March 2, 2017

TO: Honorable Chair and Members, Senate Health Committee
Honorable Chair and Members, Assembly Health Committee

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SUBJECT: County Behavioral Health Implementation of the Medicaid Managed Care Final Rule

The County Behavioral Health Directors Association of California (CBHDA) represents the behavioral health directors from each of California's 58 counties and two cities. Counties view the CMS Medicaid Managed Care Final Rule (Final Rule) as an opportunity to demonstrate the value of California's public behavioral health system. Given the substantive changes in the Final Rule, there will be a significant impact on county behavioral health systems. This memo outlines the Final Rule's impacts on county behavioral health, and the challenges counties will need to overcome to implement the regulations. The memo supports the remarks CBHDA provided to the Health Committees at the Joint Informational Hearing on Tuesday, February 28, 2017.

Applicability of the Final Rule to County Behavioral Health Systems

County behavioral health systems manage the care for Medi-Cal beneficiaries in need of specialty mental health services and substance use disorder (SUD) services. The county systems are unique because in addition to functioning as the managed care plan for Medi-Cal beneficiaries with significant behavioral health needs, counties are also often the providers of direct services through county-run clinics. As plans and providers, our county systems are committed to assuring access to recovery-oriented services for these populations through implementation of the Final Rule.

Counties as managed care entities for behavioral health:

- *County Mental health plans (MHPs).* The 1915(b) wavier provides the authority for counties to operate as mental health plans (MHPs) for Medi-Cal beneficiaries in need of specialty mental health services. Under the waiver, MHPs are designated as non-risk prepaid inpatient health plans, and are thus subject to the managed care regulations.

- *Drug Medi-Cal Organized Deliver System (DMC-ODS) Waiver Counties.* Under California's current 1115 waiver counties that opt in to the waiver are designated as

non-risk prepaid inpatient health plans for SUD services, and are thus subject to the managed care regulations.

Counties believe that the Final Rule provides an opportunity to deliver on the CMS goals for the regulations, including improving the quality of care, consumer experience, and closer alignment with Medi-Cal managed care plans. We are working with DHCS to ensure that county MHPs and DMC-ODS waiver counties will be able to implement the regulations successfully.

County MHP Costs for Implementation of the MMC Final Rule

As counties increasingly understand the extent of the new or changed requirements in the regulations, it is clear that compliance with the Final Rule represents a significant new workload. We were pleased that the Governor's proposed budget included allocations for county MHP implementation of the regulations, recognizing the state's Proposition 30 obligations for providing 50 percent of the non-federal share for implementation of new federal requirements. However, CBHDA anticipates that the estimates included in the budget may be significantly lower than the actual cost of implementation.

Counties are also concerned about budgeting for the increased administrative costs within the existing behavioral health revenue streams, which support county direct services, indirect services, and administrative costs. Many counties do not receive county general funds to support the additional cost of implementing these new requirements, so will need to assess their current budgets to ensure it accurately reflects the new activities required under the rule while maintaining existing direct service programming.

Examples of where we anticipate the Governor's proposed budget will be insufficient to cover the cost of implementation include:

- *Data collection and reporting.* The proposed budget estimates that each county will need one full time employee (FTE) to comply with new data collection and reporting requirements. In 42 CFR §438.66, the rule requires states to submit an annual program assessment report of each county MHP to CMS, which includes ten reporting domains. Though counties currently provide data to DHCS in many of the ten reporting areas, any new measures or reporting elements represents a significant amount of new work for counties such as changes to workflow, staffing, and IT infrastructure. There are other sections of the rule that will require additional data collection and reporting to DHCS, and the cumulative impacts to counties may require more than the currently estimated one FTE per county to comply with these requirements. There will also be variability between counties in how many resources, such as FTEs, will be needed to comply with the Final Rule.

- *Updates to information systems.* The proposed budget estimates that total costs for changes or updates to information systems will cost a total of $3 million, which assumes a total per county cost of less than $55,000. Given the expense of changing existing data systems, or implementing new reporting systems, we anticipate the current estimate is lower than the actual cost.

CBHDA is working with its members and DHCS to determine a more accurate estimation of cost for implementation.

Practical Challenges for Implementation

The new reporting requirements for the state's annual program assessment report is one of many that will require changes to existing county MHP processes and the development of new processes for DMC-ODS counties. While we believe successful implementation of the regulations will strengthen the public behavioral health system, there are a number of practical challenges that counties will likely encounter when implementing the regulations.

Challenges:

- *Aggressive timelines for implementation.* The timelines for implementation are aggressive and may be challenging for some counties, particularly for counties with limited administrative bandwidth. Many of the requirements have an implementation date of July 1, 2017 and others with even more significant impact – such as network adequacy – have an implementation date of July 1, 2018. The short timelines will be challenging for counties, and particularly so for small counties that counties rely on few staff members to meet the large number of new requirements.

- *Substantial new administrative requirements.* The regulations will significantly increase the administrative responsibilities of the counties to ensure compliance with the Final Rule. Examples include:

    - Increased data tracking and reporting requirements to comply with sections of the rule including, but not limited to:

        - 42 CFR §438.66 requires increased state monitoring of programs, and requires a state annual program assessment report.
        - 42 CFR §438.68, §438.206, and §438.207 require the development of network adequacy requirements and the state's certification of those networks.
        - 42 CFR §438.340 and §438.334 require the development of a state quality strategy and quality rating system.

    - Shortening of timeframes for MHP review processes, which will impact county weekend and holiday staffing. These sections include:

        - 42 CFR §438.408 shortens timeframes for appeal resolution. For expedited appeal resolution, the timeframe changes from 3 business days to 72 hours.
        - 42 CFR §438.408 shortens the timeframe for expedited treatment authorization from 3 business days to 72 hours.

Recommendation:

- Support, technical assistance, and flexibility – as permitted under the rule – will be needed to overcome these challenges. We look forward to continuing working with DHCS to ensure that counties have the resources they need to demonstrate compliance with the Final Rule.

Network Adequacy Challenges

In addition to practical challenges related to the aggressive timelines and amount of work to implement the regulations, we anticipate counties may have substantive challenges in meeting the standards as outlined in the current DHCS network adequacy proposal.

Time and Distance

Time and distance standards have not previously been applied to mental health or substance use providers and we anticipate the proposed standards may present challenges for some counties.

Challenges:

- For rural or small counties, while much of the population and services may fall within the proposed standard of 60 miles and 90 minutes, parts of the county that are more rural or remote may not meet the standard.

- For medium or large counties, there may be rural areas within the county that will face similar challenges especially because the proposed standards for time and distance are more stringent for medium and large counties.

- In many small counties, providers are located in the “hubs” of a small county, which may be more than 60 miles or 90 minutes from some beneficiaries.

- Beneficiaries in remote areas of a county may prefer to receive services in a bordering county if the closer provider hubs are in neighboring communities across county lines.

- The standards may be particularly challenging for specific provider types, such as psychiatry, for which there is a workforce shortage or in counties where there is a lack of substance use disorder service providers.

Recommendations:

- Standards with a higher number of minutes and miles should be developed for frontier medical service study areas (MSSA) within a county, where population

density is less than 11 persons per square mile[1]. There are 18 counties with at least one MSSA within the county.

Timely Access

The timely access standards as currently proposed may present challenges for certain provider types. Counties have been preparing for more stringent timeliness standards through the 1915(b) waiver special terms and conditions, which includes additional measurement and reporting requirements related to timely access to care. However, first appointment timeliness is still variable throughout the state and meeting the 10 business day standard for non-physician mental health services and the 15 business day standard for specialists – including psychiatry – may be difficult in some counties or areas within a county.

Challenges:

- First appointment timeliness for non-psychiatric mental health services was reported by 80 percent of counties in the FY 2014-15 review period. Timeliness of initial appointments ranged from 12 to 20 days depending on county size, with a statewide average of 16 days.

- First appointment timeliness for psychiatric services was reported by 64 percent of counties in the FY 2014-15 review period. Timeliness of initial appointments ranged from 21 to 43 days, with a statewide average of 34 days. The variability illustrates the larger workforce challenges throughout the state for psychiatry.

Timeliness data is captured through the annual EQRO review process and counties' submission of a timeliness self-assessment report. Counties currently have variable methods for defining and collecting the self-assessment data. Given this variability, it is important to note that while the aggregate data is helpful in demonstrating the possible challenges of the proposed timely access standards, there are limitations to the existing data. Counties are currently working with DHCS toward statewide reporting of timely access to care to include in the Specialty Mental Health Services Performance Dashboard, a requirement of California's 1915(b) special terms and conditions.

Recommendations:

- Creative solutions and tools for recruiting and training psychiatrists will be needed in many areas of the state experiencing this workforce shortage.

Alternative Access Standard

We urge the state to view alterative access standards as a viable option for counties that creatively work to ensure beneficiaries have access to services.

[1] On the Frontier: Medi-Cal Brings Managed Care to California's Rural Counties. California Health Care Foundation. March 2015. Accessed via: http://www.chcf.org/publications/2015/03/frontier-medical-rural-counties

Recommendations:

- Throughout all counties, many services provided by MHPs are not clinic-based and are provided to the beneficiary in the community. This is one of the many strengths of the county behavioral health system and should continue to be viewed as an asset for rural areas within a county where the clinician may travel to the beneficiary to ensure access to services.

- The use of telepsychiatry is a growing and effective way to provide care to beneficiaries living in remote or rural areas.

- The process for obtaining an alternative access standard should be clearly outlined and should not create additional administrative burdens for counties.

Summary

Thank you for your consideration of county behavioral health implementation of the Medicaid managed care regulations. We are dedicated to successful implementation of the Final Rule and look forward to further discussion regarding the resources counties need to ensure successful implementation within the aggressive timeframes in the rule. We remain committed to ensuring access to recovery-oriented services to beneficiaries in need of specialty mental health and substance use disorder services.