



MEETING MINUTES  
Substance Use Disorder Drug MediCal  
Waiver Advisory Group  
California State Association of Counties Conference Center  
1020 11<sup>th</sup> Street, Sacramento  
July 30, 2014

Overview

The Department of Health Care Services (DHCS) is seeking an 1115 Demonstration Waiver for the Substance Use Disorder Drug Medi-Cal (DMC) Program. The overall purpose of the Waiver is to create a model that will provide an Organized Delivery System of Substance Use Disorder (SUD) services. This Waiver will be an amendment to California's existing section 1115 Bridge to Reform Waiver.

Draft Terms and Conditions Topics for Discussion:

**Medication Assisted Treatment**

Mike Wofford, from Pharmacy Benefits at DHCS, discussed Vivitrol and oral Naltrexone as additions to the pharmacy benefits. Pharmacy is working on incorporating physician administered treatments into the available pharmacy benefits.

Stakeholders encouraged making all medications available on the DMC formulary or available from a doctor or pharmacist without a Treatment Authorization Request (TAR). Some of the concerns voiced by Stakeholders are as follows:

- Multiple access points for all medications without a TAR would help patient care
- Coordination will be important between the systems to prevent drug interactions when multiple clinicians may be prescribing to one individual
- Removing the cap on Buprenorphine may be problematic under federal law
- The DMC carve-out presents a barrier to physicians prescribing SUD medications
- DHCS work with federal partners to allow additional mobile units.

**Medical Necessity defined by DSM and ASAM**

The general consensus among stakeholders about using ASAM Criteria is positive. The ASAM Criteria has a computerized system with algorithms that is ready for distribution. Suggestion was made to consider regional model for small counties as having all of the ASAM Criteria levels in many counties may be a hurdle, especially for small counties that may have only one DMC service. It was mentioned that ASAM Criteria level IV (i.e. Inpatient Care) is not available in many counties. The stakeholders recommended the State provide training to adopt ASAM Criteria and technical

assistance for counties and also outline what happens to counties/providers when the ASAM Criteria is not used properly.

### **Case Management (CM)**

Stakeholders expressed support for including CM, but only if it is a reimbursable service. Stakeholders requested a clearer definition on CM. Concerns with where the case management service is provided were raised. Several expressed that CM should be provided at the county and provider level. Clarification should also be added regarding what level of staff may provide the service. Stakeholders also wanted to know how Health Homes will intersect with the Waiver.

### **Provider Certification Process**

DHCS confirmed that the Waiver's provider certification standards will be the same as those in the current DMC certification and that counties will not be using their own or additional standards to certify providers. The final decision on certification will still rest with the Provider Enrollment Division (PED) at DHCS and take into consideration the county recommendation. County reimbursement will be addressed. Stakeholders indicated that there should be an appeal process if a county does not certify a provider.

### **Withdrawal Management**

Stakeholders mentioned that there are sobering centers that are not technically detox, but they meet a need in public health services to provide supervision out of the ER. Some residential providers are providing detox and have high ER admission rates because patients are not monitored well. It was pointed out that the model of residential detox is limited – they need a higher level of care. Stakeholders also suggested adding free standing psych facilities which currently provide detox services to the allowable list of providers along with NTP Providers for alcohol detox.

### **Recovery Services**

Stakeholders support inclusion of recovery services for continuous care, relapse prevention, and wrap around services. Suggestion was made to distinguish recovery services from case management responsibilities. Mental health wellness centers could also be added to recovery services.

### **County Role and Implementation Plan**

DHCS clarified the timeline for counties that opt into the Waiver. Counties will submit a plan how to implement the continuum of care and obtain network adequacy. DHCS will allow counties a year to fully implement the plan and approve extensions, if needed. DHCS is working on a timeline for when counties need to notify DHCS if they will opt into the Waiver.

### **Coordination with Managed Care Plans (MCP) and Primary Care**

Stakeholders articulated issues that could be addressed in order to facilitate care coordination across the current separate systems:

- DMC carve outs work against integrated care
- Disputes happen between counties and MCPs about who has responsibility for an individual. Some providers' stress that care coordination has to be at the service level, but that there is no interaction or communication at the service level between providers.
- CFR 42 does not work in today's environment with expanded benefits. Information sharing is a barrier to client care. Plans have data that is not made available to other providers. Plans struggle to receive emergency room and incarceration data. The criminal justice system needs more information to stay involved with the client.

## **Residency Versus Service Location**

Discussion surrounded on whether payment for services will be based upon a client's county of residence or upon where the services are rendered. Stakeholders suggested that the financing follow the client. Others stated that it should be determined with the financial decisions and based on who carries the financial risk.

## **Selective Provider Contracting**

COMP expressed opposition to selective provider contracting. Some stakeholders felt network adequacy should be better defined and the reasons for appealing contract denial broadened. If the only reason a provider can appeal a county decision is based on network adequacy, the state and providers need data and criteria about what is adequate access to care.

## **County Authorization**

There were differing options on allowing counties the flexibility to authorize services in addition to residential. If this is allowed, a suggestion was made to ensure that counties do not add additional authorization requirements and add a timeline to authorize the other services. DHCS was asked to clarify what happens when a service is not authorized. Differing opinions were brought up on whether authorization is needed. Several felt that a medical necessity determination is made by the clinician in-person, not by a second person who reviews the chart later.

## **Quality assurance (QA) and State Oversight, Monitoring, and Reporting**

DHCS wants to build on good models on the Mental Health side. DHCS is looking to incentivize QA activities. A suggestion was made to have ER utilization included in utilization data. Stakeholders also suggested requiring additional data to include reporting enrollment info recorded by modality, not just in the aggregate. Accessibility monitoring should include timeliness of first treatment, not just the first face to face encounter. Stakeholders also suggested requiring quality assurance activities at the provider level.

## **Youth Treatment**

Providers agree that youth treatment in California is too limited. Stakeholders noted some of the barriers to expanding youth treatment:

- There is limited system capacity. A year will not be sufficient to increase youth treatment capacity. Providers, workforce, and benefits may need to be rolled out in phases.
- There are different rules for providers about comingling populations by age which are not consistent. The age limits should be consistent with other state requirements.
- Stakeholders requested DHCS to coordinate a workgroup to focus on youth services.

## **Other topics:**

Rates and the certification process are significant stakeholder concerns. Stakeholders were also provided an opportunity to discuss any other issues not previously raised regarding the draft document and no additional issues were raised.

## **Next Steps**

Meeting agendas and handouts are available at <http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx> All stakeholders are encouraged to submit comments to: [MHSUDStakeholderInput@dhcs.ca.gov](mailto:MHSUDStakeholderInput@dhcs.ca.gov)

The next meeting will focus on financing of the Waiver. DHCS will present the next meeting as a webinar.