

DHCS Behavioral Health Forum  
Issue Grid

Sub Comm.	Issue #	Issue Description	Stakeholder Feedback
BLUE	1	<p>Create a coordinated method for data collection and evaluation of outcomes that helps to ensure excellence in care and improved outcomes for all recipients. This involves evaluating the specific critical performance metrics and outcome measures DHCS is currently using (and going to use) in key MHSUDS areas to monitor performance, evaluate progress, inform decisions, drive actions and raise questions that may invite further analysis and investigation in order to improve care and quality using health information technology.</p> <p>Including but not limited to:</p> <p>Identify and allocate resources critical to the success of this project.</p> <ul style="list-style-type: none"> <li>• Establish a task force to help develop the strategy and set the stage for implementation.</li> <li>• Research and identify all required measurements, outcomes, and data for both treatment and prevention services.</li> <li>• Review current work by state organizations, counties, and other entities to determine areas of agreement, duplication, and gaps.</li> <li>• Clarify the unique roles and responsibilities of the range of governmental organizations and other entities that are involved in evaluation efforts across the state.</li> <li>• Develop a measurement system that builds on existing work and recommends deletion of duplicate or unnecessary work.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Overarching concern: Because SUD professionals providing services in California are poorly regulated (no license, varying standards for certification, licensed and untrained providers from other professions) it is critical that any outcome measurements be indexed to the quality of the treatment given. Regardless of the treatment setting, it is important to consider the level of skill, experience, and education present in the performance of counseling, which is the preponderance of the input of treatment.</b></li> <li>Data collection regarding the workforce, which is de facto capacity, is outdated, nonexistent, or not California-specific. Data about the size and capabilities of the workforce is urgently needed. Data about the workforce needs to be added here.</li> <li>• <b>To clarify, add to the third bullet “e.g. NQF and HEDIS measures.”</b></li> </ul>
BLUE	2	The state should clarify DHCS’s role with regard to Mental Health Services Act (MHSA) accountability.	
BLUE	3	MEDS: Better understanding the criteria for access to MEDS data	<ul style="list-style-type: none"> <li>• <b>While only clarification of MEDS access is mentioned here, the same could be said of many other important data systems including CalOMS, CSI, etc. We recommend expanding this issue to include DHCS data systems relevant to performance and outcome monitoring more generally.</b></li> </ul>
BLUE	4	Simplify Medi-Cal aid codes, enrollment & eligibility systems (2)	
BLUE	5	Improve care and quality using health information technology.	<ul style="list-style-type: none"> <li>• <b>As we are moving rapidly towards consumer/patient centric care delivery models, consumer point of use mobile technologies which are dependent on consumers’ technical and interpretation skills, and their health literacy levels need to be assessed along with the traditional clinical assessment during their first clinic visit. This ensures successful deployment of device and accurate data being captured for treatment outcome evaluation.</b></li> </ul> <p>Reference&gt; page 4 diagram National Research Council. Consumer Health Information Technology in the Home: A Guide for Human Factors Design Considerations. Washington, DC: The National Academies Press, 2011. <a href="http://www.nap.edu/catalog.php?record_id=13205">http://www.nap.edu/catalog.php?record_id=13205</a></p>

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BLUE	6	Implement a comprehensive, statewide data-driven system. <ul style="list-style-type: none"> <li>• Identify near- and long-term objectives and specify roles and responsibilities.</li> <li>• Determine the readiness of participants to meet the near-term objectives, including technology systems and data element reporting structures, and arrange technical assistance as needed</li> <li>• Work with partners and all stakeholders to ensure the continued scalability and utility of the system over time; make recommendations for modification as needed.</li> </ul>	<ul style="list-style-type: none"> <li>• Add Language: Establish a baseline expectation of no longer than every 3 years for regular modification/updates of data systems in order to ensure that needed changes can be made* *this request based on being told, “we can add that data element because it’s too expensive/time consuming/difficult to change our system.”</li> </ul>
BLUE	7	What data is currently collected? What needs to continue to be collected; what can be eliminated?	<ul style="list-style-type: none"> <li>• This information has been gathered by similar projects. Please learn from those efforts rather than starting over.</li> </ul>
BLUE	8	Strengthening and integrating data systems to assure better system wide data availability and information flow as well as user friendly data systems and reporting.	
BLUE	9	To what degree are uninsured un-enrolled individuals being effectively enrolled in Medi-Cal and engaged, as needed, in mental health and substance use services? a. Are special populations being enrolled at an adequate rate to compensate for higher rates on un-insurance? b. Are all counties performing equally well in meeting enrollment expectations?	<ul style="list-style-type: none"> <li>• Need to compare enrollment data between all sets of insured. What is the rate of enrollment outside of the Affordable Care Act and between Covered California and the Medicaid expansion population. If there are different rates for mental health and substance use disorder patients, what is the difference and what factors contribute to the difference.</li> </ul>
BLUE	10	Once enrolled, to what degree are these individuals receiving mental health and substance use services at predicted rates?	<ul style="list-style-type: none"> <li>• Again, compare rates to different types of insurance and explore factors that generate differences.</li> </ul>
BLUE	11	Review data to determine the mix of mental health and substance use services received by the expansion population as compared to the Medi-Cal existing population?	<ul style="list-style-type: none"> <li>• Why compare only to existing Medi-Cal use? The access and provision of care should be compared to private insurance as well. If there are gaps, recommendations to close them need to be made in this process.</li> </ul>
BLUE	12	What are the per service and per year costs, for primary care and specialty care, of providing mental health and substance use services to the Medi-Cal expansion population, how do these differ from predicted costs, and how do they differ from the existing Medi-Cal population?	

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BLUE	13	<p>Consider assessing:</p> <ul style="list-style-type: none"> <li>• What effect has Medi-Cal expansion had on drug-related death rates in California?” (Data Source for tracking drug-related deaths in California: CDPH, Center for Chronic Disease Prevention, Division of Chronic Disease and Injury Control, Safe and Active Communities Branch.)</li> <li>• What proportion of substance use treatment facilities offered screening for hepatitis C?” (Data Source for tracking the proportion of substance use treatment facilities offering hepatitis C screening: National Survey of Substance Abuse Treatment Services.)</li> <li>• what proportion of mental health and substance use service participants receive both mental health and substance use services on an annual basis?</li> <li>• What proportion of mental health and substance use participants are high cost users of health care services, and thus require care coordination or other similar interventions?</li> <li>• What proportion of mental health and substance use service participants receive a service encounter following screening.</li> <li>• Determine the feasibility of measuring to what degree mental health and substance abuse participants within Medi-Cal move back and forth between uninsured statuses or into commercial insurance on an annual basis? Does the rate of movement between coverage statuses differ for people with mental health and substance use diagnoses as compared to physical health-only participants?</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Bullet 1 - Cost savings for treatment impact numerous systems in California. Foster care, emergency room costs, incarceration and domestic violence should also be evaluated.</b></li> <li><b>Bullet 6 -Consider studying these variances between carriers. Is the lack of access to MH/SUD services more prevalent under one or more plans? Also, consider comparing severity when assessing crossovers between the two systems. At what level of care is the natural consequence of loss of employment (and benefits) prompting a change in insurance status? At what severity level are patients “too costly” to insure?</b></li> <li>• <b>Add HIV screening to the bullet point on Hep-C screening. The data source would be the same (NSSATS covers both).</b></li> </ul>
BLUE	14	<p>As noted above, DHCS understands the importance of establishing a central point for collection and analysis of Medi-Cal mental health and substance use service performance measurement and quality improvement issues.</p> <p>Key functions of this centralized function would be to:</p> <ul style="list-style-type: none"> <li>• collect data from all the disparate sources (including counties); analyze and interpret the data;</li> <li>• make it available on a regular basis to DHCS management and county management for system tracking and decision support;</li> <li>• publish summary information for use by the field and its stakeholders.</li> <li>• translate findings from the data analyses into annual quality improvement initiatives to be carried out on a statewide or local basis in concert with physical health plans, MHPs, and DMC.</li> <li>• collect and disseminate information on evidence based and promising practices to plans and providers in the field</li> <li>• assist county level entities to adopt their own quality improvement plans to address specific county level system and provider issues.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Add Language: Make data readily available to qualified outside researchers in order to improve and broaden data analysis and interpretation</b></li> <li>• <b>Bullet 5 -Consider the use of pilot projects to “think outside the box.” For instance, a pilot project where certified counselors are reimbursed for private practice where SUDs can be treated at lower levels of severity could yield cost saving results. Wherever possible, the “new system” should borrow from the private insurance market. If SUD patients at Kaiser are screened early and given care at low severity rates, this should be the goal for this system as well. There needs to be inventive thinking about how to replicate cost saving measures.</b></li> <li><b>Bullet 6- Again, the comparison of county success or failure rates needs to be evaluated according to the level of competency of the workforce.</b></li> </ul>

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BLUE	15	<p>Develop a comprehensive system that supports evaluation, accountability, and quality improvement.</p> <p>Including but not limited to:</p> <ul style="list-style-type: none"> <li>• Developing plans to enhance overall credibility of MHSUD services through strong performance accountability.</li> <li>• Support ongoing improvement in quality of care and prevention;</li> <li>• Support performance-based evaluation of clients as well as population outcomes</li> <li>• Demonstrate accountability to all appropriate state and county entities, and stakeholders.</li> </ul> <p>Address wellness, recovery, and resiliency; cultural and linguistic issues, including challenges related to threshold languages; underserved, un-served, and inappropriately served populations; and the need to focus on the entire life span (i.e., infants, children, youth, adults, older adults). (See Appendix A – Issue paper #1: Business Plan)</p>	
BLUE	16	<p>There needs to be a stronger and more effective DHCS web presence for health and behavioral health to facilitate stakeholder access, education and involvement.</p>	
BLUE	NEW	<p>Add issues/requirements to the issues grid:</p>	<ul style="list-style-type: none"> <li>• Please incorporate components already discussed and addressed through the EPSDT Performance Outcome System, and Katie A ACO.</li> <li>• Also add a requirement that costs of items under consideration or recommended are identified. Costs would include individual forms, training, data bases, staff time to complete the measures, scoring and interpretation of measures, and reporting of findings.</li> <li>• Add a requirement to ensure state wideness in all recommendations.</li> <li>• Add a requirement to ensure meaningful stakeholder involvement in all phases of the proposed system.</li> </ul>
BLUE	NEW	<p>Add issues/requirements to the issues grid:</p>	<ul style="list-style-type: none"> <li>• Determine how behavioral health data collection, evaluation, and information sharing can be integrated with CDCR and county jail providers</li> </ul>

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GREEN	1	<p>Identify best practices and key principles of integrated care.</p> <p>Form a service coordination and integration task force to review current promising models and identify principles and practices for effective approaches.</p> <p>Disseminate the information through various distribution channels and through training and technical assistance.</p>	
GREEN	2	<p>Under the leadership of DHCS, document and disseminate lessons learned and best practices information from the many integration projects underway in California, with an emphasis on scalable integration practices emanating from SPD enrollment, LIHP implementation, and the Duals (Cal MediConnect) Demonstration. This could include best practice guidance related to screening for mental illness and co-occurring substance use and mental illness within all DMC, specialty mental health and physical health plans, as well as stakeholder and CBO engagements strategies and multiple care coordination procedures etc... to ensure lessons learned are applied by Managed Care Plans and Counties to Medi-Cal expansion efforts .</p>	
GREEN	3	<p>Explore new approaches to purchasing MH/SUD services.</p> <p>Including but not limited to:</p> <ul style="list-style-type: none"> <li>• Funding should incentivize successful interventions that are cost-effective and result in high levels of customer satisfaction, and not base such interventions on the volume of service units or exclusively on the establishment of medical necessity.</li> <li>• Fiscal incentives should be established for providers who can document that the interventions they provide to clients are directly related to improvements in health and quality of life, thereby indicating effectiveness of services.</li> <li>• The costs of the interventions that lead to improvement need to be documented so that cost effectiveness can be measured.</li> </ul> <p>Measures should document the extent to which services are compatible with the needs, circumstances, and preferences of the population they are intended to reach, and reflected in consumer satisfaction.</p> <ul style="list-style-type: none"> <li>• The state should develop a policy for creation of a single administrative billing structure for MH,SUD, and primary care.</li> </ul> <p>Counties should have the option and authority to implement pay-for-performance reimbursement methods in provider contracts.</p>	
GREEN	4	<p>DHCS should collaborate with education and social service agencies in systems of care for children.</p>	

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GREEN	5	<p>Ensure parity for DMC &amp; MHSUD benefits in the Medi-Cal optional expansion.</p> <p>Including but not limited to: Consideration should be given to quantitative and qualitative issues in terms of the implementation of the Wellstone-Domenici Mental Health Parity and Addition Equity Act of 2008. Behavioral health is oftentimes subject to a higher level of scrutiny in terms of medical necessity.</p>	
GREEN	6	<p>Develop longer term fiscal models to move forward in area of post realignment and health care reform worlds. The state and counties have an opportunity to create financial incentives for continuing care and long-term care for chronic SUD conditions, as well as linkages with primary care and attainment of good health outcomes.</p> <p>Including but not limited to:</p> <ul style="list-style-type: none"> <li>• Create a specialized workgroup to provide options on possible fiscal incentives, as well as financing and billing barriers to integrated care models.</li> <li>• Ensure Small counties are adequately funded and clients, children, youth, and families have access to an adequately funded system of care.</li> <li>• Develop a comprehensive vision statement that addresses the adequacy of funding for MH and SUD services, and considers the impact of MH and SUD on the primary care system.</li> <li>• Develop financing strategies for MC and other funding sources that are aligned with positive outcomes &amp; best practices or MHSUD and simplify federal billing, reimbursement, cost reporting and admin processes to reduce costs, improve efficiency, and return funds to direct care.</li> <li>• Address how the EPSDT entitlement will be equally protected across the state.</li> <li>• Numerous issues related to MH financing must be addressed. Mental health funding, the administration of funding, and enforcement of regulations need to be compatible with principles of recovery, client-centered treatment, and desired client and system outcomes.</li> <li>• The challenges of the service delivery in the smallest counties should be considered in all finance related decision making. Large counties contain rural areas with similar challenges that are in need of similar consideration.</li> <li>• Standardize MH and SUD fiscal systems, including budgeting, cost reporting, and billing formats and requirements. This should be done within the broader context of reducing and simplifying state-imposed administrative burdens.</li> <li>• DHCS should establish a structure encompassing a set of priorities for SUD that looks at all the revenue sources within the SUD system, as well as SUD-related costs in health care.</li> </ul> <p>The state and counties should determine the specific roles that each will play to oversee, monitor, and assure financial accountability.</p>	

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GREEN	7	<p>Establish effective policy and processes for purchasing services. DHCS will have options for the design of state and county financing mechanisms; for example, continued fee-for-service, capitation, pay-for-performance, or other models. DHCS will also be in a position to issue guidance or direction for the county-provider relationship. A similar range of options will be available for local-level provider reimbursement – per-member per-month, case rate or other bundled reimbursement, pay for performance, and other methods. Selection of provider payment methods could also be a county option. Standardization of billing and other fiscal systems is important as long as it does not mean forcing SUD billing, budgets, and cost reports inappropriately into a MH or primary care framework. Lack of standardization in fiscal systems keeps MH and SUD locked into silos. Just as we work toward integration of patient care, we should be moving toward integration of billing and the reporting of fiscal, patient and encounter data across primary care, MH and SUD services.(all) . Including but not limited to:</p> <ul style="list-style-type: none"> <li>• Standardization of reimbursement mechanisms for providers across counties that are compliant with Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR, Part 2 confidentiality regulations. Utilize lessons learned from the dual-eligible pilots.</li> <li>• County reimbursement of providers is aligned with outcomes. This is a phased process considering all the other changes on the horizon. The system has metrics on which outcome-incentivized reimbursements can be based.</li> <li>• A preferential reimbursement for evidence-based practices.</li> <li>• Funding policy permits a balanced combination of standardization and innovation.</li> <li>• Savings in primary care (e.g., overnight stays, emergency department visits) that are produced by MH and SUD services are reinvested in the MH and SUD system.</li> <li>• Multiple services in the same day are reimbursable.</li> <li>• DHCS recognizes rural and small county issues in financing and service delivery.</li> </ul> <p>The county-of-service vs. county of residence issue in Medi-Cal reimbursement is resolved.</p>	<ul style="list-style-type: none"> <li>• The phrase “multiple services in the same day are reimbursable” (Green7) is mentioned several times in the document, but phrased differently each time, sometimes as a strong recommendation, other times as something DHCS might like to consider. I’d advocate for strong recommendation.</li> </ul>

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GREEN	8	<p>Develop a coordinated plan to ensure an adequate and trained workforce needed to support coordinated and integrated care as well as to ensure access to care when and where needed at all stages of life.</p> <p style="text-align: center;">Including but not limited to:</p> <ul style="list-style-type: none"> <li>• Work with the Office of Statewide Health Planning and Development (OSHPD) to develop a long range plan to enhance the MH and SUD workforce in terms of numbers, as well as geographic access and cultural competence.               <ul style="list-style-type: none"> <li>• Create a single-certification body for SUD counselors within state government.                   <ul style="list-style-type: none"> <li>• Establish appropriate peer and family certification standards.</li> </ul> </li> <li>• Enhance tele-health infrastructure and related training to serve underserved areas.</li> </ul> </li> <li>• Promote distance learning to enhance education and training opportunities for workforce in underserved communities and remote areas.               <ul style="list-style-type: none"> <li>• Expand loan-forgiveness programs.</li> </ul> </li> <li>• Promote outreach and incentive programs to attract more individuals to the field (Example: the Title IV-E Program in Social Services).</li> <li>• Create mechanisms for adding returning veterans with experience, training, and education in MH and SUD treatment to the California workforce.</li> <li>• Support incentives for cross training of staff in MH, SUD, and physical healthcare so that new model of integration are spread throughout the field.               <ul style="list-style-type: none"> <li>• Advocate for the addition of marriage and family therapists, and SUD-certified counselors as billable providers in Federally Qualified Health Clinics(FQHCs).                   <ul style="list-style-type: none"> <li>• Adopt the national psychiatric rehabilitation credential as a new type of MH practitioner.                       <ul style="list-style-type: none"> <li>• Create incentives for cross training of the MH,SUD, and primary care workforces.</li> </ul> </li> </ul> </li> </ul> </li> <li>• Explore credential and certification options for peer and family counselors, and care managers.(Note: prior work has been done on this topic by the California Association of Social Rehabilitation               <ul style="list-style-type: none"> <li>• Agencies and Working Well Together.)                   <ul style="list-style-type: none"> <li>• Build on current ongoing efforts to define and implement core competencies for SUD prevention staff.</li> </ul> </li> </ul> </li> <li>• Support expansion of programs like the UCLA International Medical Graduate (IMG) program bringing bilingual medical staff to California.</li> </ul>	<ul style="list-style-type: none"> <li>• I would like to see more items around network development and strategies for filling in gaps for desperately needed services, such as health psychology consultation. Research shows that behavioral interventions around chronic issues like diabetes result in better outcomes. And yet these are services that remain out of reach for individuals receiving services through Medi-Cal. Ultimately such things are cost saving measures and if we are rethinking behavioral health services generally, then let us move towards what we know works -- and make the best use of professionals who are already available.</li> <li>• Bullet 2- There needs to be discussion about whether the state needs to be the certifying agency, or whether it needs to strengthen its ability to regulate the private entities who do and verify the credentials they award.</li> </ul> <p>Bullet 2.5 – The majority of states (including the vast majority of populous states) offer a license for the SUD profession. At the very least, any workforce development discussion should include this topic. This committee should be tasked with performing a Sunrise Review Regulatory Request for this profession. One was done by UCLA more than 15 years ago and is in critical need of updating.</p> <p>The lack of access to licensed professionals who are specialists in SUD treatment is a gaping hole in California’s treatment system. This committee needs to evaluate how licensure of SUD counselors in other states impacts SUD access and treatment outcomes. Massachusetts has an interesting study delineating this issue. Other states with previous experience with “universal healthcare” also have valuable data to suggest that access to care from licensed professionals is essential.</p> <p>Bullet 6 – Add scholarships to offset certification and testing fees. Also add language that specifies that loan forgiveness be extended to all levels of education and include SUD students.</p> <p>Bullet 9 – Cross training is an inappropriate term. Cardiovascular doctors are not “cross trained” to treat orthopedic cases. A knowledge of and ability to refer between MH and SUD is desirous. The idea that someone can be cross trained to be competent in actually providing services is dangerous and short sighted. If a lack of SUD treatment providers is the problem, it needs to be addressed.</p> <p>Bullet 10- Marriage Family Therapists and Certified SUD counselors need to be included for billing purposes only within their scopes of practice and area of specialty. Marriage Family Therapists receive very little education (15 hours) and no experience requirement for the treatment of SUD. They are also not tested for competency in this area.</p> <ul style="list-style-type: none"> <li>• Consider adding a bullet that calls for a more thorough assessment of the SUD workforce size, composition, and professional capacity.</li> </ul>

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GREEN	9	<p>In the primary care setting, screening and brief intervention should not be limited to substance use issues but should be evidence based and include mental health conditions as well and that all providers of care for people with serious mental illness (SMI) should routinely screen for physical health conditions and assure coordination with primary care. (2)</p> <p>The state needs to evaluate the current mental health and substance use disorder screening tools used by both the plans and the MHPs and DHCS intends to work with counties, health plans, providers and other stakeholders to encourage all Medi-Cal plans to screen for mental illness and co-occurring substance use and mental illness in addition to the required screening for alcohol issues as the managed care system moves forward with the SBI requirement. This will be an important priority for the Department as it works with partners and stakeholders on the details of implementation.</p>	<ul style="list-style-type: none"> <li>• The issue of WHO can sign off on evaluations for MH and SUD needs to be delineated. SUD counselors needing signing from other licensed professionals with less education and experience and education in the area of SU disorders needs to be reviewed. Better coordination is needed.</li> </ul>
GREEN	10	<p>DHCS should evaluate the feasibility of using “Peer Specialists” and developing a Peer Specialist certification program as one of a number of key strategies to improve both workforce capacity and quality of care. (2)</p>	<p>Add Language: DHCS should then take steps to submit a State Plan Amendment to define the scope of work of the specialists, in accordance with the CMS rule change which allows preventive services to be provided by non-medical personnel.</p> <ul style="list-style-type: none"> <li>• The term peer specialist needs to denote “mental health peer specialists.” The term peer specialist for SUD is an antiquated term used in the infancy of the professional development for this area of specialization.</li> </ul>
GREEN	11	<p>DHCS should work with MCPs and MHPs to address issues related to timely information exchange during referral, active treatment, and inpatient phases, including: beneficiary demographic information; diagnosis; treatment plan; medications prescribed; laboratory results; referrals/discharges to/from inpatient and crisis services; and known changes in condition that may adversely impact the beneficiary’s health and welfare-- , so as to ensure effective bi-directional referrals---what’s often referred to as a “warm hand off and a hug”. (2)</p>	<ul style="list-style-type: none"> <li>• Amend to include timely information exchange with CDCR and county jail behavioral health providers</li> </ul>
GREEN	12	<p>Service Models - DHCS &amp; Counties work together to form a coordination/integration task force. (2)</p>	
GREEN	13	<p>Work closely with other key entities to develop possible MOU's, joint plans and policies, shared administrative procedures. (2)</p>	
GREEN	14	<p>Emergency Rooms (ER) High Utilizers:(2) Often emergency room services can result in duplication of claims, however while claims are duplicative the services provide are not. There needs to be greater discussion on this particular facet of emergency room services and reimbursement processes.</p>	

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GREEN	15	Re. screening in the primary care setting, stakeholders stressed that screening and brief intervention should not be limited to substance use issues but should be evidence based and include mental health conditions as well and that all providers of care for people with serious mental illness (SMI) should routinely screen for physical health conditions and assure coordination with primary care. The Department supports the importance of integrated care and while mental health screens currently occur, will be evaluating screening and assessment tools that address both mental health and substance use disorder conditions. (2) The state needs to evaluate the current mental health and substance use disorder screening tools used by both the plans and the MHPs and DHCS intends to work with counties, health plans, providers and other stakeholders to encourage all Medi-Cal plans to screen for mental illness and co-occurring substance use and mental illness in addition to the required screening for alcohol issues as the managed care system moves forward with the SBI requirement. This will be an important priority for the Department as it works with partners and stakeholders on the details of implementation.	
GREEN	16	Develop a patient and provider friendly system for sharing MHSUD clinical info. across all current clinical care providers. (2)	
GREEN	17	DHCS should consider requesting a Federal Waiver related to the Medicaid Institution for Mental Disease (IMD) exclusion as it pertains to substance use residential treatment programs under the newly expanded benefit design.	
GREEN	18	Work closely with other key entities to develop possible MOU's, joint plans and policies, shared administrative procedures.	
GREEN	19	Credentialing: The process should be effective and enhance system capacity without compromising standards or quality---all in the service of strengthening workforce and facility capacity issues. One specific recommendation is MFTs should be able to bill in MCPs and FQHCs.	
GREEN	20	FQHCs should have the ability to provide SMHS and DMC services and be paid separately from their PPS (prospective payment system) rate.	
GREEN	21	Develop an MOU between Managed Care and County Alcohol and Drug administrative structures	
GREEN	22	Develop a better approach (and capacity) for pain medication abuse	
GREEN	23	Simplify Medi-Cal aid codes, enrollment & eligibility systems	
GREEN	24	The Department should consider exempting SBIRT (Screening, Brief Intervention, Referral and Treatment) and associated behavioral health services from California's same-day billing restriction.	
GREEN	25	Attention to (and refinement if necessary) of existing regulations and contract terms to require all Medi-Cal plans (managed care and MHP), including DMC, to have effective MOUs defining mutual referral practices, clinical protocols, information sharing protocols where appropriate, and joint planning for improved care coordination at the county/community level.	

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GREEN	26	DHCS should work with providers to underscore the importance of making the providers in the various systems more aware of and conversant with the warning signs and symptoms associated with elder abuse as well as child and domestic abuse.	
GREEN	27	There is a recommendation that DHCS focus efforts on internal initiatives to increase joint planning, program implementation and program coordination within the mental health and substance use systems as well as other areas of the DHCS. This can be an integral part of DHCS's program implementation efforts as the newly acquired mental health and substance use systems are integrated with the rest of the Department, providing even stronger collaboration and integration.	
GREEN	28	The continued exploration of the feasibility of integrated health initiatives and special payment programs designed to increase physical health, mental health and substance use service coordination and integration is recommended. These include the continued active assessment by DHCS of the ACA Health Home option at some scale, and designation of Accountable Care Organizations (ACOs).	
GREEN	29	<p>DHCS should develop a new system that incorporates the following principles:</p> <ul style="list-style-type: none"> <li>• Managed Care with providers having county contracts for services</li> <li>• Ensuring that everyone who is identified as having a substance use disorder through screening, hospitalization, incarceration or treatment for a co-occurring mental illness has timely access to all medically necessary services</li> <li>• Create a simple method so that providers with county mental health contracts to have such contracts include funding and comparable rates and federal share of costs for alcohol and drug services incidental to the mental health services for people with co-occurring disorders</li> <li>• Establish a comprehensive system to ensure that everyone is screened for both mental health and alcohol and drug conditions in primary care – for the purpose of facilitating timely care and also documenting that those who don't screen positive should not be billed for care.</li> <li>• Ensure that MOUs between MediCal managed care plans and county mental health and alcohol and drug programs establish consistent integration and coordination to make sure that those who screen positive actually receive the necessary services and also to make sure that the physical health and alcohol and drug needs of those with severe mental illness are addressed in an integrated manner.</li> <li>• Eliminate fraud, but do it in a way that does not prevent people who have documented medical need for care from getting that care in a timely cost effective least restrictive setting.</li> </ul> <p>Sufficient state funding to make this work recognizing that whatever costs are added to behavioral health care the savings will accrue in physical health and criminal justice</p>	

## DHCS Behavioral Health Forum Issue Grid

Sub Comm.	Issue #	Issue Description	Stakeholder Feedback
GREEN	30	<p>SUBSTANCE USE DISORDER INTERFACE WITH MANAGED CARE PLANS (MCP)</p> <ul style="list-style-type: none"> <li>• Examine issues related to the development of Provider Networks</li> <li>• Review issues that FQHC, RHC, CAH experience in the provision of SUD services</li> <li>• Design an Info-graphic that describes the general referring process for Substance Use Disorder AOD Services-Identifying primary contact points for screening, assessment, and referral.</li> <li>• Develop a menu of Substance Use Disorder available services and contacts for information and technical assistance</li> <li>• Establish a template for MOU that includes dimensions that MCP MHP plans need to address in establishing and maintaining local provider networks</li> </ul> <p>i. Identify model plans</p> <p>ii. Determine Essential Issues and Recommendations for Reimbursement Barriers in the Provision of Substance Use Disorders Services by Federally Qualified Health Centers, Rural Health Clinics, Critical Access Hospitals. Often services require a referral from MCP</p> <p>iii. Describe local referral process for substance use disorder services. Include information on basic services, general information on accessing services locally, identify local technical assistance. High level (in terms of detail) Info-graphic on AOD services</p> <p>iv. Develop recommendations and identify models for establishing provider networks</p> <p>v. Develop a beneficiary referral model</p>	<ul style="list-style-type: none"> <li>• Any “menu” of services developed should include a designation as to what type of program or individual could competently provide each menu item.</li> </ul> <p>There is no bullet about utilization or access to care. There must be an evaluation of what care is being used and at what severity level. If managed care is “managing” SUD patients out of care due to severity and cost, this needs to be documented.</p>
GREEN	31	<p>MMMC Medical Directors Meetings and equivalent CMHDA/MHP Group</p> <ul style="list-style-type: none"> <li>• Recommendation that MHPs have a presence in the managed Care Medical Director’s forums and vice versa</li> </ul>	
GREEN	32	<p>MMMC Managed Care All Plan CEO meeting:</p> <p>Recommendation is for having an MHP presence similar to the MMMC Medical Directors Meetings</p>	
GREEN	33	<p>Monitoring:</p> <ul style="list-style-type: none"> <li>• Recommendation is for strong and careful monitoring of the effectiveness of MOUs (MCP and MHP), EQRO, CCI Complaint tracking, general QI results and other quality compliance tools and requirements.</li> </ul>	
GREEN	34	<p>Recommendation is for strong and effective coordination with A+I regarding both referral and A+I monitoring roles.</p>	
GREEN	35	<p>Recommendation is to evaluate how best to deliver DHCS Ombudsman services (given MH and SUD and Managed Care needs)Ombudsman Program</p>	
GREEN	36	<p>Recommendation is the use of MMCD data and MHSUDS data to improve QI-Dashboard development</p>	
GREEN	37	<p>Recommendation is for strengthening follow up on OOC and seeing where MMCDiv. and MHSUDS might align..esp. with timelines/sanctions</p>	
GREEN	38	<p>Recommendation is to consider if there a need for chart reviews of managed care plans for compliance with medical necessity criteria for mh/sud services</p>	
GREEN	39	<p>Screening and assessment tools used by MCPlans and MHPs for mh and sud will be re-examined. Are the tools still acceptable to MMCD, MHSUDS and Benefits?</p>	
GREEN	40	<p>Inpatient Detoxification and Intensive Outpatient Treatment SUD benefits should be made available via Medi-Cal providers more generally, not just via DMC providers.</p>	<ul style="list-style-type: none"> <li>• Add access to private practitioners for SUD treatment.</li> </ul>

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GREEN	41	Determine the proper fiscal and program arrangements between FQHCs and their ability to provide specialty mental health and Drug Medi-Cal services.	
GREEN	42	Current regulations for Outpatient Drug Free Services restrict individual counseling unless it is for assessment, treatment planning, crisis intervention or discharge. The recommendation is for the Department to consider changing this as it was seen as inconsistent with best practice.	<ul style="list-style-type: none"> <li>• Treatment needs to be “unhitched” from programs. There is a need to access SUD treatment in the same settings that MH care is available. A person shouldn’t have to go to a treatment center as his or her only means to receive counseling for SUDs.</li> </ul>
GREEN	43	The importance of meaningful stakeholder engagement is crucial. Create an ongoing forum for state and county leaders/partners as well as stakeholders to address MH & SUD issues and develop strategies for more effective coordination & integration of care. Involve counties and other key stakeholders in planning the best way to enhance credibility and accountability. Develop the forum and focus it initially on the management and implementation of Business Plan recommendations.	
GREEN	NEW	Please add issues/requirements to the issues grid	<ul style="list-style-type: none"> <li>• Add elements which would enable private/contracted providers to receive information regarding changes in requirements directly from DHCS, similar to the relationship CMHDA and CSAC have with the state.</li> </ul>
RED	1	<p>Focus on ensuring compliance with key mandates. ie: regulations &amp; standards for program quality, access &amp; availability for all services.</p> <p>My notes had "red;" so moved to red.</p>	

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Sub Comm.	Issue #	Issue Description	Stakeholder Feedback
RED	2	<p>Streamline program oversight and reduce administrative burden that could detract from investing funds in direct services.</p> <p>Including but not limited to:</p> <ul style="list-style-type: none"> <li>• Create a standardized and simplified methodology for provider reimbursement and billing.</li> <li>• Create a unified cost reporting system.</li> <li>• Simplify Medi-Cal aid codes and enrollment and eligibility systems.</li> <li>• Improve care and quality using health information technology.</li> <li>• Create standardized and combined (for dual diagnosis treatment) MH and SUD organizational certification and licensing.</li> <li>• Establish a single certification entity for SUD counselors.</li> <li>• Simplify and streamline state and county contracts.</li> <li>• Develop a patient- and provider-friendly system for sharing MH and SUD clinical information across all current clinical care providers.</li> <li>• Simplify federal billing structures and reimbursement processes for Medi-Cal in both the MH and SUD systems.</li> <li>• Provide counties with flexibility to establish rates for SUD treatment similar to MH Medi-Cal contracts with providers.</li> <li>• Develop a unified cost report system similar to the single cost report used by hospitals for Medicare.</li> <li>• Increase the efficiency and accuracy of the Medi-Cal Eligibility Determination System.</li> <li>• Reduce barriers to Medi-Cal eligibility through a simplified enrollment system.</li> <li>• Improve efficiency and timeliness of state and county MH and SUD contracts.</li> <li>• Develop a standard template contract for counties to use with providers of MH and SUD Medi-Cal services.</li> <li>• Develop standardized provider certifications for MH and SUD contracted providers.</li> <li>• Remove barriers to exchange of electronic health records and coordination of care.</li> </ul>	<ul style="list-style-type: none"> <li>• Bullet 6- Certification was better placed in the Green category as that is where professional issues and workforce development needs are addressed. The language in this bullet is better however. It should replace the single agency language in Green 8, bullet 2. Either way, it should NOT be the responsibility of two committees.</li> <li>• Bullet 16 – A standardized contract seems extremely vague. Each type and level of SUD care has different needs and should have different components. Need to specify this in this bullet.</li> </ul>
RED	3	DHCS should provide clear policy direction and planning for health care reform and related new directions.	
RED	4	<p>Develop process for state &amp; counties to define roles &amp; responsibilities to manage shared financial risk.</p> <p>Including but not limited to:</p> <ul style="list-style-type: none"> <li>• Determine where authority lies for which types of decisions.</li> <li>• Determine the extent to which discontinuities exist between authority, responsibility and financing, and where legislation, regulations, or new models are needed.</li> <li>• Fund small counties according to a formula that a). recognizes the unique fiscal and service delivery context of small and isolated service systems, and b). addresses increases in utilization, caseload growth, and cost increases.</li> </ul>	

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RED	5	<p>Simplify federal billing, reimbursement, cost reporting and admin processes to reduce costs, improve efficiency, and return funds to direct care.</p> <p>Including but not limited to:</p> <ul style="list-style-type: none"> <li>•Simplify federal billing structures and reimbursement processes for Medi-Cal in both the MH and SUD systems.</li> <li>• Provide counties with flexibility to establish rates for SUD treatment similar to MH Medi-Cal contracts with providers.</li> <li>• Develop a unified cost report system similar to the single cost report used by hospitals for Medicare.</li> <li>• Increase the efficiency and accuracy of the Medi-Cal Eligibility Determination System.</li> <li>• Reduce barriers to Medi-Cal eligibility through a simplified enrollment system.</li> <li>• Improve efficiency and timeliness of state and county MH and SUD contracts.</li> <li>• Develop a standard template contract for counties to use with providers of MH and SUD Medi-Cal services.</li> <li>• Develop standardized provider certifications for MH and SUD contracted providers.</li> <li>• Remove barriers to exchange of electronic health records and coordination of care.</li> <li>•Request the federal Centers for Medicare and Medicaid Services (CMS) to not require submission of a Medicare claim before billing Medi-Cal when the service is clearly not a covered Medicare benefit.</li> </ul>	
RED	6	<p>Encourage non-profit organizations to join together in coalitions, networks and/or partnerships. These coalitions or partnerships can be used to create and support critical business functions of the organizations. The coalitions and partnerships should be used to purchase computer hardware and software capacity, legal and technical resources for billing, contracting, and labor negotiations, as well as to plan in regional ways to fill gaps in care, evaluate outcomes, and obtain contracts.</p> <p>Including but not limited to:</p> <ul style="list-style-type: none"> <li>• Consult with others who have made this transition, such as CPCA in the community clinics and private medical practices and foundations, MH contractors, and others.</li> <li>• Support creation of umbrella legal entities to enhance the capacity of SUD providers.</li> <li>• Provide resources for consultation and facilitation of decision making. These resources will be needed at the local level to explore and plan for new partnerships and structures. State and county advocacy with foundations and federal government for some of these one-time supports is important.</li> </ul> <p>Ideally these recommendations would be completed in a time frame that would permit consideration as part of various federal, state, local, and foundation funding cycles.</p>	<ul style="list-style-type: none"> <li>• <b>Bullet 2 – Increasing capacity does not occur via creating an umbrella organization. The bed limitation needs to be the focus of this bullet.</b></li> </ul>

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RED	7	<p>Increase business capacity for SUD provider organizations to avoid loss of clinical &amp; program capacity in the face of major system changes. (2).</p> <p>Including but not limited to:</p> <ul style="list-style-type: none"> <li>• Consult with the California Primary Care Association and the California Council of Community Mental Health Agencies on the models they use for shared administrative support and capacity.</li> <li>• Identify resources to help SUD providers develop shared business functions through business partnerships, administrative service organizations, or other means.</li> <li>• Support legislation to enable MH and SUD providers to participate in federal meaningful use data funding to provide additional resources to build this capacity.</li> <li>• Work with foundations to fund joint planning efforts to develop new business structures.</li> </ul>	
RED	8	DHCS needs to provide clarity regarding claiming for specialty and non-specialty behavioral health (mh and sud) services by FQHCs, RHCs and Indian Health Service/ FQHC lookalikes using MOAs. (2)	
RED	9	Four of the five diagnoses classified in DSM-IV under the heading of “Pervasive Developmental Disorders” (Autistic Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, and Pervasive Developmental Disorder NOS) are, in DSM-5, grouped together under the single diagnosis of “Autism Spectrum Disorder.” Because treatment responsibility for outpatient services for individuals with Autistic Disorder does not rest with DHCS, it is important DHCS work with Managed Care Plans, MHPs, the Department of Developmental Services and/or the Department of Education to get clarity on what services are covered and not covered and by whom. (2)	
RED	10	<p>Leadership in addressing health disparities, dealing underserved groups and enhancing cultural responsiveness of services. (2)</p> <ul style="list-style-type: none"> <li>• Are health disparities being addressed in terms of the degree to which special populations are accessing and utilizing mental health and substance use services?</li> <li>• State and Counties should explore the feasibility of collaborating on how best to increase cultural/linguistic competence in provider networks.</li> </ul>	
RED	11	Stronger monitoring and oversight by DHCS regarding implementation and operations of the MOUs between Plans and MHPs. (2)	<ul style="list-style-type: none"> <li>• Add Language</li> </ul> <p>Add: Stronger monitoring and oversight by DHCS of the HIV Set-Aside expenditures.</p> <p>Add: Consider reevaluating how the HIV Set-Aside funds are distributed by considering other models for making the most effective use of the dollars (such as retaining some funds at the DHCS level to fund a full time position to provide technical assistance and oversight.)</p>
RED	12	Problem Resolution Process- Ensuring adequate Clinical & Administrative problem resolution processes between MCPs and MHPs. (2)	
RED	13	<p>Ensure counties are properly prepared and effectively managing the special populations that involves individual in the criminal justice system who will be accessing mh/sud services as a result of ACA. (2)</p> <p>Work with criminal justice agencies to better meet the needs of people involved in the criminal justice system.</p>	
RED	14	Counties should be the lead for setting local fiscal priorities for services, as long as they are within state and federal mandates.	

Blue - Data  
Green - Coordination/Integration  
Red - Strengthen Delivery Systems  
Purple - SUD (sub-group of red)

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RED	15	<p>Manage Drug Medi-Cal and Mental Health Realignment</p> <p>The 2011 Realignment has shifted the burden of financial risk for DMC and specialty MH services from the state to counties. Counties cannot sustain this risk without additional funding to obtain new tools to manage the DMC program, including managing the provider network.</p> <p>Additionally, in order to provide cost-effective services that produce good clinical outcomes, it is critical that counties have the authority to contract only with high-quality, financially responsible providers. Limited local resources must be allocated to services of documented effectiveness.</p> <p>A variety of solutions should be considered, ranging from state plan amendments, federal waivers, and changes to statute and regulation. Including but not limited to:</p> <p>Desired outcomes:</p> <ul style="list-style-type: none"> <li>• Counties are able to manage service quality and client access.</li> <li>• Counties can manage costs and risk under realignment.</li> <li>• Counties are able to meet local needs with a minimum of administrative burden, whether originating from federal, state, or local government.</li> <li>• The state and counties can maximize federal financial participation in Medi-Cal by taking advantage of tools such as federal waivers or state plan amendments to restructure the program.</li> <li>• Counties have the ability to build a prudent reserve in their realignment accounts without incurring a maintenance of effort liability under federal block grant requirements.</li> <li>• Counties will have an efficient cost-based federal reimbursement structure that aligns with the certified public expenditure obligations that have been transferred to local government.</li> <li>• Administrative and indirect cost obligations are minimized to preserve realigned sales tax revenues for direct services to covered beneficiaries.</li> </ul>	
RED	16	DHCS and Counties need to determine who has the lead role in deciding who should become a DMC provider.	
RED	17	<p>Develop a joint certification for MH and SUD service providers and sites</p> <p>Create a special workgroup to review and recommend a set of organizational certification standards for outpatient, day treatment, and residential programs.</p>	<ul style="list-style-type: none"> <li>• I am concerned that this workgroup may not represent the interests of current day treatment providers, so I am recommending this be added. That is, counties appear to want to replace the day treatment modality with the Intensive outpatient modality. This makes them more money but it is destroying a workable model with an ungainly one. The reasons against this have already been sent but here are my comments again: Day Care Habilitative (DCH) is a different modality from Intensive outpatient (IOP). It is the step between residential and outpatient. We currently have a perinatal program that has both (hybrid DCH-IOP).</li> <li>• Consider adding sober living, other recovery services.</li> </ul>
RED	18	Establish a single certification entity for SUD counselors.	<ul style="list-style-type: none"> <li>• Although a meaningful topic, a single agency for counselor certification needs to be with the Green committee. Remove this bullet. Consumers and stakeholders would have a difficult time reporting to three committees about this subject. There will be many crosscutting issues. This will be one of them, but it does not need to be in three committees.</li> </ul>

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RED	19	DHCS should engage in an immediate effort to develop DMC into the “good and modern” benefits continuum outlined in federal and state papers.	
RED	20	The expansion of DMC benefits raises concerns about the adequacy of utilization review and other quality oversight and management tools.	
RED	21	The Department recognizes the phrase “Outpatient Drug Free” is a term that is seen as antiquated and some believe should be eliminated. The Department agrees that this term is outmoded and is open to considering alternatives as part of a number of potential statutory and/or regulatory changes in the areas of substance use disorder services and Drug Medi-Cal treatment.	• This item needs to be moved to the discussion about private practice and licensure. This category is, for all intents and purposes, private practice with no competency requirements and little consumer safeguards. It needs to be eliminated and replaced with licensure.
RED	22	DHCS should explore options for increasing access to medication assisted treatments, such as through making additions to the Drug Medi-Cal formulary.	
RED	23	<p>There are several recommendations for consideration regarding SUD rates:</p> <ul style="list-style-type: none"> <li>• There is a concern that the DMC rates in general are too low to provide modern, quality treatment.</li> <li>• The recommendation is to revisit the reimbursement disparity between Intensive Outpatient Treatment (IOT) and Outpatient Drug Free Treatment (ODF). IOT has a wider range of services, but is reimbursed at a lower rate than ODF.</li> <li>• The recommendation is to have the ability to separately bill for additional drug testing, outside of the bundled rate.</li> <li>• The recommendation is to discontinue the Implicit Price Deflator- driven DMC reimbursement rates or replace it with a methodology that increases rates based on California State inflation.</li> <li>• The recommendation is to establish a payment structure that allows counties to recoup administrative expenses.</li> </ul> <p>For IOT, the recommendation is to develop a way to bill for treatment if less than 9 hours are provided. Value for each service with modifier? Delink? Example: If a beneficiary comes 2 of 3 days for treatment. No mechanism to bill for 2 treatments.</p>	
RED	24	<p>LPHA delivery of Outpatient Services without physician approval:</p> <p>The recommendation revolved about access issues, and the thinking that for capacity issues, it would be better if an LPHA could sign off on treatment plans rather than only a physician.</p>	
RED	25	<p>Rehab vs. Clinic Model</p> <p>The recommendation was regarding further research on what it would take to have DMC switched from the clinic model to the rehab model.</p>	• This item is antiquated. There is no “switching” between treatment approaches. Each needs to be valued. Each needs to have quality parameters and an ability to be reimbursed. Clinical and social approaches are seen in various levels in a blended fashion throughout California. This bullet needs to be removed. It doesn’t make sense in today’s treatment environment.

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RED	26	<p>Residential Treatment Concerns</p> <p>The recommendation involved giving increased attention to counties financial capacity to provide ancillary and transportation services with Residential Treatment. Specifically, some believe that it is a parity issue that room and board is not a covered benefit in a residential setting while it is in inpatient. Counties are struggling to find other funds to cover room and board, as block grants cannot be used.</p>	

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RED	27	Tele-health The recommendation is to explore the option of offering SUD services via tele-health where appropriate.	
RED	28	Group Size Limitations The recommendation is to revisit the minimum and maximum limitations to group therapy size.	
RED	29	Medical Necessity The recommendation is to further describe medical necessity in regards to SUDS. In order to standardize could it be spelled out in Regulations.	
RED	30	Recommended dialogue on improving access to MH/SUD services with a focus on: <ul style="list-style-type: none"> <li>• Ensuring Access to services is “Timely”</li> <li>• Identifying state and local policies and procedures that will improve access</li> <li>• Describing current oversight processes in place that review, document, and inform access to services</li> <li>• Detailing current local standards and protocols that promote and improve access to mental health and substance use disorder services</li> </ul>	
RED	31	<p>Pursue solutions to provide counties with greater flexibility to manage fiscal &amp; program risks as well as to implement different program and fiscal models.</p> <p>Including but not limited to:</p> <ul style="list-style-type: none"> <li>• Provide counties the authority and tools to contract with high-performing, financially responsible providers in order to provide cost effective services that produce good clinical outcomes.</li> <li>• Pursue a variety of program and federal revenues solutions ranging from state plan amendments, waivers and changes to statute and regulation.</li> <li>• Provide relief for counties from funding formulas that unduly constrain their resources.</li> <li>• Reduce financing barriers and create financial structures to support integration of care.</li> <li>• Reduce administrative barriers to integration of care and coordination between providers.</li> <li>• Create integrated site certification standards for community health clinics and SUD Medi-Cal outpatient treatment sites.</li> <li>• Provide SUD prevention services at (or aligned with) primary care sites in traditional settings, as well as at school sites and community-based health homes.</li> <li>• Other TBD</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Bullet 1 -Accountability measures must be aligned to treatment populations. Programs providing services to difficult and severe cases must not be penalized for “lack of clinical success.”</b></li> <li>• <b>Bullet 2- A pilot project for reimbursement for private practice for certified SUD counselors would be an excellent example of this.</b></li> </ul>

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RED	32	Recommendation for careful consideration of EPSDT Specifically: To the extent that the county is responsible for ensuring that EPSDT beneficiaries receive medically necessary alcohol and drug treatment services and the required pre-authorization of non-state plan EPSDT coverage, allocations to counties' Behavioral Health Subaccounts must reflect the potential growth in this entitlement.	
RED	33	Develop a joint certification for MHSUD service providers and sites.	
RED	NEW	Please add issues/requirements to the issues grid	<ul style="list-style-type: none"> <li>• Add elements which would enable private/contracted providers to receive information regarding changes in requirements directly from DHCS, similar to the relationship CMHDA and CSAC have with the state.</li> </ul>
RED	NEW	Please add issues/requirements to the issues grid	<ul style="list-style-type: none"> <li>• Develop a streamlined pre-release enrollment process for CDCR inmates;</li> <li>• Ensure that benefit exclusions (including interpretations of medical necessity) do not prevent appropriate coverage of court-ordered behavioral health treatment</li> </ul>
RED	NEW	Please add issues/requirements to the issues grid	<ul style="list-style-type: none"> <li>• Standardize benefits and levels of service across Counties and Plans to permit clear and precise MOUs and to strengthen all providers' and members' ability to seamlessly transition between the Plans and the County Mental Health and SUD services.</li> </ul>
DON'T KNOW WHAT THIS ITEM MEANS		More information about the state budgeting system to better understand financial interconnections between departments and to identify where possible savings could occur.	
SUD-PL	1	Recommendation for careful consideration of DMC oversight and accountability issues. This recommendation recognizes that: <ul style="list-style-type: none"> <li>• Under the current realignment framework, it is important that each county has sufficient oversight and authority in administering the Medi-Cal provider network to ensure adequate accountability.</li> <li>• Counties have not been given the administrative tools to promote quality services, ensure access, and focus on outcomes within the DMC program. Consequently, although counties have the responsibility for overseeing the effective and appropriate use of DMC funds, counties have virtually no input in the approval of providers.</li> <li>• The lack of county oversight, choice, and accountability in the contracting process for the expenditure of public funds for DMC providers diverges from the normal county process for contracting – which was developed for maximum accountability, choice, quality, oversight, efficiency and public participation – and significantly raises the level of legal and financial risk assumed by the county under the DMC portion of 2011 Realignment.</li> </ul>	
SUD-PL	2	Recommendation for careful discussion of DMC Administrative Issues. This recommendation recognizes that when counties assumed 100% financial responsibility for the DMC entitlement program through 2011 Realignment, a number of administrative issues immediately became cause for counties' concern. They include: <ul style="list-style-type: none"> <li>• Delays in federal reimbursement.</li> <li>• Disjointed CPE process.</li> <li>• Recouping administrative costs.</li> <li>• County Consultation.</li> <li>• EPSDT Service Costs.</li> <li>• Same Day Services.</li> </ul>	

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SUD-PL	3	<p>Recommendation for careful consideration of DMC contracting issues</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>• Counties, as local government entities that administer public funds, must have the ability to select and de-select contractors/providers on the basis of the county’s need for services and potential providers’ compliance with county fiscal, quality and performance standards.</li> <li>• In addition to the contract elements listed above under “Oversight and Accountability Issues,” other examples tied to quality and outcomes include competitive pricing, proof of financial stability, the use of and fidelity to evidence-based practices, required attendance at training events, participation in quality assurance processes, and participation in process improvement programs.</li> </ul>	<ul style="list-style-type: none"> <li>• Improving the competency and ethical component of those directly delivering the services needs to be inserted here.</li> </ul>
SUD-PL	4	<p>Recommendation for careful consideration of DMC rate setting:</p> <p>Specifically:</p> <p>Since counties provide the certified public expenditure (CPE) for DMC, the rate setting process must be an annual collaborative venture between the state and counties, similar to the process that exists on the Medi-Cal Mental Health side. The rate setting process must be undertaken each year in a timely manner and with the mutual goal of maximizing federal reimbursement.</p>	

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SUD-PL	5	<p>Recommendation for careful consideration of DMC Certification. Specifically:</p> <ul style="list-style-type: none"> <li>• DMC certification should be combined with existing alcohol and other drug program certification requirements.</li> <li>• Counties must have the authority to apply these standards to enroll providers into the local SUD treatment network. Counties would certify community-based providers and the state would certify county-run programs.</li> <li>• Standards for disenrollment need to be established and maintained.</li> </ul>	
SUD-PL	6	<p>Recommendation for careful consideration of Standardization of DMC Business Practices Specifically:</p> <p>Budget, cost report, billing and claims adjudication processes for DMC should conform to practices for Short-Doyle Medi-Cal (This means timelines, data elements, reporting requirements, communications between state and counties, etc.) to ensure quality and efficiency in both communication and administration.</p>	
SUD-PL	7	<p>Recommendation for careful consideration of DMC Cost report settlement issues and specifically to streamline the cost reporting and settlement processes.</p>	
SUD-PL	8	<p>Recommendation for careful consideration of DMC Billing issues Specifically:</p> <ul style="list-style-type: none"> <li>• Streamline the billing process</li> <li>• Explore conforming DMC billing to existing Department of Mental Health (DMH) practices</li> <li>• Create greater flexibility on billing submission deadlines</li> <li>• Clarify billing policies relating to Minor Consent and dual eligible clients</li> </ul> <p>Accept credit card payments for narcotic treatment program (NTP) slot fees</p>	
SUD-PL	9	<p>Recommendation for careful consideration of DMC Claims issues Specifically:</p> <ul style="list-style-type: none"> <li>• Examine the legal and business rules for timely reimbursement of claims</li> <li>• Simplify system for providers</li> <li>• Reduce the time to process reimbursements</li> <li>• Reduce number of disallowed claims</li> <li>• Review information technology system requirements and business processes</li> </ul>	
SUD-PL	10	<p>Recommendation for careful consideration of DMC Provider Applications &amp; Certification issues. Specifically:</p> <p>Where possible, eliminate redundancies in the provider certification process including perceived overlap with other Departments' licensing programs</p>	
SUD-PL	11	<p>Recommendation for careful consideration of DMC Technology issues Specifically:</p> <p>Determine what process enhancements are feasible including greater system compatibility and integration (i.e. Oracle, Paradox)</p>	
SUD-PL	12	<p>Recommendation for careful consideration of DMC Client Reporting issues Specifically:</p> <p>Streamline the reporting process</p>	

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Sub Comm.	Issue #	Issue Description	Stakeholder Feedback
SUD-PL	13	Recommendation for careful consideration of DMC Program Standards issues Specifically: Determine how current Alcohol and Drug Program Standards could be modified to improve operational efficiency and clinical outcomes	<ul style="list-style-type: none"> <li>• Same as purple 3.</li> </ul>
SUD-PL	14	Recommendation for careful consideration of possible DMC expansion of DMC Services Specifically: <ul style="list-style-type: none"> <li>• Broaden Medication Assisted Treatment options</li> <li>• Increase flexibility regarding the number of clients permitted in group counseling sessions that may be billed to Medi-Cal</li> <li>• Permit all SUD clients to utilize residential treatment options</li> <li>• Reimburse two treatments in one day</li> <li>• Encourage the use of the social model (as opposed to a medical model) of treatment</li> <li>• Reimburse for: <ul style="list-style-type: none"> <li>o Counseling of family members</li> <li>o Drug testing</li> <li>o HIV and Hepatitis testing</li> <li>o Greater collaboration of treatments for Co-Occurring Disorders</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Several issues in SUD-PL 14 are not currently accepted standard of care. Use of residential programs should be determined by placement criteria, not sure why all SUD clients would need residential.</li> <li>• Also there is no need to pit social model vs medical model in the 21st century. Psychosocial and medical care should both be available at any level of care when needed.</li> <li>• Add access to private practitioners to this list.</li> </ul>
SUD-PL	15	Recommendation for DMC Rate Setting issues Specifically: Examine increasing the reimbursement rates for services	
SUD-PL	16	Recommendation for DMC Licensure/ DMC Certification issues Specifically: <ul style="list-style-type: none"> <li>• Streamline the licensing and certification process</li> <li>• Examine adopting the National or Statewide Commission on Accreditation of Rehabilitation Facilities standards for provider certification</li> </ul>	
SUD-PL	17	Recommendation for DMC Medicaid Waiver(s) issues Specifically: Discuss possible exceptions requiring Centers for Medicaid and Medicare Services approval	
SUD-PL	18	Same Day Service Restriction The recommendation is to revisit the same day service restrictions. It creates access issues for some beneficiaries. Ex: A beneficiary who is in prenatal residential treatment and also requires methadone.	
SUD-PL	19	Youth Treatment Standards and Costs DMC is written for adult beneficiaries. The recommendation is that youth specific definitions and costs be created.	
SUD-PL	20	Prior Authorization for Residential Treatment The recommendation is the State consider requiring prior authorization for residential treatment. This authorization would be provided by the counties.	
SUD-PL	21	Detox Component of Residential Treatment <ul style="list-style-type: none"> <li>• The recommendation relates to consideration of a medical detoxification component as a part of Residential Treatment in the future.</li> </ul>	

Blue - Data  
Green - Coordination/Integration  
Red - Strengthen Delivery Systems  
Purple - SUD (sub-group of red)

DHCS Behavioral Health Forum  
Issue Grid

Sub Comm.	Issue #	Issue Description	Stakeholder Feedback
SUD-PL	22	<p>The recommendations of this report (Senate Office of Oversight and Outcomes (SOOO). released on May 13, 2013 a report on California AOD counselors titled, "Suspect Treatment: State's lack of scrutiny allows unscreened sex offenders and unethical counselors to treat addicts ) included:</p> <ul style="list-style-type: none"> <li>• Placing the State firmly in charge of certifying SUD counselors</li> <li>• Requiring background checks and rap-backs</li> <li>• Providing guidelines for assessing criminal backgrounds</li> <li>• Creating a centralized data system of all SUD counselors</li> <li>• Increasing oversight over the current Certifying Organizations</li> </ul>	<ul style="list-style-type: none"> <li>• Add Language: Any background checks should not automatically disqualify individuals who were imprisoned for drug-related and alcohol-related offenses, and such individuals should be recognized as having valuable experience to offer.</li> <li>• These items need to be moved to Green subcommittee. All counselor professional certification and licensure issues need to be grouped together.</li> </ul>
SUD-PL	23	<p>SUD Counselor Requirements The recommendation is to explore the possibility of strengthening the requirements of becoming a counselor.</p>	<ul style="list-style-type: none"> <li>• These items need to be moved to Green subcommittee. All counselor professional certification and licensure issues need to be grouped together.</li> </ul>
SUD-PL	24	<p>Review DMC Overly Proscriptive and Restrictive State Statutes Specifically:</p> <ul style="list-style-type: none"> <li>• There are a number of DMC-specific statutes enacted since 1980. Many of them outline the mode and method – even the number – of treatments available under the DMC program, as well as establish rate-setting and reimbursement models.</li> <li>• Moreover, since the DMC benefit is carved out of the regular Medi-Cal program, the delivery of DMC services is restricted to specially-certified facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• To clarify this further, consider adding "Consider eliminating the DMC carve-out to facilitate integration of SUD services into settings other than specialty care."</li> </ul>