The Medi-Cal Eligibility Expansion and Substance Use Disorder Treatment Services

24 July 2013
Caseload Estimates

• On 1 Jan 14, there will be 1.4 to 1.7 Million new Medi-Cal eligibles in California.

• In Contra Costa, the estimate for alcohol or drug diagnosis, households below 200% poverty – 16,754
Caseload Estimates

- In FY 10-11, 63% of statewide CalOMS SUD treatment admits (N=118,266) reported they were not Medi-Cal eligible.

- In FY 11-12, 73% of CCC admits (N=3,719) reported that they were not Medi-Cal eligible.
Categories of Coverage in the ACA

- Commercial Plans
- Subsidized Coverage Through Covered California
- Medi-Cal Expansion
- Current Medi-Cal Eligibles
Who Will be at Your Door?

• 2 Groups of Medi-Cal eligibles
  – Traditional Eligibles
    • Current DMC Caseload
  – Newly Eligibles
    • Medi-Cal Expansion Population
    • Childless adults under 138% FPL

• Persons with commercial coverage.
  – To the extent that you are able to negotiate contracts with these carriers.
New SUD Caseload

• More diverse in terms of culture and language.

• More offenders? (AB 109, PC 1210, Others)

• Statewide caseload could grow by 50% to 75%.
## SUD Caseload Estimates

<table>
<thead>
<tr>
<th></th>
<th>Current MC %</th>
<th>Current SUD Tx %</th>
<th>Expansion %</th>
</tr>
</thead>
<tbody>
<tr>
<td>African-American</td>
<td>11%</td>
<td>15.2%</td>
<td>8%</td>
</tr>
<tr>
<td>Asian-Pac. Islander</td>
<td>3%</td>
<td>.3%</td>
<td>10%</td>
</tr>
<tr>
<td>Latino</td>
<td>21%</td>
<td>35%</td>
<td>41%</td>
</tr>
</tbody>
</table>

- 23% of expansion population do not speak English well or do not speak English at all.

- Demographic changes in the expansion cohort needing or seeking SUD treatment will drive changes in outreach and engagement strategies.

- A culturally competent workforce will be essential.

## Current AODS Clients

<table>
<thead>
<tr>
<th>Medi-Cal Beneficiary</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid No</td>
<td>3719</td>
<td>73.0</td>
<td>73.0</td>
<td>73.0</td>
</tr>
<tr>
<td>Yes</td>
<td>1373</td>
<td>27.0</td>
<td>27.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>5092</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Source: AODS PSP Database. Provider data reported to CalOMS in FY 11-12.
Traditional Medi-Cal Eligibility

If you are enrolled in one of the following programs, you can get Medi-Cal:
• SSI/SSP
• CalWorks (AFDC)
• Refugee Assistance
• Foster Care or Adoption Assistance Program

You can also get Medi-Cal if you are:
• 65 or older
• Blind
• Disabled
• Under 21
• Pregnant
• In a skilled nursing or intermediate care home
• On refugee status for a limited time, depending how long you have been in the United States
• A parent or caretaker relative or a child under 21 if:
  – The child’s parent is deceased or doesn't live with the child, or
  – The child’s parent is incapacitated, or
  – The child’s parent is under employed or unemployed
• Have been screened for breast and/or cervical cancer (Breast and Cervical Cancer Treatment Program)
Eligibility for Medi-Cal Expansion

- Household Modified Adjusted Gross Income (MAGI) < 138% FPL.

- Can document immigration status and/or citizenship.
Who Will be at Your Door?

<table>
<thead>
<tr>
<th>Persons in Household</th>
<th>100%</th>
<th>133%</th>
<th>138%</th>
<th>175%</th>
<th>200%</th>
<th>300%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,490</td>
<td>$15,282</td>
<td>$15,856</td>
<td>$20,108</td>
<td>$22,980</td>
<td>$34,470</td>
<td>$45,960</td>
</tr>
<tr>
<td>2</td>
<td>$15,510</td>
<td>$20,628</td>
<td>$21,404</td>
<td>$27,143</td>
<td>$31,020</td>
<td>$46,530</td>
<td>$62,040</td>
</tr>
<tr>
<td>3</td>
<td>$19,530</td>
<td>$25,975</td>
<td>$26,951</td>
<td>$34,178</td>
<td>$39,060</td>
<td>$58,590</td>
<td>$78,120</td>
</tr>
<tr>
<td>4</td>
<td>$23,550</td>
<td>$31,322</td>
<td>$32,499</td>
<td>$41,213</td>
<td>$47,100</td>
<td>$70,650</td>
<td>$94,200</td>
</tr>
<tr>
<td>5</td>
<td>$27,570</td>
<td>$36,668</td>
<td>$38,047</td>
<td>$48,248</td>
<td>$55,140</td>
<td>$82,710</td>
<td>$110,280</td>
</tr>
<tr>
<td>6</td>
<td>$31,590</td>
<td>$42,015</td>
<td>$43,594</td>
<td>$55,283</td>
<td>$63,180</td>
<td>$94,770</td>
<td>$126,360</td>
</tr>
<tr>
<td>7</td>
<td>$35,610</td>
<td>$47,361</td>
<td>$49,142</td>
<td>$62,318</td>
<td>$71,220</td>
<td>$106,830</td>
<td>$142,440</td>
</tr>
<tr>
<td>8</td>
<td>$39,630</td>
<td>$52,708</td>
<td>$54,689</td>
<td>$69,353</td>
<td>$79,260</td>
<td>$118,890</td>
<td>$158,520</td>
</tr>
</tbody>
</table>
What will you be Getting Paid For?

- Current DMC benefits (the base)
  - Outpatient Counseling
  - NTP
  - Day Care Habilitative – Perinatal & EPSDT
  - Perinatal Residential
  - Naltrexone
What Will You Be Getting Paid For?

- Enhanced Benefits
  - Inpatient detoxification
  - Intensive outpatient
  - Day treatment
  - Individual and group counseling
  - Medical treatment for withdrawal
  - Transitional residential treatment
How Does It All Fit Together?

• Inpatient Detox – “elective” with medical necessity.
• Outpatient – no restrictions on individual.
• Outpatient detox, perhaps MAT
• Transitional Residential – 60 days?
• Does the better benefit trump the other?
  – DMC NTP vs. Enhanced NTP
  – Enhanced Outpatient vs. DMC Outpatient.
  – As of today, we know the answer is, “Yes”.
Where does Residential Fit In?

• IMD exclusion prohibits Medicaid reimbursement of treatment in a facility with more than 16 beds.

• Does “Transitional Residential” mean short term? Or maybe a component of a multi-modality Tx episode?

• What about residential detox?
Details, Details . . .

• The Base vs. Enhanced distinction has more to do with federal-state-county cost sharing.

• All DMC clients will be eligible to receive any of these services as medically necessary.
Details, Details, Details . . .

• Assuming the Governor Signs . . .
  – Trailer Bill language
  – State Plan Amendment
  – Regulatory Package: Title 22; Title 9 (NTP & maybe RDF)
  – Update to DMC certification standards
  – Further administrative guidance from DHCS
  – A managed care waiver is likely
You Know What They Say . . .
Financing

• Realignment
• State General Fund
• Where does Block Grant fit into the funding picture?
  – Reimbursement of services not covered and/or treatment for persons without coverage.
  – How long will it continue in its current form?
Operational Considerations

• Carve-out will continue
• Both Base and Enhanced benefits will be administered by counties.
  – Basically DMC operations expand – contracts, billing, etc.
• Referral and care coordination requirement for health plans
  – MOUs for this should be pursued at the County level
Operational Considerations

• The role of AODS will change –
  – No longer just a funding conduit. Provider funding levels will depend on DMC utilization.
  – With managed care, AODS will be responsible for authorizing treatment, conducting utilization review and quality improvement processes.
Changes in Provider Business and Clinical Models

• What is reimbursed is what is covered.
• Management of staff productivity will be critical.
• The amount of your contract is up to you.
• Possible requirements for greater medical oversight.
• Greater focus on client outcomes.
Operational Considerations

• Competition among providers will create more choices for clients.
• Client choice will create competition among providers.
• The first half of 2014 will likely see a relatively unregulated state of affairs. Things will start to tighten up FY 14-15.
Possible Next Steps

• State Plan Amendment
• Waiver?
  – Need for UR/UM tools that do not exist in DMC
  – Need to manage costs, manage care. Ensure return on investment in treatment (outcomes).
  – 1-3 year timeline
  – Selective Contracting or Freedom of Choice?
## FY 12-13 Outpatient Treatment Length of Stay

N=84,623

<table>
<thead>
<tr>
<th>LOS</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 days or less</td>
<td>9%</td>
</tr>
<tr>
<td>8 - 29 days</td>
<td>17%</td>
</tr>
<tr>
<td>30 - 59 days</td>
<td>14%</td>
</tr>
<tr>
<td>60 - 89 days</td>
<td>10%</td>
</tr>
<tr>
<td>90 - 119 days</td>
<td>11%</td>
</tr>
<tr>
<td>120 - 179 days</td>
<td>14%</td>
</tr>
<tr>
<td>180 - 364 days</td>
<td>16%</td>
</tr>
<tr>
<td>365 days or more</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: Dept. of Alcohol and Drug Programs ITWS. Statewide CalOMS Data for FY 12-13
Caseload

• Should look in some ways like the SSI caseload in the early 90s.
• Health care referrals may come from SBIRT.
• More likely to be from linkage points between SUD and PC
  – Chronic pain, chronic inebriate, frequent utilizers.
  – SUD + impaired health
Next Steps for Providers

• Apply for DMC Certification

• Survey Client Income Levels
  – Need to pencil out what kind of coverage your clients will have in 2014
  – And make business decisions on the basis of that data.
  – Online calculator at:
    http://www.coveredca.com/calculating_the_cost.html
Next Steps for Providers

• Marketing
  – Why should clients choose your program?
  – Why should referrers choose your program?

• Partnerships
  – Do you have the financial strength to go it alone?
  – Do you need to find strength in numbers?
Next Steps for Providers

• Stay informed on the enrollment process and activities.
  – Open Enrollment for Covered California.
  – Transition of LIHP patients to Medi-Cal.
  – EHSD eligibility process for Medi-Cal.
Questions?
Alcohol and Other Drug Policy Institute

For help with DMC certification, please request free technical assistance at:

http://www.aodsystems.com/ADPI/TCTA_Application.htm