

**Written comments submitted to the Department of Health Care Services (DHCS) Regarding the Transfer of the Drug Medi-Cal Treatment Program to DHCS**

**Comments received August 24 through August 30, 2011**

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I am writing you on behalf of California Treatment Communities (CTC), an association of behavioral health agencies that spans the State of California. CTC endorses the shift of Drug Medi-Cal and other functions from the Department of Alcohol and Drug Programs to the Department of Health Care Services. We believe that this transfer will allow for more effective delivery and integration of behavioral health and physical health services to California residents.

However, we believe that the transfer of Drug Medi-Cal functions would reap benefits more quickly if the flaws inherent in Drug Medi-Cal could be repaired prior to transferring the responsibilities to your agency. As the attached states, the "correction" is so simple that it should actually make the transition quicker, and would result in a more natural integration of both service delivery and invoicing for substance use and mental health disorders.

Integrating substance use and specialty mental health services into the Department of Health Care Services will be a substantial task. I hope that we can take this opportunity to simplify this process.

**Proposed Revisions to Drug Medi-Cal**

California is currently in the process of transferring Drug Medi-Cal (DMC) from the Department of Alcohol and Drug Programs (DADP), and specialty mental health Medi-Cal from the Department of Mental Health (DMH), to the Department of Health Care Services (DHCS). These transfers will improve the efficiency of invoicing and providing services in the case of mental health, and should hasten the integration of mental health and physical health services. Unfortunately, the same benefits are not likely to accrue for DMC, but they could.

This is a request to remedy the flaws in DMC prior to transferring this function to DHCS. The proposed solution is extremely simple and should neither impede nor delay the transfer. It will not oblige the State or Counties to incur any expense, and will permit the State and any participating County to reduce administrative expenses.

**Current Problems with DMC**

It is widely acknowledged that there are several problems with DMC. These include the following:

- DMC eligibility has not been modified to conform to the Low Income Health Program (LIHP) (or MCE). Specialty mental health Medi-Cal eligibility has conformed to these changes brought about by California's 1115 Waiver.
- DMC has very byzantine regulations found nowhere else in the healthcare field. These include restrictions on the minimum and maximum number of participants in a group and prohibitions on receiving medication and counseling services in the same day.
- DMC does not permit many good and modern medical treatments for Substance Use Disorders (SUD), even if these are more efficacious and efficient than other permitted interventions.

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**Objectives**

1. Reduce bureaucratic waste.
2. Improve access to care.
3. Give flexibility to Counties to serve both existing SUD clients and the realigned (AB 109) SUD clients.
4. Create an integrated process for all of behavioral health, encompassing both SUD and other mental health diagnoses. (Note: This is in conformity with the both the current and the pending Diagnostic and Statistical Manual of Mental Disorders (DSM) classification system.)
5. Accelerate the integration of behavioral health with physical health by using a system consistent with International Statistical Classification of Diseases (ICD) and Institute of Medicine (IOM) systems.

**Proposed Solution**

The easiest way to achieve the five objectives stated above is to simply add Substance Use Disorder to the accepted mental health diagnoses for Medi-Cal, utilizing standard DSM-IV codes for currently recognized mental health disorders. Diagnostic criteria would be used to determine what services to offer, and existing Schedule of Maximum Allowable (SMA) rates would limit the expenses incurred.

**Comments**

Currently, the State of California does not provide any State General Funds for DMC services. However, the State does use General Funds to provide services that could qualify for Medi-Cal and thus could garner Federal matching funds. This is especially true of services provided to parolees.

Many Counties wish to provide SUD services and could more easily access the Federal matching funds if this reform were to be implemented. The 109 Public Safety realignment carries very limited funds per offender for treatment services. These offenders will not be parolees post release and the treatment funds could be leveraged to obtain the Federal match if this proposal is accepted.

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I am submitting this comment on behalf of the California Opioid Maintenance Providers (COMP). We ask that you consider changing the claims process for Narcotic Treatment Programs (NTPs) to allow billing as soon as the day of service.

Under the current system, NTPs must wait until after the end of a month to bill for any services. For example, we cannot bill for any services delivered in August until September 1. Further, we then have a very limited window in which to bill, often by the 10th of the month.

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This process causes multiple problems, including impacting cash flow and getting our claims pre-empted by claims from other service providers that are allowed to bill timely.

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When this all gets in place. County Administrations are going to be the Lead in the funding so far as I see it. What funding is going to be offered to Tribal Governments who have services on Reservation Lands and in their Indian Health Clinic's? County Administrations has a bad track record including Tribal Services on Reservations and do not even come on Tribal Land to offer services to Native American Communities in some areas. Are Tribes going to be left out of this funding? Who will make sure this happens if the lead goes to County?

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RE: ADP Transition Plans for Prevention. As a prevention professional with more than 25 years in the field, I have the following recommendations on the transition:

**The functions of oversight and management of the Prevention SAPT Block Grant funding is essential; the best organizational home for Prevention is the Department of Public Health.**

- a. This \$184 million for prevention in California, or a 20 percent set aside of the whole block grant, does come with strings attached, requiring solid planning, effective approaches and reporting from a Single State Agency. Any move of the ADP prevention functions to other state departments must be linked to needed resources to maintain the funding, track outputs and outcomes, including the administrative support systems (e.g., contracts, personnel) and local assistance. These funds are the largest contribution by far to prevention services, and this funding stream is essential to the viability of prevention in California.
- b. The best home for this oversight is the California Dept. of Public Health (CDPH). CDPH's Tobacco Control Branch already provides a very successful model for a primary prevention and public health approach to substance use problems. CDPH is experienced with managing / requiring evidence-based approaches in the primary prevention field. This Department can leverage synergy between substance use prevention and tobacco control, nutrition, traffic safety and other public health-oriented issues.
  - i. In contrast, the Department of Health Care Services relies on a service delivery and billing system that does not support population-level services. Placement of prevention services under this organization home would be detrimental, and cause a significant shift away from comprehensive, proven and effective approaches to prevention.

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- c. Substance abuse prevention should have formal linkage with treatment and recovery services, along with public safety and other public health approaches. This linkage could be served via a state advisory body to provide input in the initial transition period, and also via the County Administrators association (CAAPAAC).
- d. The current administrative overhead, both at State and County levels, should be set as a cap for the new management system. This funding should not be dispersed in many small allocations to fund the re-organization and multiple levels of administration.

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Re: draft transition plan, by page (stakeholder comments in blue)

Page 10:

...California operates the Medi-Cal program in accordance with the State Plan but has also elected the option of administering part of its program under several federally approved waivers. **Waivers? Such as . . . ? The use of the past tense would suggest there are existing wavers that DMC could be folded into. What is DHCS's thinking behind this statement?**

Page 12:

...The Managed Care provider must continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance abuse treatment. **Does DCHS have any data showing the extent to which this assessment, referral and placement assistance is occurring? If not, why not? The question is asked because if DHCS is now incorporating SUD services into its portfolio, it needs to pay more attention to them and get good at it. If the data are not collected or analyzed, this needs to go on the list for the new Deputy. If the data are available, then great. How can they inform this process or future management of DMC services within DHSC?**

Page 13:

...Coordinate and ensure use of current Alcohol and Drug Program Standards. **Isn't this a component of their DMC certification function which, at present, is being retained by ADP?**

...Oversee special handling of claims. **What are some examples of this?**

Page 18:

...While these quality requirements are surely valuable, the extra workload may prove to be too burdensome for small provider entities. This example and other approaches for amending the Drug Medi-Cal Program will need to be fully vetted. **What's the point here? We've kept the bar too low for too long. Is quality secondary to provider interests? The transfer of DMC is not just a bureaucratic exercise. Every change, every action should be evaluated in terms of its impact on clients. Clearly, clients are not well served by policies that result in widespread provider attrition but their successful treatment and recovery should be the top priority.**

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...DHCS is aware that, although it is not part of the DMC program transfer process, realignment may have significant impacts upon counties and providers as California moves funding and program responsibilities from state departments to the counties.” [Realignment transfers to counties inadequate funding, responsibility but no authority, and a strategy for financing caseload growth that is speculative at best.](#)

Page 19:

KEY MILESTONES (not in priority order)

[How do these connect with the MH transition milestones? Are there similarities in time frame or activity? Are any of them connected or dependent in any way with these SU milestones?](#)

Page 21-22:

11. By October 2011, list each function to transfer to DHCS and identify the key associated processes for flow charting and process improvement. Examples include, but are not limited to:
  - a. Cost settlements
  - b. Cost reports and other required reports
  - c. Audit processes and overlaps
  - d. County encumbrance and payments
  - e. Drug Medi-Cal Program provider certification” – [I thought this was an ADP retained function. There is mention elsewhere of program standards, monitoring and, here, certification that makes me wonder what other functions, not on the original list, might also be under consideration for transfer.](#)
  
13. County – Direct Provider Contract status
  - a. By August 2011, DADP will provide a list of all current Drug Medi-Cal Program contracts to DHCS, updated monthly (ongoing)
  - b. By (TBD):
    - Review contract boilerplate language
    - Determine if contracts require CMS approval
    - Ensure that cultural competency language is in all provider contracts – [will this be a required element of contracts between counties and their providers?](#)
    - Offer DMC contracts to all counties without a current Drug Medi-Cal Program services. ) – [How will this work? This process is already underway with ADPI support. We have 2 counties ready to go now and 2-3 more in the works. One of the reasons these small counties do not currently participate in DMC is that reimbursement vs. cost does not pencil out for them. Economies of scale work against these small systems.](#)
    - Prepare plan for ensuring DMC services within counties that do not elect to offer DMC services (or specific DMC services [Any thoughts on how this might work?](#)

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17. Tribal notification (current process is SPA and Waiver) Tribal involvement is noted in several places in the draft plan. This is good. However, since DMC has historically been a county 'thing', how do tribes participate?

- a. DHCS will provide tribal notification on any changes to the State Plan or development of a waiver and obtain input as required by federal law. (Ongoing as needed).

18. Non-Medi-Cal Issues and Realignment. Monitor if and how non-Medi-Cal services currently overseen by DADP, and realignment of funding to the counties will affect the transfer of the Drug Medi-Cal Program. (Ongoing) A huge issue. Basically the realignment legislation does not realistically provide for growth in DMC.

Page 26:

...DHCS's surface review is that policy behind the certification requirement is relative to the policy associated with the DHCS mandate that health care professionals apply to become Medi-Cal providers. This points to a significant distinction between our two worlds. In health care, people are providers. In the SU field, business entities are providers. The direct service staff who work in the provider organization are conferred with quasi-professional status by virtue of operating within a licensed or certified environment. Recent SUD counselor certification regulations are a small step in the right direction but do not give SUD counselors professional standing commensurate with other health care practitioners providing similar services. DHCS and DADP will continue discussions throughout the transition year, and DHCS commits to seeking additional stakeholder input on this issue in the post-transition period.

Page 27:

Billing: Stakeholders asked DHCS to evaluate and streamline the billing process. Several stakeholders also requested that DHCS allow same day billing if more than one service is provided in a single visit. Currently providers may perform more than one allowable service in a single visit, but are only reimbursed for one service. Providers expressed frustration that this policy does not allow for a best practice approach to patient care. They explained that with a population such as substance use disorder patients, the provider must take advantage of every opportunity to provide services while the client is in the facility, as rescheduled appointments for follow up services are often broken. Same day billing for multiple visits within DMC is currently allowed under specified circumstances (Title 9 CCR §51490.1(d)). I think what is referred to may be same day billing of multiple visits within an FQHC or similar context. At a minimum, a bit more information about the nature of problem may be needed.

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At this time DHCS does not anticipate a change in this approach. It is not likely that CMS would approve a State Plan Amendment that reflects rate setting at the local level, if federal funds are involved. However, if a managed care waiver is approved and counties are funded by a capitation methodology, counties could potentially have discretion to reimburse providers or groups of providers via case rates or other bundled reimbursement approaches. How do pay for performance reimbursement methods fit in here?

Page 32:

...The new DHCS organizational structure is shown in Appendix C. Future updates to this plan will show the specific branches and sections that this transfer will affect or create.

However this plays out, the need to maintain equal footing for the SUD Division not a matter of maintaining a semblance of the organizational status quo nor fears about being a tiny budget unit within a vast department. The real issue is the mission not the budget. Substance use disorders kill people. Chronic liver disease and cirrhosis is the #9 cause of death<sup>1</sup> in California. The number grows higher as drug overdoses, automobile fatalities related to alcohol, and SU-related causes of death such as trauma are included. The number may be less than those for cancer or cardiovascular disease but the lives lost are no less important.

Beyond the 'do no harm' approach taken to this transition, does DHCS have any thoughts about how to start making improvements that will ultimately save more lives?

A further note on SUD mortality:

In 2007, the CDC<sup>2</sup> shows the following detail on alcohol and other drug (AOD) related deaths.

989	Behavioral & mental disorders due to AOD
2,903	Alcoholic liver disease
3,281	Accidental poisoning (AOD selections)
168	Poisoning/exposure (AOD selections)

Total = 7,341

Adding to this figure the 2,238 AOD-involved driving fatalities<sup>3</sup>, clearly identified SU-related deaths in 2007 total 9,579. This would place SU deaths at number six, between accidents (#5 with N=11,426) and Alzheimer's disease (#7 with N=8,495). As noted above, this is a conservative estimate.

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<sup>1</sup> State of California, Department of Public Health, Death Records, 2009.

<sup>2</sup> CDC Wonder Database. <http://wonder.cdc.gov>

<sup>3</sup> California Department of Motor Vehicles. California DUI Fact Sheet: 1999-2009.