California Council of Community Mental Health Agencies
Leaders in the partnership that developed and promoted Proposition 63

MASTER CONTRACT BETWEEN HEALTH PLAN AND COUNTY MENTAL HEALTH DEPARTMENT THAT COVERS SERVICES BY PROVIDERS WITH CONTRACTS UNDER MEDI-CAL WITH COUNTY

The new duals demonstration envisions that health plans will receive a capitated amount of federal and state funds and be responsible for Medicare covered mental health and alcohol and drug services.

Counties are responsible under Realignment and the Medicaid plan for "carved out" mental health and alcohol and drug services paid for by MediCal, but not by Medicare. Counties contract with their own network of providers for these and other services for which they are responsible.

It is acknowledged that the line between what mental health services Medicare does and does not pay for creates many situations in which a single visit may include some services that are billable under Medicare and some which are not.

Currently, counties pay their providers under their contracts and together they complete the information required to bill Medicare. For those costs not covered by Medicare, they then submit bills to the state to send to CMS for the federal share for MediCal. For those services not covered by Medicare, this same arrangement would be continued under the duals demonstration. For these services, the federal funds for county provided services billable under MediCal but not Medicare are "carved out" from the demonstration project and paid to counties in the same way that MediCal funds are paid now.

It is our recommendation that this process be continued under the duals demonstration. This requires that the health plans enter into contracts with counties whereby the health plans agree to pay counties for the Medicare covered portions of care provided by counties and the counties' network of providers. It is our understanding that this is what Los Angeles County is already working to establish and that the state should be urging that plans and the other counties start working on the same approach.

The contracts would cover the terms and conditions for authorization and care coordination (including physical health and mental health coordination and integration) and rates. The rates must fit the MediCal rate structure since that is what the counties and their providers utilize, including for duals. Any different type of payment structure would create disparities between how services to duals are reimbursed and how the same services are reimbursed when provided to people in the same programs when provided to a MediCal only enrollee. While some of the services are eligible for Medicare reimbursement, the health plans will receiving capitated federal funds and the customary billing rates for Medicare would not apply. This allows all of the providers that counties contract with to be part of the networks that the health plans use and ensures that there will be providers to cover the full range of covered benefits under both Medicare and MediCal.
Contracts should also address the role of these providers in helping the County and the Health Plan meet the performance objectives related to the quality withholds and financial incentives for these providers and their ability to share in the county's share of funds recouped if the measures are met.

This still allows health plans to have their own direct contracts with providers for those services that are fully covered by Medicare. The desirability and feasibility of this option would be up to each health plan as such contracts would not be set up to get any funds from counties or the federal share for the services covered by MediCal and not Medicare.

The alternative is for the health plans to try to rely completely on their own networks or to contract directly with all of the providers that counties contract. We anticipate that this would raise many complications. First of all, the health plans most likely have a natural network only for the types of services covered by commercial plans or Medicare. This tends to exclude the rehabilitation Medicaid option services provided by counties and their contracted community mental health agencies for people with severe and disabling mental illnesses but which are seldom part of other networks or coverage or the needs of the broader population. Moreover, if someone needs the services that are only reimbursable by MediCal the federal funds can only be accessed if these are billed through counties as they must provide the CPE (Certified Public Expenditure) that is part of the billing system under that carve out portion of the state Medicaid plan. It also runs the risk of forcing a client to have to go to more than one provider to get all of their needs met.

The agencies providing that care generally only have contracts with county mental health departments and are not generally part of other networks so it would also mean adding dozens or in some larger counties possibly hundreds of providers to a network.

It also creates challenges for the rate structure as counties use a MediCal cost based rate for each provider. Medicare and commercial plans tend to pay all providers the same rate. Federal Medicaid audits and accounting rules applicable to cost based contracts generally prohibit such a provider accepting a lower rate for the same service when paid from Medicare or another insurer or purchaser of care. The Medicaid rules are based on the premise that if the rates reflect average cost per service then if a unit of service is paid from other funds and it is paid at a lower rate than Medicaid , it is subsidizing that unit of service since the other funding is not covering that service's full costs. The Medicaid rules do not allow for that and audit disallowances require an agency/county to rebate that amount back to the federal government.

Hopefully this paper is adequate to inform state, county and health plans about this master contract approach and is consistent with what is being proposed in each of the eight counties. To the extent that any of the plans or counties envisions a different approach we would insist that there be meetings with providers and our association to ensure that it works as we are skeptical that any other approach can work.