HEALTH MANAGEMENT ASSOCIATES

MAXIMIZING COUNTY BEHAVIORAL HEALTH PROGRAMS IN CALIFORNIA:

A DOLLAR AND SENSE ROAD MAP TO MEETING STATE AND FEDERAL REQUIREMENTS

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Over the past half-century, California developed a complex model of county-based mental health and substance use services for individuals with Medicaid, known as Medi-Cal in California, and those without insurance coverage.

Adding to the complexity, recent federal and state changes, including the expansion of Medicaid under the Affordable Care Act, the Mental Health Parity and Addictions Equity Act (MHPAEA), and the Medicaid Managed Care Final Rule, are forcing counties to change the way they deliver services.

Although counties have developed significant experience in the delivery and administration of behavioral health services over the past decades, the confluence of new laws in a short period of time has added complex regulatory structures that strain their operations. Counties have been forced to expand their operational capabilities – essentially needing to function as managed care organizations. Importantly, counties have had to either create new infrastructure or overhaul existing programming to meet new certification standards and the letter of the law.

County behavioral health administrators, along with County Administrative Officers and County Boards of Supervisors, are at a crossroads: they must quickly decide whether to build these new capabilities internally or to partner with an external entity, commonly referred to as a third-party administrator (TPA).

In making this decision, county administrators must balance the challenge of negotiating and managing a new, unknown vendor relationship against building new internal administrative capacities that are outside their core capabilities and competencies.

This paper provides an overview of the impact of this new regulatory landscape, as well as considerations that county leadership and stakeholders can explore when pursuing a relationship with a TPA.

THE PERFECT STORM FOR COUNTY BEHAVIORAL HEALTH PROGRAMS

California's history of providing mental health services via counties with a combination of state and county funding dates back to 1957 with the passage of the Short-Doyle Mental Health Act. Nearly a decade later, California implemented Medi-Cal in 1966 to provide health coverage to qualifying low-income residents.

Over time Medi-Cal Mental Health care has evolved beyond the historical provision of the Short-Doyle Mental Health Act that created the county mental health coverage for people with Severe Mental Illness (SMI). County Mental Health agencies were transformed into Behavioral Health Programs (BHP) with the addition of the Substance Use Disorder Services that we know today. Through a series of state budget policy decisions during periods of recession in 1991 and 2011, California increased the role of counties as the financial and service delivery platform for publicly funded behavioral health services through an initiative known as state-county realignment.

Today, Medi-Cal mental health services are delivered through a unique state-county partnership under a §1915b freedom of choice waiver received initially in 1995 from the Center for Medicare and Medicaid Services (CMS). The state Department of Health Care Services (DHCS) oversees the Medi-Cal program administration through the operations of 56 unique County Mental Health Plan (MHP) contracts.

County MHPs fall under the federal Medicaid managed care plan classification as prepaid inpatient health plans (PIHPS). As PIHPs, county mental health plans are subject to the same state and federal rules that govern the physical health Medi-Cal managed care plans. This is in the same manner that the federal MHPAEA requires mental health services to be provided in parity with physical health services, which is covered in greater detail below.

Historically, California provided SUD treatment services as a Medicaid State Plan benefit through the Drug Medi-Cal (DMC) Alcohol and Drug Treatment program. The historical DMC "State" plan program operated as a fee-for-service system of contracted providers that offered a limited set of SUD treatment services and markedly low provider reimbursement [1].

In 2015, California received federal 1115 waiver authority to implement a new five-year Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot. Counties could opt into the pilot. Forty counties submitted and received approval for their DMC-ODS implementation plans. The remaining 18 counties chose not to expand SUD services under the pilot. These non-participating counties offer limited residential-based services to perinatal women and youth under the state plan program and have limited county-funded outpatient treatment and withdrawal management services for all other adult Medi-Cal beneficiaries.

Statewide, there are 56 County Mental Health and SUD treatment programs that collectively are referred to as county BHPs. These BHPs have undergone significant change over the past six years with the 2014 Medi-Cal adult expansion, the implementation of MHPAEA, and the passage of the new Medicaid Managed Care Rule.

The 2014 Medi-Cal expansion provided full BHP coverage to all income-eligible and otherwise qualified adult residents under

age 65. By October 2016, Medi-Cal had 3.7 million new adult enrollees between the ages of 19 and 64. The influx of new Medi-Cal enrollees increased the demand for mental health services and significantly increased the demand for SUD treatment services provided by the county BHPs. Additionally, the BHPs experienced minimal increases in staffing and administrative resources required to address the new and significant demand for services [2].

SECTION ONE: GAP ANALYSIS/NEEDS ASSESSMENT

California is in the midst of multiple new requirements that involve a wide range of structural changes for BHPs. For many years, HMA has worked with both state and county programs and has developed an effective Gap Analysis and Needs Assessment framework for BHPs to analyze and consider their needs to perform under evolving state and federal program requirements. By identifying gaps and risks among BHPs, the analysis helps determine needed BHP structural changes to ensure that counties are aligning with new regulations. The analysis guides leaders on how to address identified gaps by either building or partnering with an outside entity to acquire needed compliance and operations solutions.

NEW REQUIREMENTS – MENTAL HEALTH PARITY ADDICTION EQUITY ACT (MHPAEA)

New federal and state requirements related to MHPAEA[4] require parity between and among physical, behavioral, and substance-use disorder services[3,4]. BHPs must ensure the delivery of these services is in compliance with federal parity requirements, meaning that behavioral health benefits must be on par with physical health benefits. For example, under MHPAEA, treatment limitations and cost-sharing requirements can be no more restrictive than those that apply to medical and surgical benefits.

MHPAEA requires BHPs to comply with the same inpatient, outpatient, prescription drugs, and emergency care requirements that MCOs are subject to, including[5]:

- Aggregate lifetime and annual dollar limits;
- Financial requirements;
- Quantitative treatment limitations;
- Non-quantitative treatment limitations; and
- Information requirements.

NEW REQUIREMENTS – MEDICAID MANAGED CARE[6] FINAL RULE[7]

In 2016 CMS released an updated Medicaid Managed Care Rule requiring significant changes for both physical and mental health managed care plans[6,7,8]. Examples of some of the major new requirements for county MHPs include[6]:

- Medical Loss Ratio at 85%
- Beneficiary Informing Requirements
- Grievances & Appeals
- Care Coordination
- Quality Assessment & Performance Improvement
- Managed Care Quality Strategy
- Network Adequacy
- Provider Screening & Enrollment
- Beneficiary Support System
- External Quality Review Organization (EQRO) Validation of Network Adequacy
- Quality Rating System

Consequences and penalties of not meeting compliance with these policy rules include:

- DHCS withholding county payments
- DHCS imposing civil penalties on the county MHP[1*,9].
- DHCS taking other actions deemed necessary to encourage and ensure contract and regulatory compliance.
- DHCS terminating the county's contract with the MHP[2*]

CONDUCTING A GAP ANALYSIS TO ASSESS COMPLIANCE TO NEW RULES

HMA has identified six key factors that should be considered in determining whether to build, buy, or partner with an external organization to address identified gaps. When considering the build, buy, or partner solutions available, counties will need to weigh the total investment costs, implementation timeframes, learning investments, performance track records, disruption to their current operations, and the ability to control the overall implementation. Evaluating these six factors are critical in determining a cost-effective approach to improving program capacity and quality.

Table 1 shows the risks associated with all three potential solutions.

WEIGHING THE OPTIONS

BUILD – Internal development of new infrastructure and capacity using internal oversight, resources, expertise, and intellectual property.

BUY – Procurement of all components of new infrastructure and capacity from a third-party. This can include licensing services and technology or solution acquisition.

PARTNER – Alignment with an entity to integrate and offer a joint solution, such as alignment with an external entity (for example, another county) or TPA who offers ongoing services and support.

TABLE 1: RISKS ASSOCIATED WITH BUILD, BUY, AND PARTNER STRATEGIES

Factor	Build	Buy	Partner
Investment Cost	Medium/High	High	Low
Implementation Timeframe	High	Medium	Low
Learning Investment	High	Low	Medium/High
Performance Track Record	Low	High	High
Disruption to Current Operations	High	High	Medium/High
Ability to Control	High	Medium	Medium/High

[1*] pursuant to Section 1810.385

[2*] pursuant to Section 1810.32

A thorough gap analysis includes discovery, documentation, and scoring. These phases of analysis should be documented in a gap report. The discovery phase includes a combination of key staff interviews and a desk review of policies, procedures, and supporting documentation.

The key staff interviews are used to validate the policies and procedures and to solicit staff expertise in identifying gaps if they exist. The documentation phase will document all information gathered that supports compliance with the rules being implemented. The completed gaps analysis and assessment will allow the BHP to validate that all programmatic functions are captured, and that the information shared by staff is correct. Upon the completion of the validation process, a program's readiness score is calculated to assess compliance with the rules. Most gap analyses will use a scoring methodology that identifies the level of compliance – full, partial, or non-compliance.

IDENTIFYING SOLUTIONS TO REMEDIATE GAPS

A completed gap analysis provides an inventory of issues that require remediation. It also identifies the pros and cons of various solutions, from outsourcing with a vendor to developing internal capabilities, to remediate gaps. Remediation recommendations are then developed that identify the level of complexity and a risk assessment of implementation. An effective gap analysis and report of its findings be used to create an action plan to embark on a build, buy, or partner approach. The next section explores in more depth the benefits of partnering with an external entity and the efficiencies that a TPA can bring to a county BHP.

SECTION TWO: EXPLORING THE USE OF AN EXTERNAL PARTNER

Nationwide, both physical and specialty health plans frequently leverage external TPAs for a wide range of supportive activities and systems. TPAs are organizations with specialized skills and systems to support health plan operations and functions. They provide the operational engine for a health plan, including information technology supports and systems, human capital expertise to perform all or a series of health plan functions, and the creation of targeted solutions for compliance. TPAs also bring administrative efficiencies to support cost-effective and efficient health plan operations for the longer term.

A county BHP could choose to partner with a TPA to leverage external competencies and systems to assist with all aspects of efficient health plan operations, while also creating some budget predictability and control that is often not available when building internal capabilities.

Typical TPA services include clinical and quality management, analytics and reporting, network contracting and credentialing, customer service, and claims payment. A sample list is included in **Table 2**. TPAs generally offer an array of services that can be tailored and customized to meet the county program's unique needs. The development of a TPA relationship can also allow a county to quickly ramp up and expand internal systems, capacity, and expertise.

A BHP administrator may find that partnering with a TPA frees up limited county resources to focus more on the provision of clinical services and less on back-end administrative functions. This redirection may enhance the BHP's ability to focus on its consumer care delivery while simultaneously gaining important and cost-effective operational efficiencies. A list and description of the typical TPA health plan administrative services available to county BHPs is represented in **Table 2.**

TABLE 2: COMMON TPA SERVICE OFFERINGS

TPA Service Category	Sample Activity
Clinical Management	▪ Screening, triage, and appointment assistance ▪ Utilization management ▪ Intensive care management ▪ Aftercare and transitions of care ▪ 24/7 crisis system management
Quality Management	▪ NCQA and URAC ▪ HEDIS reporting ▪ NOMS / TEDS reporting ▪ State-specific reporting ▪ Grievances and appeals tracking and management
Analytics and Reporting	▪ Data warehousing and intuitive reporting ▪ Practice management dashboards ▪ Predictive modeling ▪ Medical economics for medical loss ratio management
Administrative Services	▪ Call center/customer service ▪ Management information systems for eligibility and service history ▪ Claims adjudication
Network Management	▪ Credentialing ▪ Contracting ▪ Pay for performance programs ▪ Specialized network contracting for telehealth, autism, home- and community-based services ▪ Provider profiling and technical assistance

SECTION THREE: MAXIMIZING FEDERAL FUNDING FOR ADMINISTRATIVE FUNCTIONS

California primarily finances the non-federal share of Medi-Cal behavioral health services through 1991 and 2011 state realignment funds allocated to the counties. BHPs use realignment funds for program costs known as certified public expenditures (CPEs), which are eligible for federal financial participation (FFP) under Medicaid. CPEs allow government entities like counties to certify that program funds expended are public funds used to support the full cost of providing Medicaid-covered services or administrative program activities. Counties draw down federal matching funds related to their administration of the BHP by completing and submitting cost reports to DHCS, thereby "certifying" the expenditure of the non-federal portion for Medicaid. The state, in turn, reimburses counties and seeks reimbursement from CMS.

Counties that contract with a TPA to perform BHP administration functions for Medi-Cal enrollees are eligible for match through FFP funding, as well as enhanced state general funding that provides cost-sharing to counties made available for new state mandates funded through Proposition 30 of 2012.

Administrative activities eligible for FFP include paying claims, operating a call center, overseeing contracted providers, making medical necessity determinations, and conducting utilization reviews. A review of county administrative claiming activities can help counties identify opportunities to attain increased funding. Specialty Mental Health (SMI) and the Drug Medi-Cal programs have unique claiming procedures that can unlock enhanced federal and state funding opportunities for specific county administrative activities. The review should focus on the Medicaid Administrative Activities (MAA) process in addition to Drug Medi-Cal and Specialty Mental Health claiming procedures. **Table 3** takes a deeper look at the Specialty Mental Health claiming process.

County BHPs can establish an annual baseline cost for performing all of the administrative activities required to meet their MHP and Drug Medi-Cal contract obligations. This cost estimate can then serve as the funding floor within the TPA contract. Some counties establish contracts with TPAs that establish minimums and maximums. Others establish service level thresholds as a base contract plus volume. This approach allows counties to allocate one-twelfth of the annual TPA contract cost as a monthly contract amount that can be used to provide budget predictability estimates of the total program's cost of operation on both a monthly and annual basis in addition to the total cost over the term of the contract.

TABLE 3: SPECIALITY MENTAL HEALTH PROGRAM - CLAIMING CATEGORIES

Certification Category	Definition	TPA services eligible for FFP? (Y/N)	Enhanced FFP eligible	Cost Reporting-Forms	Cost Reporting Instructions - Details by Reporting Line	Evidence required
1. Direct Services	Services covered under the Medi-Cal program for eligible individuals	Yes at 50% FFP	•No	1982 A- Treatment Cost Report (10)	Not Applicable	Monthly invoice with 1/12th contract total from TPA is adequate. If services are provided to both Medicaid and non-Medicaid; methodology must include factoring only the Medicaid portion
2. Admin – up to 15%	Central support services to achieve DHCS Services program and operations objectives and provide management information and business control functions for the Directorate	Yes at 50% FFP	•Yes, for Prop 30 added mandates •Yes, in some instances	1982 B- Administrative Cost Report (10)	Line 2 – Performance Outcome Systems IT hardware and software updates * non-federal share is reimbursed at 100% state general fund (SGF) Line three**- Federal Medicaid Managed Care & Parity Rule(s) **non-federal share is shared between the county (50% county general funds (CGF)) & DHCS (50% SGF)	Monthly invoice with 1/12th contract total from TPA is adequate. If services are provided to both Medicaid and non-Medicaid; methodology must include factoring only the Medicaid portion
3. Quality Assurance/ Utilization Review (QA/UR)	The evaluation of the appropriateness and medical need of health care services and procedures and facilities according to evidence-based criteria or guidelines and under the provisions of the MHP and DMC contracts.	Yes at 50% FFP	•Yes, for Prop 30 added service •Yes, an additional 25% FFP (75% FFP) for clinical services related to QA/UR from a certified QIO or QIO like entity	1982 C- Quality Assurance/Utilization Review Cost Report (10)	Lines 1 through 7 identify claiming for QA/UR processes. QIO and direct county QA/UR functions are reported at either 75% (Skilled Medical Admin FMAP) or 50% (non-clinical staff) Lines 9-14 identify claiming for Performance Outcome Systems, (skilled Medical staff) 75% & (non-skilled) 50%	Monthly invoice with 1/12th contract total from TPA is adequate. If services are provided to both Medicaid and non-Medicaid; methodology must include factoring only the Medicaid portion
4. Medicaid Administrative Activities (MAA)	Activities eligible to receive federal reimbursement for the cost of performing administrative activities that directly support efforts to identify and enroll potential eligible individuals into Medi-Cal	Yes at 50% FFP	•Yes, for Prop 30 added mandates	1982 D- Medi-Cal Administrative Activities Cost Report (10)	General TPA services	Monthly invoice with 1/12th contract total from TPA is adequate. If services are provided to both Medicaid and non-Medicaid; methodology must include factoring only the Medicaid portion

ADDITIONAL STATE GENERAL FUND FOR NEW MANDATES

Passed in 2012, California's Proposition 30 provides counties with constitutional protection in the shift of local public safety programs from the state to local control and the shift of state revenues to local government to pay for those programs[11].

The proposition ensured that any new mandates placed on counties after January 1, 2014, are eligible for additional state funding. DHCS Information notice 18-012 describes the services and reimbursement methodology[7]. Activities required under new mandates such as the Medicaid Managed Care Rule and the MHPEA are eligible. These include:

- Hiring new employees
- Redirecting existing staff time not previously reimbursed by any state or federal funding source
- The procurement of new contracts to conduct new administrative and utilization review and quality assurance
- All other activities associated with the final rule including the translating of materials, programming, updating and modifying technology systems, any additional documentation retention costs, and any other associated costs related to new mandates

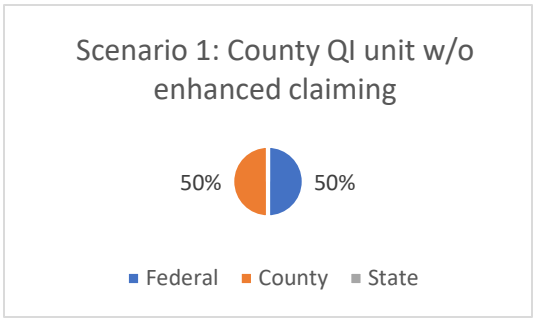
POTENTIAL FOR ENHANCED MATCH FOR QIO-LIKE ENTITY

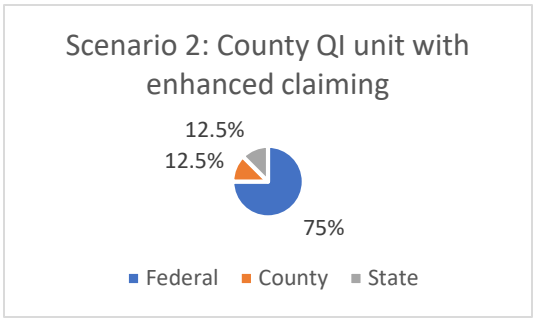
Federal regulatory requirements related to the Social Security Act (Act) section 1902 (a)(30)(A) and 42 CFR 431.630 requires state Medicaid agencies to provide methods and procedures to safeguard against unnecessary utilization of care and services to assure "efficiency, economy and quality of care" under Medicaid programs operations. These functions are often embedded in the individual county BHP mental health and SUD departments.

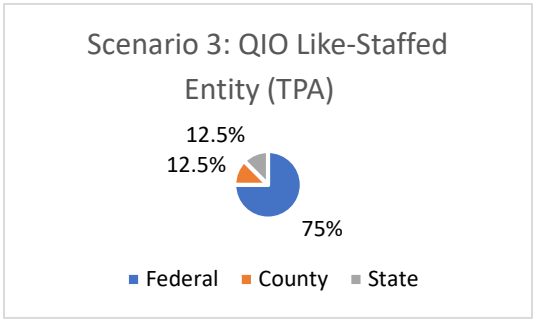
Some counties may find that contracting with a qualified TPA enables the BHP to attain a higher level of compliance and bolster the overall program fidelity to the new Managed Care and Mental Health parity rules. A TPA can bring significant industry expertise, experience, and technological solutions that will allow the County to advance its goals of improving quality of services rendered. Contracting with a qualified TPA may free the county from administrative health plan functions, allowing the BHP to focus its resources on developing additional capacity related to direct provision of services to clients.

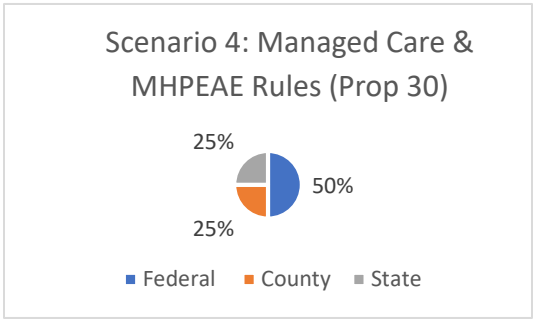
Furthermore, the county may be able to draw a 75% federal match for medical and utilization review functions provided by a Quality Improvement Organizations (QIO) or QIO-like entity.

Use of an experienced QIO-like entity and its associated activities can allow a county BHP to strengthen its programmatic quality improvement activities through the use of TPA's experience and expertise while providing new incentives to attain a higher federal match. The claiming scenarios below illustrate BHP standard and enhanced claiming opportunities.









Section 1903(a)(3)(C) of the QIO legislation specifies that 75% FFP is available for state expenditures for the performance of medical and utilization reviews or external quality reviews by a QIO, or by an entity that meets the requirements of section 1152 of the Act through the use of QIO-like entities.

A QIO or QIO-like entity can perform two different activities:

- Clinical and utilization review functions required by law to conform to this regulatory requirement.
- Actively engage beneficiaries, families, and consumers, as applicable, in case reviews as described in §475.102, and quality improvement initiatives as described in §475.103

Use of a QIO provides a county BHP the opportunity to receive a 75% federal match for QIO-related contracted services. Many TPAs already have QIO-like entity recognition from CMS and can provide services eligible for an enhanced federal match.

If a county opts to pursue this approach, the BHP maintains overall contractual responsibility for program oversight and compliance activities, even if key core functions around quality improvement and compliance, including those related to the areas of fraud, waste, and abuse are delegated to a TPA.

Partnering with an experienced TPA can also support counties in streamlining their existing quality improvement, assessment, and compliance responsibilities. BHPs cannot overlook their need to maintain continuing investments in the quality improvement areas.

BRAIDED PROGRAM FUNDING

County BHPs are funded through a variety of federal, state, and county general funds along with federal mental health and Substance Abuse Prevention and Treatment (SAPT) block grant funds. California counties are obligated to ensure that all federal, state and county funding sources are appropriately utilized and accounted for. Many funding sources are restricted for specific uses. **Figure 1** identifies the myriad county behavioral health funding sources that finance BHP mental health and SUD services.

Maximizing the flexibility of unrestricted dollars for non-Medicaid reimbursable programs is key in allowing counties to fund housing and other navigation services that address the social determinants of health.

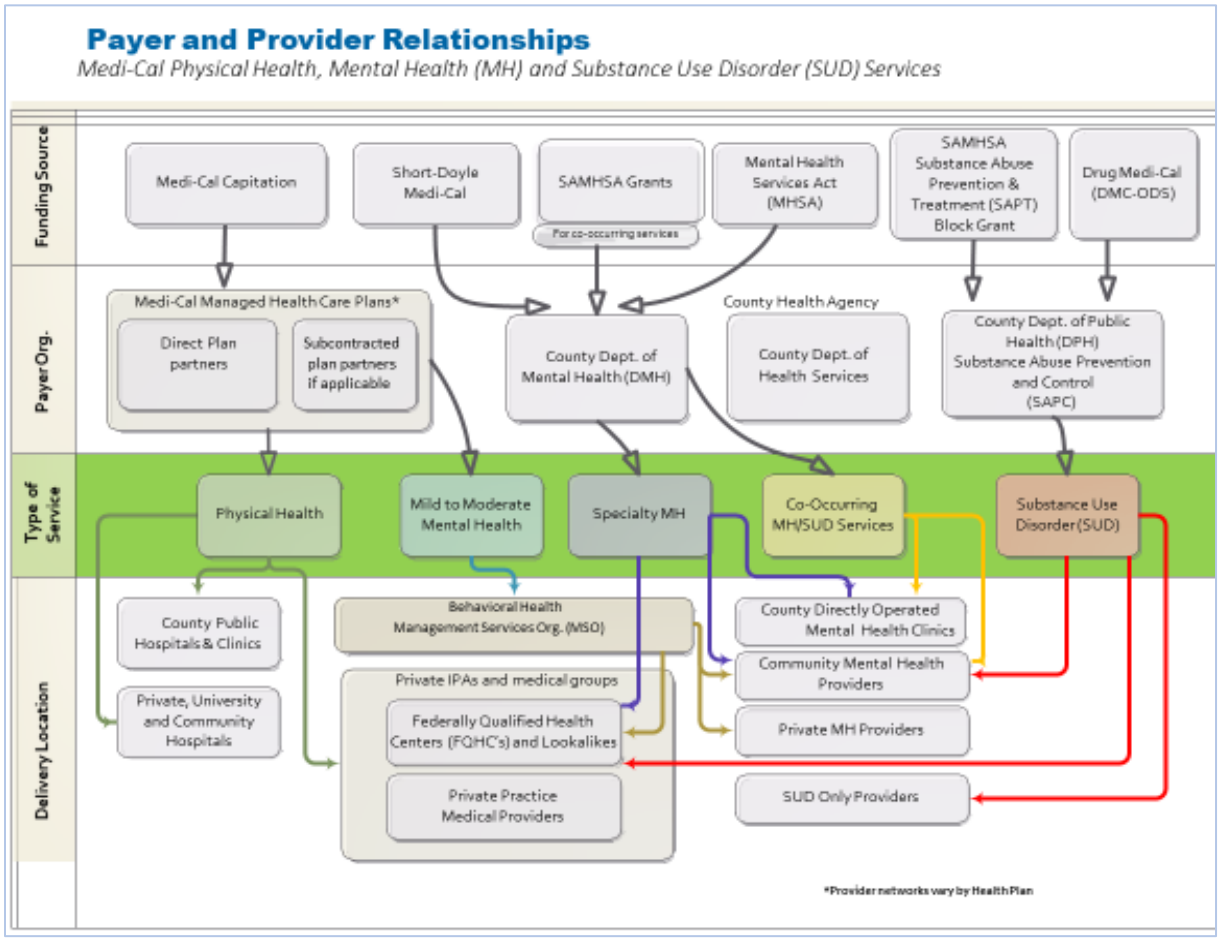


Figure 1. The Los Angeles County Payer and Provider Relationship framework identifies the complicated program funding structure and relationships between county BHP programs, their funding sources, and types of service offered along with the service delivery provider networks.

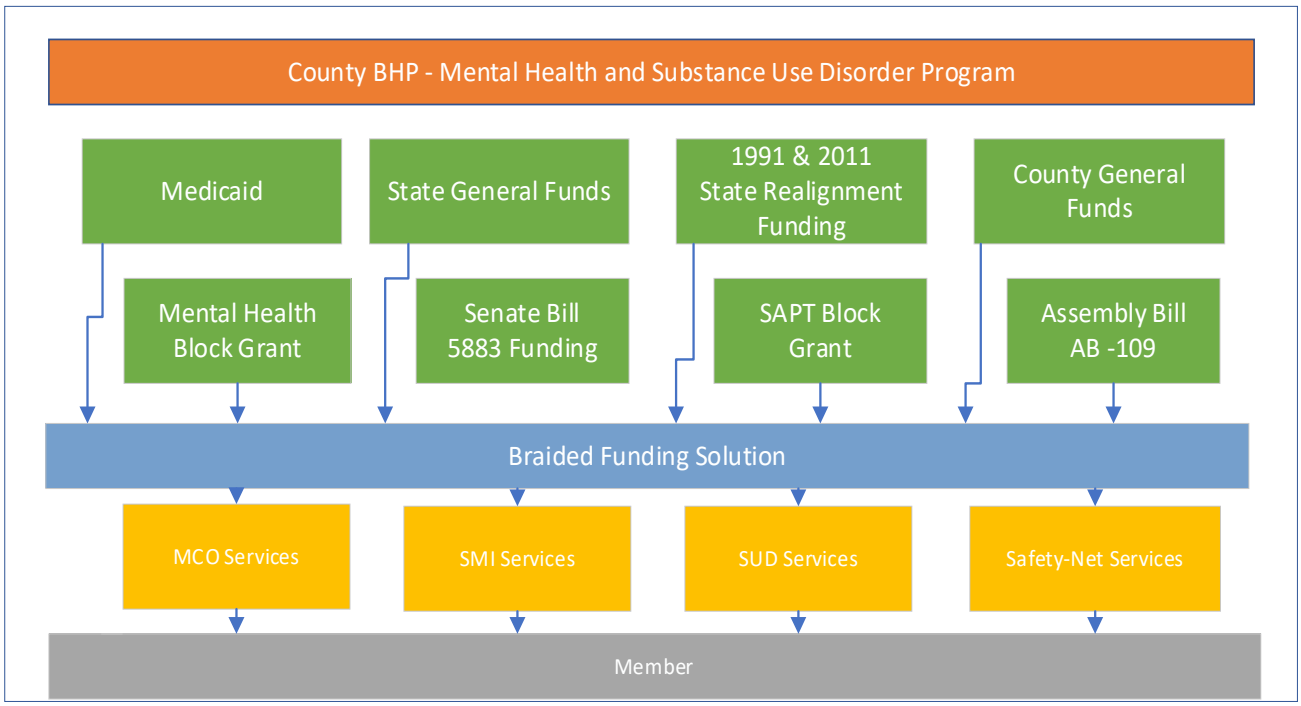


Figure 2. County BHP – MH & SUD Program

Braiding the various funding sources together to ensure optimization of federal reimbursement for Medicaid and accurate reporting for each funding source is a complex endeavor[12]. Technology solutions exist to enable a "braided" funding methodology (mental health parity, Drug Medi-Cal, SAPT, Mental Health block grant, county general funds, and realignment funding) and thus allow counties to provide a coordinated set of comprehensive behavioral health services that encompass standardized reporting developed in accordance with federal, state, and grant funding requirements. **Figure 2** illustrates the "braided funding solution" that a TPA can offer to assist BHPs with the coordination of program funding sources and highlights the importance of coordinating all available federal, state, and local funding to maximize the full value of the multiple funding sources[13].

A TPA braided funding solution can provide a BHP with the ability to provide a full set of services regardless of program funding source. The braided solution can allow BHPs to provide parity and ensure comparability to all members regardless of funding source and reporting requirements.

Technology solutions for braided funding models should be able to achieve the following:

- **Service accessibility**: In complex program arrangements, consumers are often not aware of their own
- eligibility for specific programs. Eligibility should be informed by the system, not the member.
- **Clinical management**: The system should link the clinical authorization and funding information seamlessly for the providers and consumers**.**

- **Funding source accountability and reporting:** A single service encounter may require services funded by multiple sources. Systems should accurately compile and report service cost and purpose information so that it can be relayed to program funders.
- **Provider interaction:** Providers delivering services under multiple programs have multiple reporting and outcome requirements. The system should provide a single access point to satisfy these requirements.

SECTION FOUR: CONTRACTING WITH AN EXTERNAL PARTNER

If a county chooses to contract with an external vendor for additional health plan operations support, basic considerations include the funding model, which service activities to include, whether to pursue a joint purchasing contract with additional counties and the responsible internal division and processes for contract oversight.

- **Contract Design**
  The simplest is likely a set monthly fee for core services. To protect against unpredictable volumes and not overpay, the county could negotiate "overage" fees for services above and beyond the volume agreed to in the base amount.
- **Single Contract Versus Joint Procurement**
  Within the confines of a TPA contracted model, there are also options for both single and multiple counties to contract with the same TPA under a shared services arrangement. The single county contract has the advantage of focusing on the needs of a singular county BHP. This singular contracting model highlights the county's needs and the TPA's capabilities streamlining and reducing the timeline for county BHP approval. However, depending on the variation, there may be more difficulties in establishing best practices and process standardization across counties.

  The multiple county contract model or joint purchasing agreement with a TPA has the advantage of uniformity, ease of administration, the ability to compare best practices across counties, and the opportunity to obtain the best pricing and efficiencies when combining shared services into a single operational platform. The process of meeting all the involved county's participation requirements and BHP approvals will lengthen the time for each county to agree on standardized deliverables. California's Advancing and Innovating Medi-Cal (CalAIM) initiative recognizes the pooling of resources as an opportunity to create administrative efficiencies[16].

California Advancing and Innovating Medi-Cal (CalAIM), is a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program.https://www.dhcs.ca.gov/calaim

RECOMMENDATIONS FOR SUCCESSFUL OVERSIGHT OF TPA

- ***Pre-Delegation Audit***

  The successful oversight of a TPA relationship begins with a pre-delegation audit. The pre-delegation audit will ensure that any activity delegated to a TPA complies with 42 CFR 438.230 and all contractual requirements. Pre-delegation audits ensure that the TPA has the systems, policies, and procedures, and staffing capabilities in place to successfully meet the expectations and contractual requirements outlined within the delegation or TPA contract. BHP delegation of activities does not relieve the county from the ultimate responsibility of compliance with any delegated activity[14]. A successful pre-delegation audit helps to ensure that the delegated entity understands the contractor's requirements and expectations by ensuring contractual compliance upon go-live on day one.

- ***Annual oversight audits***

  BHPs should conduct annual TPA oversight audits to evaluate the TPA's performance in accordance with the county's contractual requirements outlined within the TPA contract. An annual oversight audit will help to ensure that the contracted TPA complies with all federal and state regulatory accreditation, credentialing, and statutory standards in addition to the terms of the contract between a county BHP and contracted TPA. Furthermore, the BHP likely will need to demonstrate to state entities strong delegation oversight.

- ***Reporting***

  Identify all required reporting elements, format, frequency, and due dates. Include this list as an exhibit in the contract to ensure all sides are aligned with the scope of reporting requirements.

- ***Aligning incentives***

  BHPs can include performance incentive payments tied to desired outcomes to ensure alignment around program goals. Examples may include a bonus payment if the TPA achieves certain thresholds like a defined percent of downstream provider contracts, including value-based payments or the achievement of certain clinical and quality metrics like low re-admission rates or high rates for seven-day post-hospitalization follow-up care.

- ***Use of Corrective Action Plans (CAPs) and potential performance penalties***

  In the event that a TPA's performance of delegated activities is considered unsatisfactory, the county should initiate a Corrective Action Plan (CAP) in accordance with the BHP-TPA contract to remediate the performance issues and to ensure that the TPA's deficiencies are resolved in a reasonable time frame.

CONCLUSION: LOOKING TO THE FUTURE

In the face of increasingly burdensome requirements and complex population needs, county BHPs have a number of opportunities to develop new operational efficiencies that allow their programs to increase clinical capacity and reduce burdens related to health plan administrative functions. With limited administrative resources, implementing additional functions and adhering to new regulations often comes at the expense of other core BHP functions. Partnering with external organizations, such as TPAs and QIO-like entities, allows BHPs to comply with state contractual requirements, state and federal regulations and conform to Mental Health Parity.

County BHP programs should explore options to partner with experienced organizations that will ensure program regulatory compliance and maximize all available federal funding, while simultaneously increasing quality and patient experience for consumers. This type of partnership would allow the BHPs to focus on its role as a provider of clinical services.

Furthermore, in an environment where it is increasingly difficult to hire qualified and experienced staff, external partners allow the opportunity to access an expanded workforce, resources, and expertise. External partners also bring access to industry leadership and insight into best practices employed in other areas proven to achieve outstanding results.

There is no one size fits all solution, as each BHP embodies unique organizational features. Internal needs assessments and gap analyses can help identify county-specific BHP opportunities to maximize program funding and increase operational agility. Consulting firms and TPAs alike can assist in the determination of the path forward and assist in the identification of available funding opportunities to help secure needed BHP program resources specific to the unique realities each county faces. The county-specific needs assessment/gap analysis will result in a customized roadmap that will identify the BHP's opportunities to attain value and maximize all available state and federal funding resources while simultaneously increasing organizational efficiencies.

APPENDIX A:
EXAMPLES OF BEHAVIORAL HEALTH TPAS

Contract Examples of Behavioral Health TPAs

Contract Examples	Services provided by the TPA
Mendocino County	Operate the county's mental health and/or substance use disorder services: • 24/7 Access and Crisis Line (ACL) • Facilities for provision of TPA Services • Administration and Staff Coverage • Claims processing & Adjudication • Medi-Cal Claims Processing and Review • Provide Mobile Outreach & Support • Manage Mental Health Services Program • Operate the Quality Improvement Program • CalWORKs Mental Health Services • Operate MHSA Prevention & Early Intervention (PEI) Services • Operate MHSA Community Services and Support (CSS) programming • Maintain Medical Necessity Criteria for SMI program • Provide 24/7 Clinical Coverage and Access to UM Staff • Evaluation & Utilization Management for Behavioral Health Services • Service Authorization for residential services • Program Reporting
Orange County	Provides a range of distinct services, including: • 24-7 Mental health and DMC-ODS access line for screening and referrals • Outpatient psychiatry and therapy network contracting and credentialing • Payment of inpatient professional fees at fee for service hospitals & IMD facilities • Medi-Cal claims processing and review • 24/7 Clinical Coverage and Access to Clinical Staff • MH and DMC regulatory Reporting
San Diego County	Operates the county's mental health and/or substance use disorder services: • 24/7 Access and Crisis Line (ACL) • Includes 30 hours per week chat service to support suicide prevention • Centralized Contact for Medi-Cal Inpatient, Crisis Stabilization and Crisis Residential Beds • Create and maintain an internal electronic bed board identifying 24/7 availability of Medi-Cal psychiatric inpatient, crisis stabilization, and residential crisis beds • Central staff to coordinate information with Emergency Departments • Utilization Management for Behavioral Health Services • Manage contracted FFS Provider Network • Treatment Evaluation Resource Management (TERM) Provider Referrals and Clinical Quality Review [behavioral health issues are considered to be severe and meet Title 9 Medical Necessity for Specialty Mental Health Services] • Management Information System (MIS) support services including system administration • EHR Training Services • Provide administrative and quality review services for the TERM provider network • General Administration • Participate in and support continuing broad-based public processes for any redesign of the overall health service delivery system

APPENDIX B:
MENTAL HEALTH PARITY AND ADDICTIONS EQUITY ACT (MHPAEA) REGULATORY IMPACT ON COUNTY BHP PROGRAMS

MHPAEA Rules that went into effect on May 31, 2018

Regulation	Regulation Impact
§438.3(h)	**Inspection and Audit of Records and Access to Facilities** An MHP or its subcontractors must make available at any time for inspection and audit any records or documents of the premises, physical facilities, and equipment where Medi-Cal-related activities or work is conducted for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.
§438.3(n)	**Parity in Mental Health and Substance-Use Disorder Benefits** MHPs must provide for services to be delivered in compliance with federal regulatory requirements related to parity (Subpart K of CFR Part 438).
§438.3(u)	**Record-Keeping Requirement** MHPs must retain and require subcontractors to retain records, as applicable, for no less than ten years.
§438.10	**Information Requirements** Each MHP must provide all required information to beneficiaries in a manner and format that may be easily understood and is readily accessible. This includes making oral interpretation available in all languages and written translation available in each prevalent non- English language. Each MHP must comply with the language and formatting requirements of the Final Rule.
§438.208	**Care Coordination** Each MHP shall implement procedures to deliver care to and coordinate services for all of its beneficiaries.
§438.210	**Coverage and Authorization of Services** Each MHP must have in place and follow, written policies and procedures for processing requests for initial and continuing authorizations of services. This includes having mechanisms in effect to ensure consistent application of review criteria for authorization decisions and processes for notifying providers and beneficiaries of decisions. Each MHP must comply with specified timeframes for authorizing services.
§438.214	**Provider Selection** Each MHP must implement policies and procedures for the selection and retention of network providers that meet the requirements specified in the Final Rule.
§438.230	**Sub-Contractual Relationships and Delegation** Each MHP must ensure that it subcontracts with network providers comply with the content requirements specified in the Final Rule. Each subcontract shall be in writing and shall include a requirement that the MHP monitor the subcontractor's compliance with the provisions of the subcontract and the MHP contract and a requirement that the subcontractor provides a corrective action plan if deficiencies are identified. Each MHP shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the DHCS, notwithstanding any relationship(s) that the MHP may have with any subcontractor.

§438.242	**Health Information Systems** Each MHP must maintain a health information system that includes the basic elements specified in the Final Rule to effectively collect, analyze, integrate, and report data. The MHP shall submit encounter data to DHCS at a frequency and level specified by the DHCS and CMS. The MHP shall ensure the collection and maintenance of sufficient beneficiary encounter data to identify the provider who delivers service(s) to the beneficiary.
Subpart F 438.424	**Grievance and Appeal Systems** Each MHP must have a grievance and appeal system in place for beneficiaries. This includes giving beneficiaries timely and adequate notice of adverse benefit determination in writing consistent with the requirements specified in the Final Rule, handling of grievances and appeals; resolution of appeals; and recordkeeping**.**
§438.608	**Program Integrity Requirements** Each MHP must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. This includes a compliance program that contains all of the elements specified in the Final Rule.
§438.62	**Continued Services to Enrollees** Each MHP must implement a transition of care policy consistent with the requirements in the Final Rule that meets the State defined transition of care policy.
§438.68	**Network Adequacy** MHPs must comply with the network adequacy standards developed by DHCS, including time and distance standards.
§438.206	**Availability of Services** MHPs must comply with timely access, and cultural and accessibility considerations to ensure that all services covered under the State plan are available and accessible to MHP beneficiaries in a timely manner.
§438.207	**Assurances of Adequate Capacity and Services** Each MHP must give assurances to DHCS and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area following the state standards and reporting requirements.
§438.334	**Quality Rating System** Each MHP must submit to DHCS the data necessary for DHCS to issue a quality rating, using the quality rating system adopted under this section.
§438.602(b) §438.608(b)	**Screening and Enrollment of Providers** Each MHP shall ensure that all network providers are enrolled with DHCS as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR Part 455, subparts B and E. This includes the MHP screening and periodically revalidating all network providers in accordance with federal requirements and promptly notifying DHCS of any excluded parties found. The MHP may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon determination that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider and notify affected beneficiaries.

APPENDIX C:
MEDICAID MANAGED CARE RULE- COUNTY REGULATORY IMPACT ON COUNTY BHP PROGRAMS

Medicaid Managed Care Rules that went into effect on July 1, 2018

Regulation	Regulation Impact
§438.62	**Continued Services to Enrollees** Each MHP must implement a transition of care policy consistent with the requirements in the Final Rule that meets the State defined transition of care policy.
§438.68	**Network Adequacy** MHPs must comply with the network adequacy standards developed by DHCS, including time and distance standards.
§438.206	**Availability of Services** MHPs must comply with timely access, and cultural and accessibility considerations to ensure that all services covered under the State plan are available and accessible to MHP beneficiaries in a timely manner.
§438.207	**Assurances of Adequate Capacity and Services** Each MHP must give assurances to DHCS and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state standards and reporting requirements.
§438.334	**Quality Rating System** Each MHP must submit to DHCS the data necessary for DHCS to issue a quality rating, using the quality rating system adopted under this section.
§438.602(b) §438.608(b)	**Screening and Enrollment of Providers** Each MHP shall ensure that all network providers are enrolled with DHCS as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR Part 455, subparts B and E. This includes the MHP screening and periodically revalidating all network providers in accordance with federal requirements and promptly notifying DHCS of any excluded parties found. The MHP may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon determination that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider and notify affected beneficiaries.

APPENDIX D:
SPECIALITY MENTAL HEALTH (SMI) MEDI-CAL COST CERTIFICATION FORMS

BHPs incurring increased Medi-Cal Administrative and Utilization Review/Quality Assurance costs to implement new provisions of these federal regulations may claim FFP and SGF reimbursement consistent with federal and state guidance (10).

MC 1982 A: SD/MC Quarterly Claim for Reimbursement - Treatment Cost

MC 1982 B: SD/MC Quarterly Claim for Reimbursement - Administrative Cost.xls

MC 1982 C: SD/MC Monthly Claim for Reimbursement - Quality Assurance/Utilization Review (QA/UR) Cost

MC 1982 D: SD/MC Quarterly Claim for Reimbursement - Medi-Cal Administrative Activities (MAA)

MC 1982 G: SD/MC Quarterly Claim for Reimbursement - Medi-Cal Administrative Activities (MAA)

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