

Summary #2 of Stakeholder Comments
July 25, 2011, Meeting Series with Stakeholders of the Drug Medi-Cal Program

Meeting with Clients, Families and Client Advocates

- Concern the Drug Medi-Cal only provides a maximum of 5 options that are out of date and may not be appropriate
- Invite client advocate groups such as Faces & Voices of Recovery; National Association of Methadone Advocates; National Association of Advocates for Morphine Treatment and Join Together
- Majority of clients are homeless or working and not able to join in this process
- Average clients really have no idea what activities are occurring at the state
- Bi-monthly, clients attend a forum in which to elicit input and discuss current issues which include:
 - Access to services
 - Waiting lists
 - Minimum of 5 services
 - Los Angeles discontinuing sober living houses
- Clients are concerned whether services will be hampered by the transition
- Strive to have state level materials and questions clear to clients and at a level for their understanding of what is being asked of them.
- Clients can only relate at the service level; therefore outreach efforts really needs to be through the providers
- Develop a survey with questions for providers to ask their clients
- Drug Medi-Cal is not a “benefit” - it is not based on science, and was not created to have a benefit of care. It is difficult to fit a continuum of care into an insurance model. More types of counselors and peer providers are service providers in this area than are currently covered as Medi-Cal providers.
- Substance abuse stigma is greater than that of mental health
- AB 106 has greater intent and recovery/treatment should be placed on the forefront.

Meeting with Providers and Provider Advocates

- If the Department of Alcohol and Drug Programs (DADP) combines with the Department of Health Care Services (DHCS) under a single deputy director the fear is that alcohol and drug will get swallowed up
- The concept of an alcohol and drug merger with mental health has resulted in hearings around the state where the idea was rejected because it does not make sense
- Untreated alcohol and drug costs the state \$50 billion dollars
- Internet technology continues to be a concern. Providers do not have updated equipment for the required data collection and reporting
- Using the term behavioral health is problematic and minimizes alcohol and drug issues and representation. Alcohol and drug issues are not “behavioral” but rather are a chronic disease.
- Alcohol and drug representation was not considered important in the 1115 waiver process due to the size of population and representation. The 1115 waiver behavioral health workgroup identified the lack of substance use disorder but this was not included in the final document
- 620,000 Native Americans are self-identified with alcohol and drug issues
 - Great disparities in education and health exist for Native Americans
 - This population gets left out of partnerships with counties; however DADP has done a good job at establishing these relationships to serve Native women and others

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- The American Recovery and Reinvestment Act calls for state consultation with issues that impact tribal communities.
- There is a shortcoming in the Medi-Cal Drug Program
 - The pharmacy benefit is severely outdated
 - The lack of Buprenorphine use in Narcotic Treatment Programs (NTP).
 - One of the “five services” is Naltrexone and its not being used at all
 - another drug, Vivitrol, can be used by physician’s offices if the county is willing to fund it, but it is not included in the “five services.”
 - The disallowance of same day services is very restrictive and does not recognize the need to maximize the provider’s access to the client
 - 200 minutes per month for the Naltrexone Treatment Program is currently allowable; however more time is actually needed
 - Need more individual services at first and then later a transition to group services
 - No availability to provide two services in one day is a problem. For example if a pregnant women goes for a Methadone treatment and a counseling session in one day- only one of those claims will be paid
 - Need to be allowed to provide services outside of the building/clinic, such as to incarcerated individuals, the home bound, those hospitalized, etc.
- Eliminate Title 22 and 9 regulations and allow federal rules to guide program
- The term behavioral is a huge stigma and becomes a moral issue rather than a disease
- Behavioral health is a co-morbid issue and requires the evaluation of mental health and substance abuse and yet there is a distinct separation between the two
- Based on a UCLA study behavioral health has almost become synonymous with mental health
- For prison healthcare, medical care means physical care only. Mental health services are provided in prisons; however substance abuse is not included or is separated out
- Very interested in collaborating with the state and-need high level commitment with the willing to execute decisions
- Counties can inform DHCS what works and what doesn’t; also can provide necessary data
- Having a blend of state, counties and providers participating in these meetings works best
- There is a large need for expanding services to include other health coverage

Meeting with Counties and County Representatives

#1 What are your comments/thoughts on the organizational placement of the Drug Medi-Cal Program and Behavioral Health leadership within DHCS?

- The Drug Medi-Cal program may get “lost” in the transition, due both to the fact that:
 - the Medi-Cal Specialty Mental Health Services (SMHS) waiver program also being transitioned is much larger
 - the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant is a much larger portion of California’s alcohol and drug treatment services.
- The new DHCS Deputy Director for Behavioral Health (mental health and substance use disorder services) should be familiar with both fields, have a strong voice, and be aware of the intricacies of both programs.
- Mental Health and Drug Medi-Cal policies are much different.

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- Two independent divisions/programs could be created even if there is a single DHCS Deputy Director for Behavioral Health.
- Some counties were concerned where the Block Grant and other non-Medi-Cal alcohol and drug programs would be realigned. The SAMHSA Block Grant and Drug Medi-Cal programs will still require coordination after transition.
- DHCS should consider how the different specialty mental health services and Drug Medi-Cal fiscal and payment systems might better be coordinated or integrated.
- There should really be a multi-stage, multi-year plan for transitioning, realignment and integrating alcohol and drug, mental health and physical health care in the context of the new 1115 waiver, realignment, federal health care reform, standardized electronic health records and possible Medicaid behavioral health parity.
- The term “behavioral health” is not well defined or well-understood. There is the danger that some advocates/stakeholders will not understand that “behavioral health” includes substance abuse services.
- There are some historical sensitiveness with the term “behavioral health.” In a behavioral health integration, substance abuse services must be well-funded with strong leadership.
- Many physical health conditions also impact behavioral health conditions (e.g. substance abuse or mental health).
- The current Drug Medi-Cal program does not include collateral, family therapy, or consensual residential treatment for minor consent beneficiaries.
- Before the Sobkey/Smoley lawsuit, Drug Medi-Cal had a very robust program. But, the Legislature began to reduce funding for Drug Medi-Cal fearing that this lawsuit would create a runaway entitlement program.
- With the federal health care reform expansion in 2014, there is the opportunity to receive up to 100% federal financial participation (FFP) for these new beneficiaries. This may allow the Drug Medi-Cal program to provide a richer continuum of services.
- SAMHSA identifies many of the best practices models and services for alcohol and drug treatment.

#2 How do we better engage with stakeholders?

- It was recommended that a DHCS staff member come to either the monthly or quarterly meetings of the County Alcohol and Drug Program Administrators Association of California, Inc. (CADPAAC).
- The State committed to identifying other relevant Drug Medi-Cal related workgroups for the transition, including the Narcotic Treatment Program Advisory Board.
- DHCS could use existing linkages to reach out to alcohol and drug advocates, experts and stakeholders.
- DHCS has the expertise to better link with the federal Centers for Medicare and Medicaid Services (CMS) in order to try to get approval of a broader service package.

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#3 How can DHCS and DADP best ensure continuous and uninterrupted administrative supports to the Drug Medi-Cal program?

- The claims billing and payment system is a “black box.” Claims go in, and at some time payments come back out often without adequate explanations of adjustments, denials or disallowances. The State needs to collaborate more with the county and provider billing and fiscal people.
- Reimbursement is made more difficult because it is hard to confirm clients’ current Medi-Cal eligibility. Many Drug Medi-Cal providers do not have Place of Service devices or electronic billing systems at all.
- The Other Health Care Coverage requirements and claims edits are difficult.
- Transition must transfer all Medi-Cal knowledge and staff from DADP to DHCS. The State will need to continue its linkage to the counties.
- Aligning billing timelines for Drug Medi-Cal and specialty mental health services could produce administrative efficiencies.
- The State should consider allowing Drug Medi-Cal providers the full federally-allowed 12-month time period to submit claims. However, providers also want to bill and be paid as quickly and flexibly as possible.

#4 What proposed Drug Medi-Cal Program changes and efficiencies do you recommend?

- The Medi-Cal transition needs to effectively link with realignment (specifically linkage of Drug Medi-Cal with the Block Grant), federal health care reform, the upcoming data exchanges and federal electronic health records requirements. These initiatives point to programmatic and place of service integration, not just common billing. A high proportion of clients have both mental health and substance abuse diagnoses.
- There will be a lot of administrative obstacles at both the State and provider level to build a new electronic health records and financial record. Confidentiality requirements are different and more stringent for substance abuse services than for mental health.
- Integration with primary care needs to consider the current “carve-out”, managed care versus fee-for-service, behavioral health parity, and federal health care reform opportunities for health homes and accountable care organizations.
- UCLA and CADPAAC have done a lot of work to try to train counties and providers on models of integration.
- To treat co-morbid conditions in a one-stop shop, the State should allow billing of more than one service per day.
- SAMSHA is looking to coordinate or integrate more closely with CMS to provide more alcohol and drug services through Medicaid.
- State regulations can be streamlined to only include federal Medicaid requirements.
- Though the Narcotic Treatment Program accounts for approximately 60% of all services, and Outpatient Drug Free Counseling another 35% -- there is great variability between urban and rural counties. Some counties also have a richer array of non-Medi-Cal services (including the Block Grant), than others.

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- Many providers would advocate for the inclusion of early screening and brief intervention services.

#5 Other Issues

- Related to the varying service array, many Medi-Cal beneficiaries receive their Drug Medi-Cal services out-of-county.
- Providers may be able to assist the State in reaching out and including client and family member stakeholders through:
 - counties and providers handing out a survey to clients;
 - having providers give input on the difficulty of getting beneficiaries eligible for Medi-Cal;
 - setting up client information booths in community settings;
 - creating or plugging into existing substance abuse client focus groups; and/or
 - interviewing county eligibility/intake staff or have these staff provide surveys to substance abuse service applicants.