



MEETING MINUTES
Substance Use Disorder Drug MediCal
Waiver Advisory Group
California State Association of Counties Conference Center
1020 11th Street, Sacramento
April 2, 2014

Waiver Advisory Group Members in attendance:

Toby Douglas, DHCS
Karen Baylor, DHCS
Marlies Perez, DHCS
Susan Blacksher, CAARR
Molly Brassil, CMHDA
Kelly Brooks, CSAC
Donne Brownsey, COMP
Sandra Goodwin, CIMH
Veronica Kelley, San Bernardino County

Judith Martin, CSAM, (SFDPH)
Steve Maulhardt, COMP
Kerry Parker, CSAM
Rick Rawson, UCLA
Tom Renfree, CADPAAC
Al Senella, CAADPE
Andy Williamson, Solano County
Jerry Wengerd, Riverside County

Overview

The Department of Health Care Services (DHCS) is seeking an 1115 Demonstration Waiver for the Substance Use Disorder Drug MediCal (DMC) Program. The intent is to demonstrate how California delivers DMC services to California's beneficiaries through an organized delivery system. The Waiver needs to be consumer-focused; use evidence based practices and improves program quality outcomes. This will be a stakeholder involved and transparent process to gather input from all impacted parties including other state departments, consumers, associations, counties and providers.

The Department is also pursuing simultaneous projects pertaining to the DMC program. While the Waiver will be a demonstration of those counties which opt in, there will also be improvements made to the existing DMC system. There is currently an emergency regulations package in process which contains DMC program integrity changes. There will also be a regulations package outlining the new DMC expanded benefits in addition to other programmatic changes which did not fall within the current emergency regulations authority.

There was discussion on the timeline for the Waiver. The Department has an internal Waiver team coordinated through project management. The project plan will be made available in the near future.

The Department also identified that there are discussions taking place with the Centers for Medicare and Medicaid Services (CMS) regarding California's intent to pursue an 1115 Waiver.

Gaps in the Delivery System

An initial Waiver stakeholder conference call occurred on January 21, 2014 to discuss the gaps in the current delivery system of DMC. These key areas were used in order to develop the agenda for the Waiver Advisory Group meeting. DHCS acknowledged there are gaps that still need to be identified. As the workgroup proceeds, gaps will be flushed out and key areas will be identified and added for later discussion.

Organized Delivery System Discussion

Single Point of Entry

Identifying where clients enter into the DMC system brought several ideas forward. There was input from stakeholders that it could be a mixed model without one single point of entry so that there wouldn't be a delay in services. Various current county models were discussed and it was suggested that instead of re-creating the model that the Department look within California and out-of-state to garner ideas. Entering into the system should be a flexible process which would allow beneficiaries to enter at any point in the continuum of care and to move up and down within the system as clinically indicated. The system should also include internal referral mechanisms to other levels of care for the providers within the system. An alternative to a single point of entry was to establish an authorization system with the counties.

Several concerns were brought up surrounding the issue of entering the system. Discussion included the need to ensure parity for services and build quality assurance into the system. Interactions with the health plans and primary care were also highlighted as essential areas to discuss. There was debate on how beneficiaries should enter the narcotic treatment provider (NTP) facilities. The issue of the current NTP slot process was discussed as some felt that it limits access and is outdated. The Department relayed that it is currently looking into the slot process with the Department's Narcotic Treatment Programs Advisory Group.

Medical Necessity Criteria

The general input was to use the Diagnostic and Statistical Manual (DSM) V diagnosis and the American Society of Addiction Medicine (ASAM) placement criteria in order to establish medical necessity for beneficiaries. Discussion around who should diagnose and or administer a service occurred; whether it should be a certified counselor and/or a licensed physician. Some recommended that this new delivery system mimic the mental health field for diagnosis.

Stakeholders discussed the option of requiring a separate Medical Necessity criteria for Narcotic Treatment Program (NTP) services. Concerns with this suggestion involved creating two separate systems when a beneficiary should have access to all levels of care regardless of where they enter into the system. The stakeholders stated that no matter where the beneficiary enters the continuum of care that they should be assessed and provided information on NTP services. There were also discussions on moving Medical Necessity to a single point of entry. This idea was not well-received by the stakeholders as they did not want to limit access for the beneficiaries.

Treatment Authorization

On the topic of treatment authorization for residential services, the stakeholders suggested that the counties provide the authorization. However, when there is an immediate need, the suggestion was to begin the treatment and then create a timeframe for the county to approve the authorization of services. Stakeholders requested the Department to provide information on how authorization is conducted for other health care services. It was determined that more work needs to be done in this area.

Selected Provider Contracting

Stakeholders provided feedback on how the selective provider contracting may impact the services and stated that ensuring access to services is imperative. Suggestions were made to have the counties determine, manage and monitor the contracts based on a standardized process and criteria for awarding contracts. Sole sourcing was one idea on how to allow potential new providers into the system after request for proposals were already closed. Concerns were raised that counties could limit NTP providers due to stigma or unfairly reject current providers. Ensuring state oversight through monitoring counties and the creation of an appeal process at the state level were a few potential solutions.

Crisis Services

The stakeholders stated that beneficiaries showing up to treatment required on demand care since they were willing at that point to receive services. Discussion ensued that beneficiaries placed themselves and those around them in danger and/or decline when using drugs and/or alcohol which constitutes a crisis. The ASAM criteria was recommended for the determination of the level of care needed in addition to other needs such as medical, pregnancy or mental health.

Continuum of Care

Stakeholders reviewed and discussed the proposed levels of care on the Continuum of Care handout. Two levels of care were added to the chart: Inpatient Medical Detox and Recovery Support Services. Stakeholders strongly recommended to waive the Institute from Mental Disease (IMD) exclusion for detoxification and residential services and have no limitation on bed capacity in order to fully demonstrate the effectiveness of the continuum of care which requires approval from CMS.

There was discussion on the average length of stay for detox and short-term residential services, group size, and testing flexible schedules for intensive outpatient. It was stated that ASAM has guidelines that could be used to develop standards. National Institute on Drug Abuse (NIDA) and Substance Abuse and Mental Health Services Administration's (SAMHSA) level of care guidelines could also be other resources. With regard to Sober Living Environments (SLE), it was recommended there be requirements and county oversight for this level of service. It was recommended that the Proposition 36 model be reviewed, which included housing with treatment provided, in addition to the voluntary California Association of Addiction Recovery Resources (CAARR) SLE standards and current county models.

Evaluation

Darren Urada, from the University of California at Los Angeles (UCLA), provided a broad overview on the parameters that could be evaluated in the Waiver. Ideas for various approaches included differences in differences, comparison counties or stages of implementation comparisons.

Penetration rates, ASAM matching and placement, outcome measures and cost savings to other systems were also presented as ways to measure the access, quality and cost of the demonstration Waiver.

Next Steps

Stakeholders and interested parties agree to use the same meeting format for the subsequent Waiver Advisory Group meetings. Members asked for any updates regarding discussions with CMS. All stakeholders were encouraged to submit comments to: MHSUDStakeholderInput@dhcs.ca.gov

The next meeting is April 15, 2014 at the California Association of Counties Conference Center located at 1020 11th Street in Sacramento. Interested parties can attend in person or call into the conference call at 1-888-769-9728 passcode 6585523. Agendas and handouts are available at <http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx>