The Coordinated Care Initiative and Behavioral Health Services

Frequently Asked Questions | September 2012

California's Coordinated Care Initiative (CCI), adopted in July 2012, promotes integrated delivery of medical, behavioral, and long-term care Medi-Cal services, and also provides a road map to integrate Medicare and Medi-Cal for people on both programs, called "dual eligible beneficiaries."

The CCI, pending federal approval, will be implemented in 2013 in eight counties: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside and San Bernardino.

The CCI includes two parts: 1) Mandatory enrollment of all Medi-Cal beneficiaries (including dual eligibles) into managed care for all Medi-Cal benefits, including long-term services and supports (LTSS[1]); and 2) Optional enrollment into integrated managed care that combines Medicare and Medi-Cal benefits, known as the "duals demonstration."

This document answers common questions about how behavioral health services will be coordinated under the duals demonstration.

1. What behavioral health services will be available to beneficiaries enrolled in the duals demonstration?

Demonstration health plans will be responsible for providing enrollees access to all medically necessary behavioral health (mental health and substance abuse treatment) services currently covered by Medicare and Medicaid.

While all Medicare-covered behavioral health services will be the responsibility of the health plans under the demonstration, some Medi-Cal specialty mental health and substance abuse services will not be included in the capitated payment made to the participating health plans (i.e. they will be "carved out). Demonstration plans will have a written agreement with county agencies to ensure enrollees have seamless access to the rehabilitative and targeted case management services administered by the counties.

2. What does it mean that Medi-Cal specialty mental health and Drug Medi-Cal services are "carved out" of the duals demonstration?

Specialty Mental Health Rehabilitative and Targeted Case Management Services and Drug Medi-Cal services listed in the following table will continue to be financed and administered by county agencies under the provisions of the 1915(b) waiver and the approved state plans. They will be excluded from the health plan's capitation payment. Health plans will be

[1] LTSS include In-Home Supportive Services (IHSS), Multipurpose Senior Service Program (MSSP), Community-Based Adult Services (CBAS), and nursing facilities.

responsible for coordinating with their local county agencies to provide seamless access to these behavioral health services for individuals who meet medical necessity criteria.

Behavioral Health Services Excluded from the Demonstration

Specialty Mental Health Services (1915b waiver)	Drug Medi-Cal benefits
1. Portion of psychiatric inpatient hospital services not covered by Medicare as the primary coverage/payer 2. Mental health services (individual and group therapy, assessment, collateral, plan development)* 3. Medication support services* 4. Day treatment intensive 5. Day rehabilitation 6. Crisis intervention 7. Crisis stabilization 8. Adult residential treatment services 9. Crisis residential treatment services 10. Psychiatric health facility Services 11. Targeted case management	1. Methadone maintenance therapy 2. Day care rehabilitation 3. Outpatient individual and group counseling 4. Perinatal residential services 5. Naltrexone treatment for narcotic dependence

* These are bundled services and when unbundled some may be covered by Medicare

3. How many dual eligible beneficiaries are using specialty mental health services today in the eight CCI counties?

About 28 percent of the roughly 240,000 adults served by the county mental health plans statewide are dual eligible beneficiaries. The table below shows dual eligible beneficiaries receiving mental health services through the counties in the eight CCI counties.

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

4. How many dual eligible beneficiaries use Drug Medi-Cal services?

In fiscal year 2010-11, of the 62,000 Drug Medi-Cal admissions statewide, about 8,381 were dual eligible beneficiaries. About 44 percent (3,679) of these dual eligible beneficiaries using Drug Medi-Cal services resided in Los Angeles County.

5. How will the state ensure beneficiaries get all the services they need if some are carved out of the demonstration?

The state is implementing a “strategy for shared accountability” to ensure health plans and counties have aligned incentives to coordinate services that are in the beneficiaries’ best interest. The state is requiring that health plans and county’s mental health and substance

use agencies expand existing or develop detailed written agreements (MOUs) that describe how the screening, assessment, referral and ongoing care and problem resolution processes will work for beneficiaries who meet the medical necessity criteria for specialty mental health and substance use services. Additionally, there will be ongoing quality monitoring and measurement of health plan performance on improving beneficiary behavioral health outcomes.

6. **What criteria will be used to determine whether county-administered services are medically necessary?**

   To determine responsibility for covering Medi-Cal specialty mental health services, health plans and counties will follow the medical necessity criteria for specialty mental health 1915b waiver services described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210. For Drug Medi-Cal services, health plans and counties will follow Title 9, California Code of Regulations Section 51303 and 54301. Disagreements will be addressed through a joint problem identification and resolution process between the health plans and county agencies, as described in their MOUs.

7. **Will county agencies be incentivized or rewarded for providing services, such as targeted case management, that may result in reduced inpatient admissions or emergency department visits?**

   To incentivize high quality care delivery, the demonstration includes a “quality withhold” in which 1%, 2%, and 3% of the health plans capitation is withheld in years one, two and three, respectively, and the health plans can earn it back by meeting set performance metrics. Under the currently proposed behavioral health shared accountability strategy, one of these metrics each year would be tied to behavioral health coordination. Upon achieving the behavioral health coordination metric, the current proposal would require the health plans to share a portion of those funds earned back from that particular measure with their county partners. The metrics will graduate in difficulty and become more outcome-oriented each year. The total amount tied to each withhold measure is still being decided.

8. **During the passive enrollment process how will continuity of care be guaranteed for beneficiaries currently receiving services through the counties?**

   Ensuring continuity of care is a CCI priority. Health plans will be reuired to follow existing federal and state laws around continuity of care and also be required to provide out-of-network access to Medi-Cal doctors for up to 12 months and Medicare doctors for up to six months if certain conditions are met.

9. **What responsibility will demonstration health plans have to manage health conditions with behavioral manifestations that currently are excluded from specialty mental health services, such as traumatic brain injury and dementia?**

   The participating health plans are responsible for guaranteeing the delivery of all medically necessary services covered by Medicare and Medi-Cal today. Health plans must ensure that members receive appropriate referrals for all medically necessary services. Under the demonstration, health plans will be responsible for providing enhanced care coordination for high-risk members to ensure they receive appropriate medical, behavioral and long-term services and supports.