

1115 Waiver Update- Development Status of IHS Program Organized Delivery System

Program Directors' Meeting
October 31, 2016
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History

- Medi-Cal began developing a plan for re-organizing the funding of substance use disorder services for eligible Medi-Cal beneficiaries in 2014, still being rolled out
- Multiple reasons for this re-organization, including Federal mandates to expand mental health and substance abuse coverage

State plan overview

- Counties gatekeepers for all Drug Medi-Cal services, and all funding and much of the oversight is now tied to counties
- Requires Organized Delivery Systems to utilize evidence-based practices, including ASAM
- Expands coverage to include residential treatment
- Only “opt in” counties can participate in expanded coverage

Opportunities for IHS-funded programs

- Initial recognition that newly available Drug Medi-Cal (DMC) funding for residential treatment could be very meaningful for our **residential programs** (could increase funding by 25-40%)
- Good time to facilitate DMC participation in our **ambulatory programs**, which had previously been prohibitive. Our programs are already providing services, it would be beneficial to receive funding for substance use disorder services.
- Helps us to offer culturally-sensitive services to our patients
- Since many of our programs cover multiple counties, and for residential programs accept referrals from anywhere in the state, having to go through counties for all services would be a problem (would require contracts and referral agreements with all counties from which patients live) --□ led to effort to form Drug Medi-Cal Organized Delivery System

Challenges in an ODS for Indian Country

- Early research into current clinical capacity indicates that we collectively have most of the necessary levels of care for an ODS
- We are currently in need of a way to administer the system, which will require some command and control

Collaboration

- State, CMS, CCUIH, CRIHB and Area Office have worked together to come up with ways that tribal and urban Indian programs (TUIPs) can participate within an Organized Delivery System (ODS) that best serves the needs of our patients
- Tribal Organized Delivery System (includes Urban programs) is written into the official, CMS-approved State-waiver
- Much of the year has been spent considering models for a Tribal ODS with the assistance of the CMS' Innovation Accelerator Program contractor

What are the requirements to administer this program?

- Mechanism for reimbursement for services
- Quality assurance and improvement including provider credentialing, ensuring and improving access, expanding capacity, having a QI committee
- Program integrity (guarantee that funds being used correctly, avoiding fraud)
- Case coordination (making sure patients are able to move to appropriate levels)

Staffing Requirements

Area	Notes
1. Leadership	<ul style="list-style-type: none"> Minimum dedicated 0.5 FTE with managed care experience for leadership of entire IHPODS 0.5 FTE for clinical director with managed care, UM or care coordination experience Leadership position may be combined into 1 person depending on final size of IHPODS
2. Provider network	<ul style="list-style-type: none"> 1.0 - 2.0 FTEs for 40 providers for contracting, credentialing, provider relations and coordination of training needs Adjust for final provider count, including all necessary providers for sufficient capacity Supplement with contract resources during implementation phase
3. Beneficiary access line	<ul style="list-style-type: none"> Seek estimates from counties for expected call volume 24/7 coverage model needs to be determined (buy or build)
4. Assessment/Medical necessity determination	<ul style="list-style-type: none"> Need more information on model for IHPODS Determine number of assessments, medical necessity determinations needed and estimate staffing assumptions
5. UM	<ul style="list-style-type: none"> 1.0 FTE for every 20 – 25 avg daily census in bed-based services requiring authorization (may be adjusted based on needed frequency of reviews) Part-time analytical resource for utilization analysis depending on UM program requirements (share with QA and program integrity)
6. Care coordination	<ul style="list-style-type: none"> Need more information on model for IHPODS FTEs generally based on caseload ratios based on required activities and enrolled beneficiary acuity (example from Medicaid integrated health plan—1:1750 low level, 1:75 medium, 1:50 high need)
7. QA	<ul style="list-style-type: none"> Part-time FTE for required QA activities Part-time FTE for analytical/reporting
8. Program integrity	<ul style="list-style-type: none"> Part-time FTE for required program integrity based on projected claims volume Part-time FTE for analytical/reporting
9. HIT staffing	<ul style="list-style-type: none"> TBD depending on final model, sources of HIT systems
10. HIT systems <ul style="list-style-type: none"> a. Eligibility b. Provider c. Clinical (Med nec, UM, CC) d. Claims 	<ul style="list-style-type: none"> TBD depending on final model and entity type

CMS Contractor estimated the total FTE's at about 4-5

Who should administer the program?

▫ Models

- 1) Large tribal or urban Indian provider (residential program?)
- 2) New entity (formation of consortia or non-profit)
- 3) CRIHB
- 4) Hybrid (including Tribal/State Direct Partnership with IHS lead)

CMS Contractor Recommendations

- Need “single point of accountability” primarily so state can hold responsible for program oversight and integrity and guarantee performance of the health programs
- Administrative entity should not also be provider entity
- Other administrative elements could be shared
- Rules out #1 and hybrid which makes each health program the “single point of accountability”
- The administrative structure should leverage existing capacity, to the extent possible, to minimize administrative cost (because the Drug Medi-Cal funding is so limited, can’t work with large admin costs)

- Provider of funds including pre-payment
- High level monitoring incl EQRO, program integrity, etc
- ASAM-level determination for RT
- Claims payment?

State



Single point of accountability (CRIHB?)



Clinical entity (IHS?)

- Management of service delivery contracts between state and T/UIHP
- Monitoring of T/UIHP DMC providers
- Contracting with out-of-network DMC providers
- Monitoring of out-of-network DMC providers
- Quality assurance (incl credentialing)
- Performance improvement plans for non-performance
- Claims payment?

- Case coordination of level changes, continuing care
- Case management
- Overall monitoring of service breadth
- Access monitoring
- Toll-free line



Contracted DMC Provider

T/UIHP



ACTIVITY LEGEND

Red – Mandatory, non-transferable

Blue - Transferable

Timeframe

- State is implementing ODS in phases corresponding to geographic areas, as well as topics
- Primary focus on Phase 3, Central Valley
- Indian Country is Phase 5, and tentatively scheduled to begin Fall 2017
- In the meantime, we need to determine and design the administrative structure, so we can plug in the clinical elements

The background features abstract, overlapping green geometric shapes, primarily triangles and polygons, in various shades of green, creating a modern and dynamic visual effect.

Questions?

Comments?