Issue Brief

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by Matthew Newman, MPP

Expanding Substance Use Care: Health Plan Teams Up with Seven California Counties

Many Californians experiencing substance use disorders have co-occurring mental or physical health conditions. For Californians insured through Medi-Cal, receiving comprehensive care can be extremely challenging because they must navigate different systems of care. Counties finance and administer substance use disorder (SUD) services and specialty mental health services — often through separate programs — while Medi-Cal managed care plans finance and administer physical health services and nonspecialty mental health services.

To overcome these obstacles, seven mostly rural Northern California counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) worked with Partnership HealthPlan of California ("Partnership"), a County Organized Health System and the sole Medi-Cal managed care plan in these counties, to create an integrated, regional pilot program.[1]

This effort, called the Wellness and Recovery Program, is part of the state's Drug Medi-Cal Organized Delivery System (DMC-ODS) and regionalizes SUD services across these seven counties, with the counties providing financial resources, Partnership providing centralized program administration, and county and non-county providers under contract with Partnership delivering services for enrollees. Participating counties remain financially responsible for the cost of DMC-ODS services. Rather than paying providers directly, however, the counties pay Partnership for each Medi-Cal enrollee who uses SUD services in a given month (a "per-user per-month," or PUPM, payment). Partnership, in turn, contracts with and pays participating providers. With Partnership as a single entity administering all the physical health and SUD services provided to a Medi-Cal enrollee, the program has the potential to more readily identify and address gaps in care and ensure that services are coordinated across providers.

Unlike both traditional Drug Medi-Cal services as well as SUD services provided under DMC-ODS programs elsewhere in the state, eligible enrollees in counties participating in the regional pilot can receive most services from any participating provider, no matter which of the seven counties the provider practices in. This regionalization relieves individual counties of the responsibility of developing individual comprehensive provider networks and a full spectrum of services. It is the only instance in the state in which a Medi-Cal managed care plan partners with a county or counties in DMC-ODS.

Substance Use Care in Medi-Cal

Prior to the implementation of DMC-ODS, Medi-Cal enrollees received SUD treatment through the standard Drug Medi-Cal program.[2] The program covered a limited set of services, including outpatient counseling and Narcotic Treatment Programs (NTPs), with many people entering services as a result of court mandates for drug-related offenses.[3]

DMC-ODS came about as an effort to bring substance use treatment more fully into the health care system by offering a comprehensive set of services through a formally organized structure with high expectations for quality and access. DMC-ODS was established in 2015 as a demonstration project through a Medicaid

Section 1115 waiver that allowed for the expansion of Drug Medi-Cal services to create a broader continuum of care, including withdrawal management, medication-assisted treatment, and multiple levels of residential treatment, as well as case management and care coordination with physical health and mental health. In December 2021, the California Department of Health Care Services (DHCS) received approval to reauthorize DMC-ODS as part of the permanent managed care authority under the state's Section 1915(b) waiver.[4] County participation in DMC-ODS is voluntary, although more than 95% of the state's population is represented by the counties that have elected to participate. However, for many smaller counties, the added costs and administrative requirements of participation have presented significant obstacles.

Under the traditional DMC and DMC-ODS arrangements, SUD services (like specialty mental health services) are "carved out" from the rest of the Medi-Cal benefit — generally provided by managed care plans — and instead are financed and administered by counties. This arrangement leverages county expertise in working with the providers and populations in SUD and specialty mental health, but it can also result in services delivered in isolation, with little coordination or integration with physical health services. And, because the financing streams for specialty mental health/SUD services and physical health services are separate, there is little financial incentive for counties and managed care plans to work together.

Providers, policymakers, and advocates have long sought to better integrate behavioral health services and physical health services, but political, operational, and financial issues have hindered many such efforts. By consolidating the administration of services within a single multicounty entity, the regional Wellness and Recovery Program has the potential to overcome some of the obstacles to integration and to deliver better coordination of services across SUD and physical health while expanding access to care by allowing Medi-Cal enrollees to seek care in any county within the pilot region.

Program Overview

Building on the work done to bring Partnership to the region beginning in the 1990s, a group of county officials initiated the regional DMC-ODS pilot out of an interest in expanding SUD services and recognition that, as individual counties, they lacked the capacity to develop and run the new program. DMC-ODS establishment required ensuring network adequacy, providing all the required services, maintaining a 24-hour access line, reporting extensive data, and addressing other administrative, logistical, and legal issues. Through the Wellness and Recovery Program, Partnership, a National Committee for Quality Assurance-accredited plan with deep experience in managing and coordinating care across physical health specialties, has responsibility for all these functions and ensures compliance with all state and federal managed care requirements.

Developing the Financing Model

After deciding to explore participation in the DMC-ODS regional model, the counties and Partnership faced the tasks of determining how the program would operate and, more dauntingly, how it would be financed. Initially, the parties considered developing a traditional capitation model in which counties would pay Partnership a fixed amount for each enrollee each month regardless of whether or to what extent SUD services were utilized. Such a capitation arrangement, a PUPM, offers several advantages in terms of administrative simplicity and alignment of incentives for improving quality and reducing overall cost of care. Specifically, such an arrangement allows a health plan (or other recipient of such payments) to administer and manage a set of benefits in order to minimize costs, ensure investments in preventive care, and take advantage of long-term savings. In addition, revenues, which vary only with enrollment but not service utilization, are predictable, and administrative complexity associated with invoicing the payer is minimized.

A capitation arrangement, however, was not suitable (at least in the initial stages) for the regional DMC-ODS pilot. Very little data existed to estimate the likely extent or cost of service utilization. Participating counties had not previously delivered the full range of services included in the DMC-ODS program, so historical data on cost and utilization were of little value. Also, data from other counties participating in the DMC-ODS pilot were of limited use, as these counties were also developing new programs and had potentially different patient population characteristics and cost bases. Without better data on program utilization and cost, developing capitated rates required unacceptable levels of assumption and uncertainty. The counties could not be certain of the cost of the program or to what extent they might be overpaying or underpaying for services used by their residents. And, as the state entity responsible for administering the Medi-Cal program — both behavioral health services and physical health services — DHCS (and the Centers for Medicare & Medicaid Services, or CMS, which oversees the Medicaid program nationally) could not be sure of adequate funding to cover necessary services, requiring Partnership to use revenues from another source (e.g., those designated for physical health services) to subsidize SUD services as needed.

Ultimately, a system based on a PUPM payment was agreed to. Under this arrangement, each county pays Partnership a fixed amount for each county resident/Partnership enrollee who accesses any SUD service in a given month. This amount varies from county to county depending on the costs, mix of expected utilizers, and historical data regarding services in that county. Partnership invoices each county for administrative and quality assurance costs as well as for each user who accesses services in a given month. The counties' payments of these invoices form the basis of certified public expenditures (CPEs), which are used to draw down federal matching funds.[5] The counties submit documentation of these expenditures to DHCS, and in turn, DHCS pays the state and federal matching funds to the counties.

Partnership contracts with and pays SUD providers, primarily on a traditional fee for service (FFS) basis, with rates negotiated between the providers and Partnership (except for NTPs, which are paid with rates set by the state). Partnership submits the required data to DHCS via the 837 claim file for all encounters paid for during the prior month.

At the close of the fiscal year, the counties and Partnership engage in a process to reconcile the PUPM payments made to Partnership with the actual claims cost incurred by each county. Partnership then completes and forwards a reconciliation report to DHCS, which prepares a final payment report. The parties then agree on a revised PUPM amount for the subsequent fiscal year.

This PUPM arrangement satisfied several stakeholder concerns. For counties, the system ensures that they pay only for services delivered directly to their residents. For the state, this arrangement — including the reconciliation — ensures that funds for the Drug Medi-Cal program are not comingled with funds for other Medi-Cal services (e.g., physical health services and specialty mental health services).

Other Program Features

Besides the financing model, several additional program features had to be developed and implemented. One significant challenge was that the program was required to cover all Medi-Cal beneficiaries, not just those the state had assigned as Partnership members (a 5% to 10% difference at any given time).[6] The counties and Partnership also needed to address how to provide 24-hour access, handle referrals and changes in level of care across the system, provide case management, and build out the required levels and types of service. In addition, a series of administrative and legal issues needed to be resolved, including the development and negotiation of contracts delegating county responsibilities to Partnership, contracts between Partnership and county providers, and data

use agreements (along with information technology procedures and practices) that adequately protect patient privacy and comply with federal requirements while ensuring that providers have access to needed patient data and information.[7] Further, the program required that each county enter into a CMS-approved contract with the state, that a provider network be developed (or expanded) and credentialled, and that training be conducted to educate county staff about managed care and to educate Partnership staff about SUD services. Once the program was ready to launch, a communication and outreach plan was needed as well.

Obstacles

Participants faced many obstacles in developing the program; obtaining state and federal approval of the Wellness and Recovery Program took more than five years in total. Initial discussions among the counties about establishing a regional program with Partnership began in 2015, the year the DMC-ODS waiver was approved. With agreement among the counties that an integrated regional model was worth considering, Partnership leadership was brought into the discussion and development of the contours of the program began. As the process unfolded, individuals representing the counties, Partnership, and DHCS reported frustrations with the long process. Representatives of several counties reported that DHCS was averse to adopting a PUPM, or capitation, approach because of their reluctance to adjust the county-based model. Representatives also voiced concerns about the quality and usefulness of the existing cost data and potential cross-subsidization across parts of the Medi-Cal program. Other observers reported that counties were reluctant to incur costs beyond their obligated payment amounts and that a PUPM arrangement risked counties paying more than the amount required. For all parties involved, establishing the Wellness and Recovery Program represented a new way of doing things, which required bridging differing institutional cultures, developing new relationships, and establishing new procedures.

Limited Financial Integration

Ultimately, the PUPM arrangement agreed upon, while allowing for improved clinical integration, still leaves financial incentives largely unaligned. Under a capitation arrangement, the managed care plan would have a financial incentive to make investments in preventive services, case management, and care coordination to manage overall health care costs, whether related to SUD services or physical health services. Under the PUPM model, by contrast, the benefits from any investments that counties might make that reduce the need for physical health services, for example, would be enjoyed exclusively by Partnership, even though Partnership had not financed the investments; the converse is equally true.

Path Ahead for Integration

While it is too soon to state definitively whether the pilot, launched in 2020, has been effective in improving access to care and integrating services, early evidence suggests the program is achieving these goals.[8] A logical question, then, for policymakers and program administrators is whether and to what extent this pilot can serve as a model for future integration efforts, including integrating specialty mental health services with physical health and SUD services.

As the regional Wellness and Recovery Program enters its second year of operation, those looking to improve integration between behavioral health services and physical health services should be pleased. While the road to implementation has been a long one, it is clear that the seven counties and Partnership have done a large portion of the difficult work that is required to provide a foundation for integration efforts. The PUPM-plus-reconciliation arrangement can be replicated by other counties and managed care plans. Because of the post-hoc reconciliation, the need to develop precise payment rates upfront is diminished. At the same time, experience gained from both the regional model counties and other DMC-ODS programs brings more and better data about cost and utilization on which to

base rates and perhaps a more sophisticated financing system. The pilot has DHCS and CMS approval, which should facilitate the pursuit of similar arrangements by other plans and counties.

Looking ahead, one important challenge will be developing a pathway to financial integration, including a mechanism for measuring and allocating shared savings. If such an arrangement were to be expanded to mental health services, counties and managed care plans would need to develop an approach addressing mental health's more varied and complex set of services. Nevertheless, there are clearly more similarities than differences between the SUD and mental health financing and service delivery systems that make a future integration pilot likely feasible.[9]

The fact that Partnership is a County Organized Health System, and thus the only Medi-Cal managed care plan in each participating county, simplifies the administrative work of establishing a regional integrated program. To expand any such efforts beyond the current pilot would require addressing the complexities in counties with more than one managed care plan. In addition, broader integration efforts might need to address any county concerns about a loss of control over the financing and delivery of behavioral health services. Finally, additional resources might be needed, at least initially, as integration and improved access increase utilization among a population that has long experienced limited access to the behavioral health services they are entitled to under the Medi-Cal program.

About the Author

Matthew Newman, MPP, is principal and cofounder of **Blue Sky Consulting Group**, a public policy and economics consulting firm specializing in helping clients address their most challenging strategic and analytical issues.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. "**Wellness & Recovery Program**," Partnership HealthPlan of California, accessed March 4, 2022.

2. This arrangement still exists in counties not participating in DMC-ODS.

3. Molly Brassil, Carol Backstrom, and Erynne Jones, ***Medi-Cal Moves Addiction Treatment into the Mainstream: Early Lessons from the Drug Medi-Cal Organized Delivery System Pilots***, California Health Care Foundation (CHCF), August 3, 2018.

4. "**CalAIM 1115 Demonstration & 1915(b) Waiver**," California Department of Health Care Services (DHCS), last modified March, 1, 2022. Certain SUD components are authorized under the CalAIM Section 1115 demonstration and Medi-Cal State Plan, including continuing DMC-ODS services for short-term residents of institutions for mental diseases (IMDs) (Section 1115) and new contingency management services in DMC-ODS for treatment of stimulant use disorder (Section 1115).

5. Under the terms of the Medicaid program, states must pay a share of the cost of the services used by their residents. To receive the federal matching share of these costs, known as federal financial participation (FFP), states must document their contributions. Certified public expenditures are one mechanism by which a governmental entity can document that it has paid the nonfederal share and receive FFP. The governmental entity must certify that the funds expended are public funds used to support the cost of providing Medicaid services and, based on this certification, the state can claim FFP.

6. It generally takes one to two months for the state to assign new beneficiaries to Partnership, a factor that is most significant for beneficiaries who lose their eligibility while incarcerated.

7. Title 42 of the Code of Federal Regulations contains confidentiality requirements for substance use disorder patient records.

8. ***2020–2021 Statewide Annual Report: External Quality Review Report: Drug Medi-Cal Organized Delivery System***, Behavioral Health Concepts.

9. For more information on voluntary integration options for counties and managed care plans, see Anil Shankar and Diane Ung, ***Voluntary Behavioral Health Integration in Medi-Cal: What Can Be Achieved Under Current Law***, CHCF, October 21, 2019.