal would be for a county to serve as a specialty Medi-Cal managed care plan with responsibility for covering physical health services as well as the behavioral health services already covered under its MHP and Drug Medi-Cal contracts. For example, DHCS could contract with a county to provide full scope Medi-Cal coverage for those individuals who qualify for specialty mental health services or services under the Drug Medi-Cal program. Alternatively, a Medi-Cal managed care plan could enter into a sub-contract with the county to cover certain beneficiaries. These arrangements would allow a county to serve as a single accountable entity with legal responsibility for both behavioral and physical health services. These two approaches are addressed in the next sections.

Direct Medi-Cal Managed Care Contract

Under this model, DHCS would enter into a new Medi-Cal managed care contract directly with a county to provide comprehensive health services, including physical health services, for Medi-Cal beneficiaries who enroll with the county.

DHCS has broad authority to contract with Medi-Cal managed care plans under multiple statutory provisions, which have been added over the years in connection with various pilots and the implementation of the different Medi-Cal managed care models. One statute, for example, authorizes DHCS to “contract ... with any qualified individual, organization or entity to ... provide for the delivery of services in a manner consistent with managed care principles, techniques and practices directed at ensuring the most cost-effective and appropriate

scope, duration, and level of care.”⁴⁶ This statute is not limited to any particular geographic area, model of managed care, or scope of services, and by its terms can be used whenever DHCS determines a managed care contract would be cost-effective and appropriate.

Other statutes specifically authorize DHCS to pursue exclusive contracts with County Organized Health Systems (COHSs);⁴⁷ to pursue Geographic Managed Care (GMC) pilots in specific geographic areas (San Diego and Sacramento Counties);⁴⁸ and to expand managed care into new, rural counties.⁴⁹ These authorities also do not limit the scope of Medi-Cal covered services that may be included pursuant to such contracts. In addition, DHCS retains the statutory authority it has had for decades to enter into contracts with one or more “pre-paid health plans” to provide Medi-Cal benefits⁵⁰ and to enter into pilot programs to “aggressively seek the development of alternative forms of financing and delivering healthcare services.”⁵¹

A key barrier to utilizing DHCS’s authority to award managed care contracts under this option would be the limitations or prior agreements applicable to the other Medi-Cal managed care plans in the area, which are specific to the details of existing DHCS contracts and the managed care model operating in the county.

- ▶ **COHS Counties.** State law grants DHCS authority to enter into exclusive contract with COHS plans. While the COHS boilerplate contract does not include a specific exclusivity provision, the plans currently are exclusive in nature (although they are not exclusive with regard to the MHP or Drug Medi-Cal services, which are carved out of the contract), and DHCS may not be willing or able to modify its existing contracts without the COHS’s agreement.⁵² A COHS likely would need to agree to an amendment to the terms of its contract (or a modification in the next renewal of its contract) to enable DHCS to contract directly with a county to provide coverage for enrollees previously served by the plan.

Additionally, most Medi-Cal managed care plans operating under the COHS model are exempt from many of the federal Medicaid managed care

plan requirements because of federal legislation passed specifically for California.⁵³ For some COHS plans, maintaining this exemption requires that the plan enroll all Medi-Cal beneficiaries residing in the plan's county.⁵⁴ A new Medi-Cal managed care plan that competes with an existing COHS thus could potentially disqualify the COHS from the federal exemption.

- ▶ **Two-Plan Model Counties.** In Two-Plan model counties, DHCS regulations have historically provided that all care would be provided through one of two contracted plans, a local initiative and a commercial option.⁵⁵ The commercial option is not required to be a nongovernmental entity and is subject only to the requirement that the contract must be awarded through a competitive bid process. The local initiative must either be organized by the county government or stakeholders in the region or else be designated by the county government or stakeholders in the region and approved by DHCS. While a county could potentially qualify under either of these options, adding a new county plan would require one of the current Medi-Cal managed care plans that contract with DHCS in the Two-Plan model county to lose its contract. To change these requirements, DHCS could modify its regulations to permit the operation of a third plan in the county. DHCS recently made such a modification to allow it to potentially contract with Kaiser, demonstrating that DHCS can make changes to the Two-Plan model without legislative action.⁵⁶

If the county already serves as one of the Two-Plan model plans, it could approach DHCS and the Department of Managed Health Care to inquire about modifying the scope of its Medi-Cal managed care contract and Knox-Keene license to cover specialty mental health services and/or specialty SUD services.

- ▶ **GMC Model Counties.** Unlike the other Medi-Cal managed care models, the GMC model does not have restrictions on the number of plans that may operate in the region. As a result, DHCS could contract with a county subject to those models (currently, Sacramento and San Diego Counties) to serve as a new plan. The county contract would

need to be structured as a prepaid health plan and would be subject to the requirements applicable to Medi-Cal managed care plans.

The state's various models of Medi-Cal managed care are currently authorized under the state's section 1115 demonstration project waiver, called "Medi-Cal 2020." If DHCS were to award a new plan under any of these models, modification of the current waiver would be required to identify the new plan. Currently, the state's authority to operate the different managed care models is contained in the Medi-Cal 2020 demonstration, which includes various attachments identifying the currently contracted plans, the scope of services they provide, and the requirements for beneficiary enrollment.⁵⁷ These attachments would need to be modified by DHCS and approved by CMS before an additional plan can be added in a county.⁵⁸ Requests for amendments must be submitted 120 days prior to the planned implementation date and may not be retroactively approved.⁵⁹ In addition, CMS would need to approve the county's Medi-Cal managed care plan contract.

If the new Medi-Cal managed care plan contract were to place the county at financial risk for the cost of providing services to its enrollees, the county would likely need to acquire a Knox-Keene license. Putting the processes and applications in place to be approved for such a license can take months or longer.

As with the options discussed earlier, the county specialty plan contract option implicates various finance and payment issues, including establishment of capitation rates and the funding of such payments. For example, if a county seeks to create a more robust integration of specialty behavioral health and physical services, the county could also seek to reform or consolidate the funding mechanisms applicable under its current MHP or Drug Medi-Cal contracts. DHCS and the county (and potentially the legislature and CMS) would need to either separate the reimbursement under the specialty care plan contract so that the county receives two different payment streams, or move the county to a single capitated rate inclusive of specialty mental health and Drug Medi-Cal services. The county would also need to address the financing mechanisms applicable to the specialty health plan and to consider how integrated the funding and reimbursement will be.

Medi-Cal Managed Care Plan Subcontract

As an alternative to contracting directly with DHCS as a Medi-Cal managed care plan, a county could seek to have responsibility for services delegated to it by a local Medi-Cal managed care plan via a subcontract. For example, the county could agree via contract to take over responsibilities from the Medi-Cal managed care plan for the provision of physical health services to certain enrollees, or the county could agree to provide nonspecialty behavioral health services. The latter option is contemplated in the current Medi-Cal managed care plan boilerplate contracts, which provide that Medi-Cal managed care plans “may subcontract with a county mental health plan to ensure access to Outpatient Mental Health Services” and that, when they do so, “[a] subcontracted network shall be deemed adequate upon submission and approval of Contractor’s subcontract boilerplate for a county mental health plan.”⁶⁰ Other types of subcontractual arrangements are also possible under each of the Medi-Cal managed care models.

DHCS boilerplate contracts for Medi-Cal managed care plans expressly authorize plans to subcontract with other entities “in order to fulfill the obligations of the Contract.”⁶¹ All subcontracts must be in writing and meet federal requirements, Knox-Keene Act requirements, and Medi-Cal laws and regulations. The subcontracts must meet certain requirements, which are consistent with those required under federal law.⁶²

Medi-Cal managed care plan subcontracts are not effective until approved by DHCS in writing (or approved by operation of law if DHCS fails to act within 60 days of its acknowledged receipt).⁶³ DHCS also has a right of prior approval over any amendments that would change compensation, services, or term, and DHCS must be notified in the event the subcontract is terminated.⁶⁴ Importantly, subcontractors must agree “to hold harmless both the State and Members in the event the Contractor cannot or will not pay for services performed by the subcontractor pursuant to the Subcontract.”⁶⁵ DHCS and other state agencies must be given the right to inspect or copy all records of subcontractors (including both first-level and more downstream subcontractors) for a term of at least five years.⁶⁶

A Medi-Cal managed care plan must describe to DHCS “systems for ensuring that subcontractors, who are at risk for providing services to Medi-Cal Members, as well as any obligations or requirements delegated pursuant to a Subcontract, have the administrative and financial capacity to meet its contractual obligations.”⁶⁷ It must also submit “policies and procedures for a system to evaluate and monitor the financial viability of all subcontracting entities.”⁶⁸ DHCS maintains control during the term of the contract by reserving the authority to “[r]equire Contractor to temporarily suspend or terminate personnel or subcontractors.”⁶⁹

As long as the contractual and regulatory requirements are met, the Medi-Cal managed care plan and the subcontractor have flexibility in how to structure the agreement. For example, boilerplate contracts explicitly provide that “Contractor may compensate providers as Contractor and provider negotiate and agree,” and that “[u]nless DHCS objects, compensation may be determined by a percentage of the Contractor’s payment from DHCS.”⁷⁰ Many Medi-Cal managed care plans in California have delegated significant plan functions to other entities via subcontract, including having the third party entity agree to cover services for a portion of the primary plan’s enrollment or delegating responsibility for coverage, network development, and reimbursement of a subset of services (e.g., mental health services within the primary plan’s scope of coverage).

Consistent with this authority, a Medi-Cal managed care plan could delegate a portion of its responsibilities to the county. This option is available in each of the state’s managed care models, subject to DHCS approval. Depending on the scope of the arrangements and the level of financial risk taken by the county under its subcontract, the county may need to acquire a Knox-Keene license. Because the subcontractual arrangement would not result in a new DHCS contract, the limitations imposed on the number of plans operating in the county would not apply.

Conclusion

Current state laws reflect Medi-Cal's fragmented delivery system and create separate contracting processes and standards for Medi-Cal behavioral and physical health services. Notwithstanding this fragmentation, current authorities also include multiple pathways through which a county could pursue greater integration of Medi-Cal physical and behavioral health services. These include options for a noncounty entity such as a Medi-Cal managed care plan to serve as an MHP or Drug Medi-Cal contractor, for a Medi-Cal managed care plan to

subcontract with a county to develop a network of services for "mild to moderate" mental health issues, and for a county to expand its role by contracting with DHCS to serve as a full-scope Medi-Cal managed care plan for beneficiaries with serious behavioral health issues. Stakeholders interested in developing a framework for integrated care in partnership with DHCS can pursue these different options potentially without further legislative action.

Endnotes

- 1 The county-operated mental health plans operate under the Specialty Mental Health Services waiver approved by CMS pursuant to Social Security Act section 1915(b). The Medi-Cal managed care plans and the Drug Medi-Cal Organized Delivery Systems operate under the California Medi-Cal 2020 Demonstration waiver approved by CMS pursuant to Social Security Act section 1115(a).
- 2 Throughout this article, “Medi-Cal managed care plan” refers to those plans contracting with DHCS under the County Organized Health System (COHS) model, Two-Plan model or Geographic Managed Care (GMC) model (inclusive of managed care expansion regional models), and does not include mental health plans (MHPs) or counties contracting for Drug Medi-Cal or Drug Medi-Cal Organized Delivery System contracts.
- 3 See, e.g., Sarah Arnquist and Peter Harbage, *A Complex Case: Public Mental Health Delivery and Financing in California*, July 2013.
- 4 Logan Kelly, Allison Hamblin, and Stephen Kaplan, *Behavioral Health Integration in Medi-Cal: A Blueprint for California*, February 2019, www.chcf.org/publication/behavioral-health-integration-medi-cal-blueprint/.
- 5 Welf. & Inst. Code § 14189.
- 6 Welf. & Inst. Code § 14712(a); see also Welf. & Inst. Code § 14680.
- 7 Welf. & Inst. Code §§ 14712(c), 14714(i), 14680(d); 9 Cal. Code of Regs § 1810.305(b).
- 8 Welf. & Inst. Code § 14712(a); 9 Cal. Code of Regs § 1810.305(c).
- 9 Welf. & Inst. Code § 5600, et seq.
- 10 Welf. & Inst. Code § 14714(a)(2).
- 11 We note that the current approval period for the section 1915(b) waiver expires June 30, 2020. Counties should consult their own contracts, as individual contracts could differ from the DHCS boilerplate agreements.
- 12 9 Cal. Code of Regs. 1810.323(a), (h).
- 13 MHP Contract, Exhibit E § 3.A(1) (p. 2 of 16).
- 14 MHP Boilerplate Contract (July 1, 2017–June 30, 2022), Exhibit E, § 3.E(2) (p. 5 of 16); Exhibit A – Attachment 11, § 2.B. (p. 3 of 10); see § 42 C.F.R. 438.10(f)(1).
- 15 9 Cal. Code of Regs. § 1810.323(j).
- 16 Welf. & Inst. Code § 14712.
- 17 Welf. & Inst. Code § 14684(a).
- 18 Welf. & Inst. Code § 14684(a); 9 Cal. Code of Regs. § 1810.305(b).
- 19 42 C.F.R. § 433.51.
- 20 42 C.F.R. § 438.230(b)–(c).
- 21 To the contrary, state law authorizing DHCS to enter into MHP contracts specifically contemplates the use of subcontractors, although in context these references appear intended to encompass network providers that are part of the MHP network.
- 22 DHCS, California MHP Contract 2017-22, Exhibit A, Attachment 1 ¶ 3, Delegation.
- 23 DHCS, California MHP Contract 2017-22, Exhibit A, Attachment 1 ¶ 4, Subcontracts.
- 24 DHCS, California MHP Contract 2017-22, Exhibit A, Attachment 1 ¶ 4.A, Subcontracts.
- 25 9 Cal. Code of Regs. § 1810.438(a).
- 26 CMS Supplemental Approval Letter and Certified Public Expenditure Protocols (Oct. 5, 2016), available at [www.dhcs.ca.gov/services/MH/Pages/1915\(b\)_Medi-cal_Specialty_Mental_Health_Waiver.aspx](http://www.dhcs.ca.gov/services/MH/Pages/1915(b)_Medi-cal_Specialty_Mental_Health_Waiver.aspx).
- 27 Welf. & Inst. Code § 14124.24(d) (providing that Drug Medi-Cal services are only reimbursement to Drug Medi-Cal providers with an approved Drug Medi-Cal contract).
- 28 DHCS, Drug Medi-Cal contract, Exhibit A, Attachment I, Section 2.A. DHCS has not issued a template Drug Medi-Cal contract to the public; we have reviewed a version of the Drug Medi-Cal contract for one county. Individual contracts may vary in key details, and counties should consult their own contract.
- 29 See DHCS, MHSUDS Inf. Notice 14-06, *Senate Bill (SB) 1020 (Chapter 40, Statutes of 2012)*; Gov’t Code § 30025(f)(16)(B).
- 30 Welf. & Inst. Code § 14124.24(e); DHCS, Drug Medi-Cal contract, Exhibit A, Attachment I, Section 1 and 2.A.
- 31 See CHCF Issue Brief, *Medi-Cal Moves Addiction Treatment into the Mainstream: Early Lessons from the Drug Medi-Cal Organized Delivery System Pilots* at 3–4 (Aug. 2018) (describing barriers in the standard Drug Medi-Cal System).
- 32 DHCS, Drug Medi-Cal contract, Exhibit B § 3.B.
- 33 Medi-Cal 2020, Special Terms and Conditions Part X, *Drug Medi-Cal Organized Delivery System*.
- 34 Medi-Cal 2020, Special Terms and Conditions ¶ 132.a.
- 35 Welf. & Inst. Code § 14124.20.a
- 36 Welf. & Inst. Code § 14124.21(a).
- 37 Welf. & Inst. Code § 14124.21(b)(1).
- 38 Welf. & Inst. Code § 14124.21(b)(2).
- 39 Welf. & Inst. Code § 14124.23.
- 40 DHCS, DMC Agreement, Exhibit A, Attachment I, Part IV — Definitions, § 2 ¶ W, X.
- 41 Medi-Cal 2020, Special Terms and Conditions Section X.
- 42 Medi-Cal 2020, Special Terms and Conditions ¶ 132.a. (June 7, 2018).
- 43 DHCS DMC-ODS Boilerplate, Exhibit A, Attachment I § II.B.vi
- 44 Interestingly, some of the approved DMC-ODS contracts have removed this language from the contracts. The Alameda County contract has redacted section 5 of the general terms and conditions, related to subcontracts, but the other DMC-ODS contracts we reviewed did not.
- 45 DHCS DMC-ODS Boilerplate, Exhibit A, Attachment I ¶ 107–108.
- 46 Welf. & Inst. Code § 14087.3.
- 47 Welf. & Inst. Code §§ 14087.5, et seq.
- 48 Welf. & Inst. Code §§ 14089, et seq.

- 49 Welf. & Inst. Code § 14087.98.
- 50 Welf. & Inst. Code §§ 14200, et seq.
- 51 Welf. & Inst. Code §§ 14490, et seq.
- 52 Welf. & Inst. Code § 14087.5 (authorizing exclusive COHS model contracts). However, the COHS boilerplate contract does not make reference to exclusivity.
- 53 See California Medi-Cal 2020 Demonstration, Special Terms and Conditions at 20.
- 54 See Section 4734 of the 1990 Omnibus Budget Reconciliation Act of 1990.
- 55 22 Cal. Code of Regs. § 53800.
- 56 22 Cal. Code of Regs. §§ 53800(c), 53810. The regulations now authorize contracts with a third plan in Two-Plan model counties. The plan must qualify as an Alternate Health Care Service Plan (AHSCP). 22 Cal. Code of Regs. §§ 53800(c), 53810. Qualification as an AHSCP is limited to entities meeting requirements that a county would not meet, such as being a nonprofit entity that serves at least 3.5 million enrollees statewide.
- 57 Medi-Cal 2020 Demonstration Special Terms and Conditions § VII, *Demonstration Delivery Systems*, Attachment L, Attachment M, and Attachment.
- 58 Medi-Cal 2020 Demonstration, Special Terms and Conditions ¶ 7.
- 59 Medi-Cal 2020 Demonstration, Special Terms and Conditions ¶ 8.
- 60 Two-Plan Boilerplate Contract, Exhibit A, Attachment 21 ¶ 1.B.1; COHS Boilerplate Contract, Exhibit A, Attachment 21 ¶ 1.B.1.
- 61 Two-Plan Boilerplate Contract, Exhibit A, Attachment 6 ¶ 14; COHS Boilerplate Contract, Exhibit A, Attachment 6 ¶ 13.
- 62 22 Cal. Code of Regs. §§ 53250, 53867; Two-Plan Boilerplate Contract, Exhibit A, Attachment 6 ¶ 14.
- 63 22 Cal. Code of Regs. §§ 53250, 53867; Two-Plan Boilerplate Contract, Exhibit A, Attachment 6 ¶ 14.C.
- 64 Two-Plan Boilerplate Contract, Exhibit A, Attachment 6 ¶¶ 14.B.13, 14.C; COHS Boilerplate Contract, Exhibit A, Attachment 6 ¶¶ 13.B.13, 13.C.
- 65 Two-Plan Boilerplate Contract, Exhibit A, Attachment 6 ¶ 14.B.15; COHS Boilerplate Contract, Exhibit A, Attachment 6 ¶¶ 13.B.15.
- 66 Two-Plan Boilerplate Contract, Exhibit A, Attachment 6 ¶¶ 14.B.8, 14.B.10; COHS Boilerplate Contract, Exhibit A, Attachment 6 ¶¶ 13.B.8, 13.B.10.
- 67 Two-Plan Boilerplate Contract, Exhibit A, Attachment 18 ¶ 2.G; COHS Boilerplate Contract, Exhibit A, Attachment 18 ¶ 2.G.
- 68 Two-Plan Boilerplate Contract, Exhibit A, Attachment 18 ¶ 2.J; COHS Boilerplate Contract, Exhibit A, Attachment 18 ¶ 2.I.
- 69 Two-Plan Boilerplate Contract, Exhibit E, Attachment 2 ¶ 16.E.3; COHS Boilerplate Contract, Exhibit E, Attachment 2 ¶ 16.E.3.
- 70 Two-Plan Boilerplate Contract, Exhibit A, Attachment 8 ¶ 1; see also COHS Boilerplate Contract, Exhibit A, Attachment 8 ¶ 1 (“The Contractor may enter into a Subcontract if the compensation or other consideration which the subcontractor shall receive under the terms of the Subcontract is determined by a percentage of the Contractor’s payment from the State, unless DHCS objects.”)