



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

24 July 2013

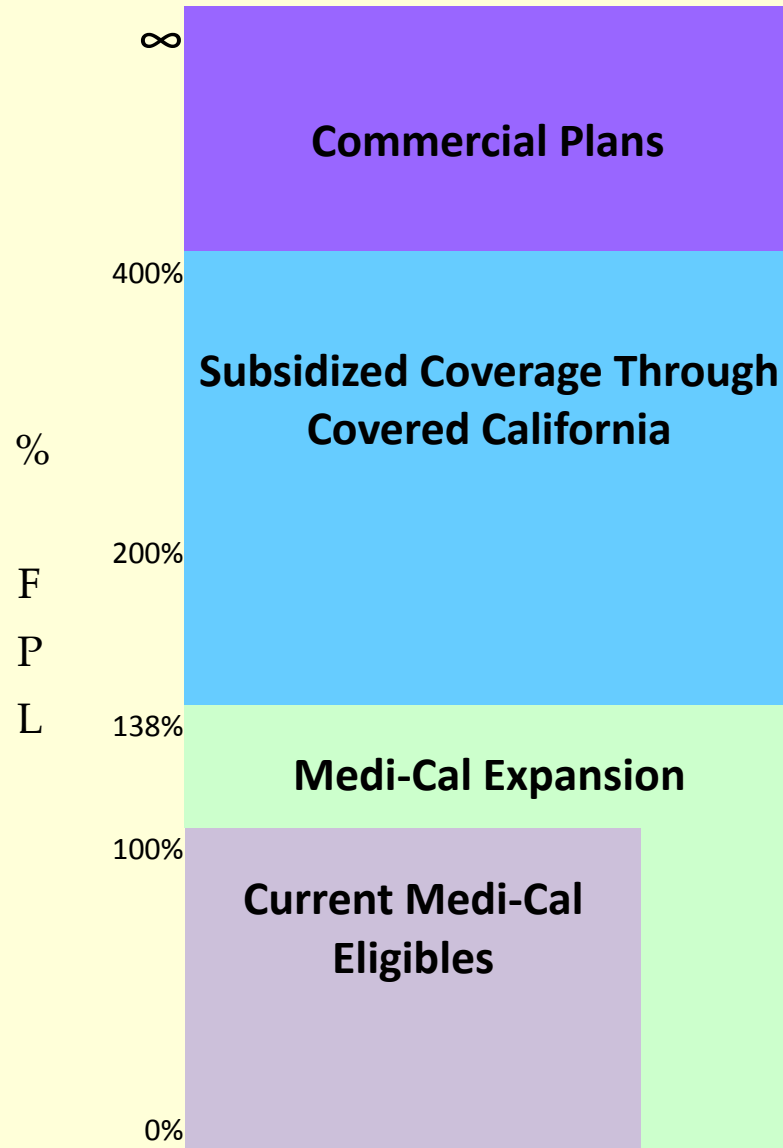
Caseload Estimates

- 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
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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.
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Categories of Coverage in the ACA



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.
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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%.
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SUD Caseload Estimates

	Current MC %	Current SUD Tx %	Expansion %
African-American	11%	15.2%	8%
Asian-Pac. Islander	3%	.3%	10%
Latino	21%	35%	41%

- 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

Medi-Cal Beneficiary

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	3719	73.0	73.0	73.0
	Yes	1373	27.0	27.0	100.0
	Total	5092	100.0	100.0	

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)
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Eligibility for Medi-Cal Expansion

- Household Modified Adjusted Gross Income (MAGI) < 138% FPL.
 - Can document immigration status and/or citizenship.
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Who Will be at Your Door?

Gross Annual Income as a Percent of Federal Poverty Level 2013							
Persons in Household	100%	133%	138%	175%	200%	300%	400%
1	\$11,490	\$15,282	\$15,856	\$20,108	\$22,980	\$34,470	\$45,960
2	\$15,510	\$20,628	\$21,404	\$27,143	\$31,020	\$46,530	\$62,040
3	\$19,530	\$25,975	\$26,951	\$34,178	\$39,060	\$58,590	\$78,120
4	\$23,550	\$31,322	\$32,499	\$41,213	\$47,100	\$70,650	\$94,200
5	\$27,570	\$36,668	\$38,047	\$48,248	\$55,140	\$82,710	\$110,280
6	\$31,590	\$42,015	\$43,594	\$55,283	\$63,180	\$94,770	\$126,360
7	\$35,610	\$47,361	\$49,142	\$62,318	\$71,220	\$106,830	\$142,440
8	\$39,630	\$52,708	\$54,689	\$69,353	\$79,260	\$118,890	\$158,520

What will you be Getting Paid For?

- Current DMC benefits (the base)
 - Outpatient Counseling
 - NTP
 - Day Care Habilitative – Perinatal & EPSDT
 - Perinatal Residential
 - Naltrexone
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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
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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”.
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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?
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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.
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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
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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?
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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
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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.
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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.
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Operational Considerations

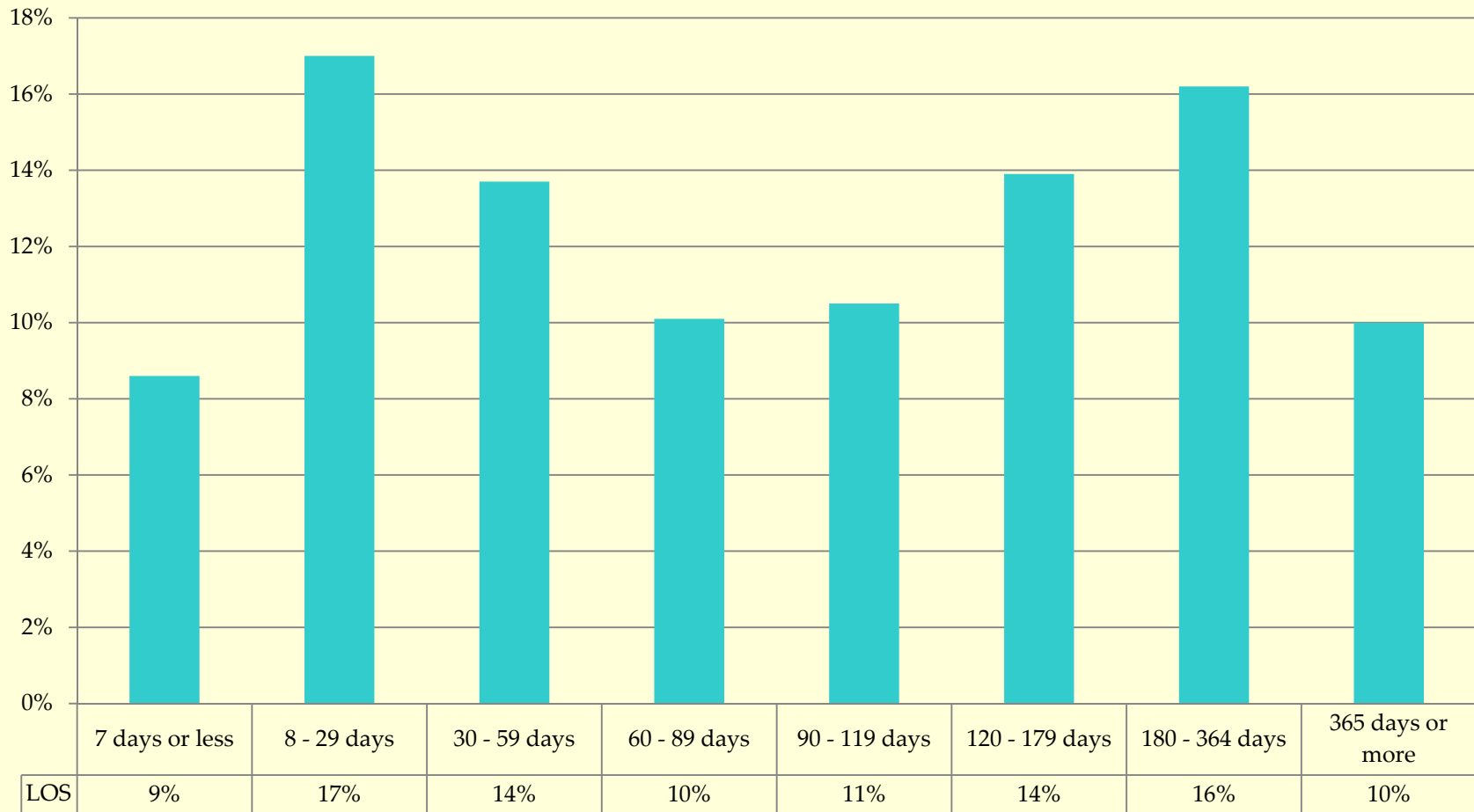
- Competition among providers will create more choices for clients.
 - Client choice will create competition among providers.
 - The first half of 2014 will likely see a relatively unregulated state of affairs. Things will start to tighten up FY 14-15.
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Possible 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?
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FY 12-13 Outpatient Treatment Length of Stay

N=84,623



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
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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](http://www.coveredca.com/calculating_the_cost.html) at:
http://www.coveredca.com/calculating_the_cost.html
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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?
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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.
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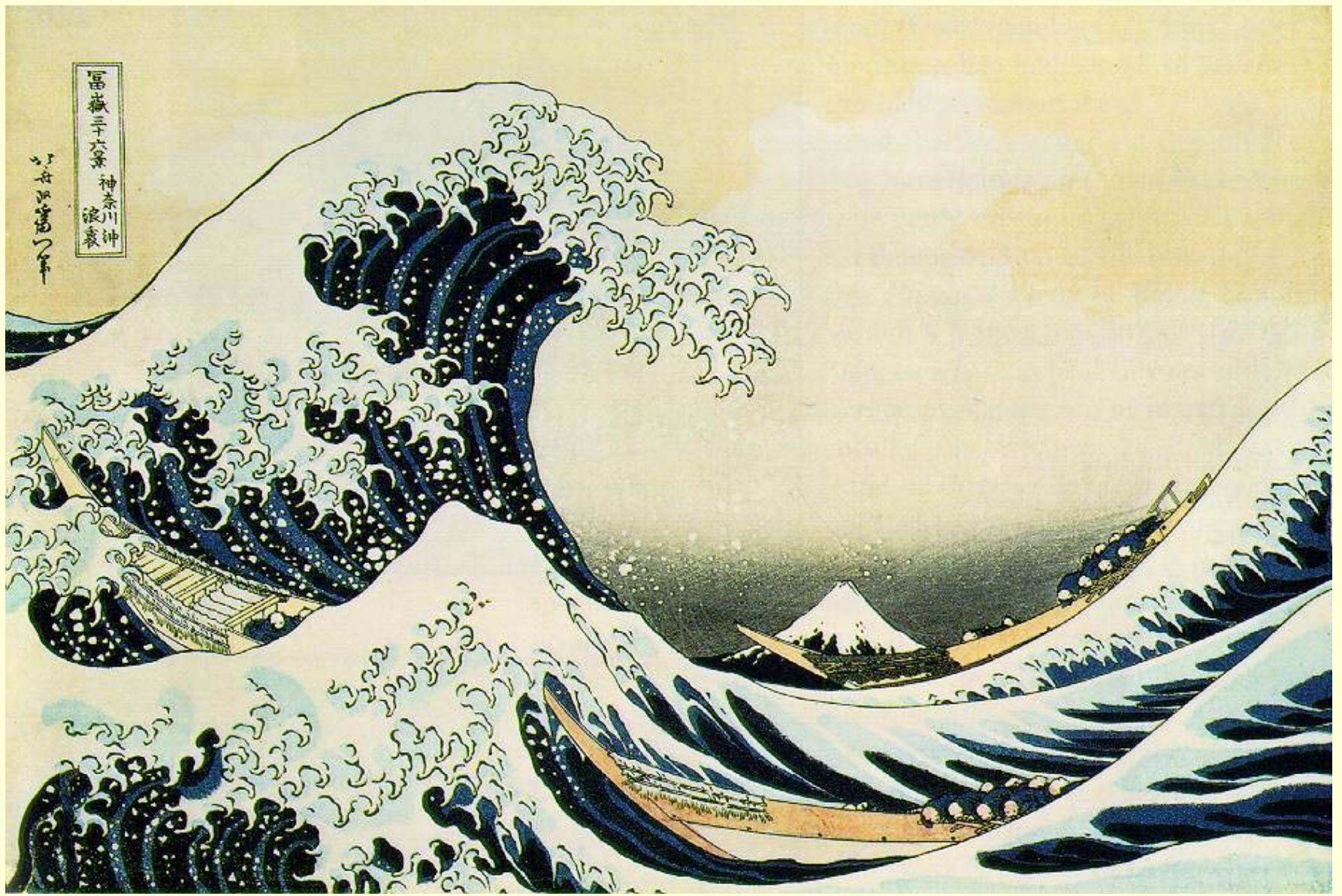
Questions?



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



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