Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

Medi-Cal Healthier California for All
Behavioral Health Workgroup
January 30, 2020

Welcome and Introductions

Agenda

10:00	Welcome & Introductions
10:15	Administrative Integration Functions
11:00	Clinical Documentation and Oversight Considerations
12:15	Lunch
1:00	Clinical Documentation and Oversight Considerations *continued discussion*
1:30	Integrated Service Delivery Considerations
3:00	Public Comment
3:15	Closing and Next Steps

Meeting Objectives

The objective this Behavioral Health workgroup meeting is to:

- Provide recommendations regarding clinical documentation and DHCS oversight.
- Identify opportunities for integrating beneficiaries' experience of care to create a seamless behavioral health delivery system.
- Provide recommendations for aligning, as appropriate, service definitions between mental health and SUD.

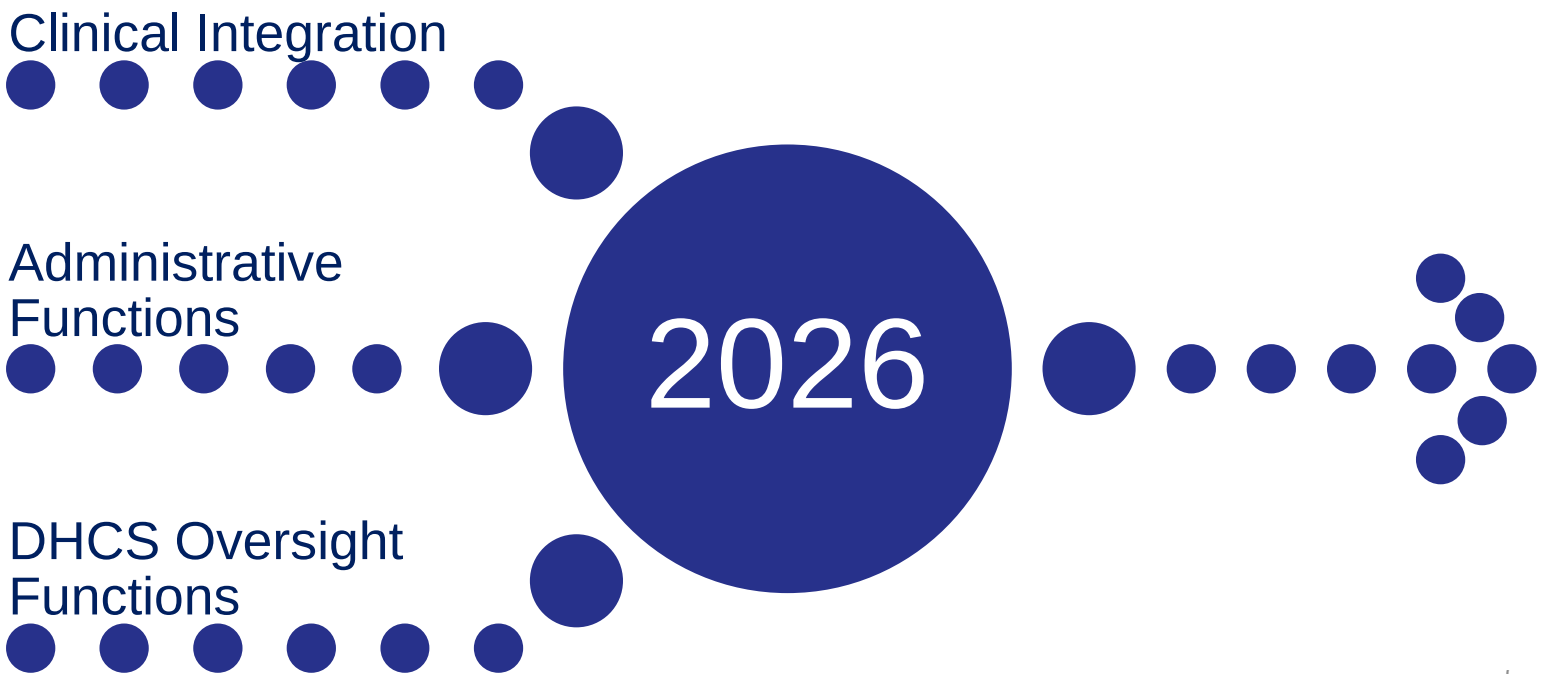
Administrative Integration Functions and Timeline Considerations

Administrative Integration Functions

Clinical Integration	Administrative Functions	DHCS Oversight Functions
• Access Line • Beneficiary Informing Materials	• Contract • Data Sharing/Privacy Concerns • Electronic Health Record Integration • Cultural Competence Plans	• Quality Improvement • External Quality Review Organization • Compliance Reviews • Network Adequacy • Licensing and Certification

Timeline

- The goal would be to submit for a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, SMHS and SUD services under the next 1915(b) waiver in **2026**.
- Successful implementation will require careful sequencing and planning and a phased-in approach where cohorts are considered.



Integration Phases

Phase	Timeline	Activity
Phase I	Jan 20 – Jan 21	• Plan and implement changes to medical necessity • Develop and implement standardize screening tools • Plan and implement changes to documentation standards
Phase II	Jan 20 – July 21	• Plan and implement payment reform
Phase III	July 20 – July 21	• Plan and consolidate, as applicable, DHCS compliance reviews • Plan and consolidate, as applicable, external quality review contracts and requirements
Phase IV	July 20 – Dec 21	• Plan and consolidate quality improvement plan requirements • Plan and consolidate cultural competence plan requirements
Phase V	July 20 – Dec 22	• Plan and implement necessary changes to licensing and certification requirements, as appropriate • Plan and consolidate network adequacy requirements
Phase VI	Jan 23 – Dec 25	• Plan and implement necessary changes to county EHRs • Plan and implement necessary changes to county access lines • Develop and implement State Plan Amendments • Develop and implement a single county contract • Develop beneficiary informing materials

Workgroup Discussion

- What, if anything, is missing from DHCS' list of administrative integration priorities?
- What recommendations do you have about the timeline and proposed phases for integration by 2026?
- What else, if anything, should DHCS consider when these planning and implementing these changes?

Clinical Documentation and Oversight Considerations

Proposed Changes: Documentation Requirements

DHCS will engage stakeholders to discuss treatment plan requirements and documentation standards, moving away from disallowances for noncompliance. As opposed to requiring notes to link to a static treatment plan, providers could use problem lists and progress notes to communicate diagnoses, conditions, and treatment interventions as they evolve over time.

Providers would ***no longer be required to identify whether a condition is a primary mental health condition or a primary substance use disorder*** in order to provide services and receive reimbursement. DHCS would aim to align documentation expectations with physical health, moving away from payment disallowances based on "wrong" primary diagnoses in patients with both MH conditions and substance use, no matter where they receive services.

Disallowances and recoupments continue to be required for instances of fraud, waste and abuse.

Clinical Diagnostic Assessments

DHCS would move away from current state requirements about standardized diagnostic MH assessments.

Other than a **screening tool** to determine the appropriate MH delivery system (MH vs MCP) and the **appropriate immediate SUD treatment plan** (ASAM criteria screen), counties should not require providers to complete standardized assessments PRIOR TO providing care as these can result in barriers to care.

Providers should use validated, evidence-based and age-appropriate assessments and treatment plans, but there is **not one statewide tool that meets all MH needs** in all circumstances.

For SUD: DHCS will continue to require the **ASAM Criteria (Assessment):**

- Within 72 hours of residential or inpatient care
- Within 30 days of outpatient care
- Counties may not require completion more often than every 6 months for all services except NTPs, which is annual.

Discussion

- Are DHCS' proposed changes to clinical documentation standards on the right track? If not, what alternatives do you propose?
- If current documentation standards are revised, what monitoring and oversight activities should be implemented in place of monitoring to specified standards? How should DHCS ensure counties provide quality care?
- What should auditors review that would add value? What would ensure high standards without adding unnecessary burden?
- Should a provider be permitted to document patient refusal when a criteria is not met (e.g., history & physical exam requirement in SUD outpatient care)?
- Should DHCS remove the SUD requirement for medical clearance prior to treatment? Alternatively, should DHCS consider requiring medical clearance for SMH and SUD?

Integrated Services Delivery Consideration

SMH and SUD Services

Specialty Mental Health

- Mental Health Services
- Targeted Case Management
- Intensive Care Coordination**
- Therapeutic Foster Care**
- Therapeutic Behavioral Services**
- Intensive Home Based Services**
- Medication Support Services
- Day Treatment Intensive/Day Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Crisis Residential Treatment Services
- Adult Residential Treatment Services
- Psychiatric Health Facility Services**
- Inpatient Psychiatric Hospital Services

Substance Use Disorder Services

- Outpatient Drug Free
- Recovery Services
- Case Management
- Physician Consultation**
- Narcotic Treatment Programs/Opioid Treatment Programs
- Naltrexone
- Medication Assisted Treatment
- Intensive Outpatient
- Partial Hospitalization**
- Residential (Perinatal)**
- Residential (ASAM)
- Withdrawal Management**
- Inpatient SUD (including VID)

** = services that are dissimilar

Service Definition Review

- The next several slides highlight the existing services definitions, as defined in the SMH State Plan and SUD State Plan or DMC-ODS Special Terms & Conditions, for the following service modalities: outpatient, intensive outpatient, medication services, residential services.
- The text on slides 17-20 surrounded by an asterisk (*) denotes similarities in the descriptions of the service.
- In reviewing the service definitions, please consider the following questions:
  - What are the opportunities and challenges for creating an integrated service definition?
  - What elements of the existing definitions should be retained? Removed?
  - What are the key considerations?
  - Do you have specific recommendations for revisions?

Comparing Service Definitions

Mental Health Services (MH State Plan)	Outpatient Drug Free (SUD State Plan)
• Individual, group or family-based interventions to *reduce mental or emotional disability, restore, improve and/or preserve individual and community functioning*, and continue the ability to remain in the community with the goals of *recovery, resiliency, learning, development, independent living and enhanced self-sufficiency* and that are not provided as a component of [an otherwise bundled service]. • Provided face-to-face, by telephone or by telemedicine with the beneficiary or significant support person(s) anywhere in the community. • Services include these components: *Assessment, Plan Development, Therapy (Individual or Group)*, Rehabilitation, *Collateral*	• Services to stabilize and rehabilitate patients with SUDs are covered under DMC when prescribed by a physician as medically necessary. • ODF Services include: *Intake, Individual and Group Counseling*, Patient Education, Medication Services, *Collateral Services*, Crisis Intervention Services, *Treatment Planning and Discharge* • Individual counseling only for intake, crisis intervention, collateral services, and treatment and discharge planning. • Each ODF participant is to receive at least two group face-to-face counseling sessions every 30 days focused on short-term personal, family, job/school and their relationship to substance use. • Reimbursable group sessions may last up to 90 minutes.

Comparing Service Definitions

Medication Support Services (MH State Plan)	Medication Services (SUD State Plan and SUD Managed Care)
• Medication Support Services include one or more of the following: prescribing, administering, dispensing and monitoring drug interactions and contraindications or psychiatric medications or biological that are necessary to alleviate the suffering and symptoms of mental illness. • May also include assessing the appropriateness of reducing medication usage when clinically indicated. • Individually tailored to address the beneficiary‘s needs	Medication services are provided as a part of the following State Plan services: • Outpatient Drug Free • Intensive Outpatient • Naltrexone • Narcotic Treatment Programs Medication services are also provided as a part of DMC-ODS (SUDS managed care): • Medication Assisted Treatment

Comparing Service Definitions

Day Treatment Intensive/Day Rehabilitation (State Plan)

- Day Treatment Intensive (DTI) is a structured, multi-disciplinary program including community meetings, a therapeutic milieu, therapy, skill building groups, and adjunctive therapies, which provides services to a distinct group of individuals.
- Services are available for at least three hours each day.
- DTI must have a clearly established site for services.
- This services includes one of more of the following service components:
  - *Assessment*
  - *Plan Development*
  - *Therapy (Individual or Group)*
  - Rehabilitation
  - *Collateral*

Intensive Outpatient (State Plan)

- Intensive Outpatient Treatment (IOT) counseling services are provided to patients a minimum of three hours per day, three days a week, and are available to all patients for whom it has been determined by a physician to be medically necessary.
- The components of Outpatient Drug Free Treatment Services are:
  - *Intake *
  - *Individual and Group Counseling*
  - Patient Education
  - Medication Services
  - *Collateral Services*
  - Crisis Intervention Services
  - *Treatment Planning* and Discharge Services

Comparing Service Definitions

Crisis Residential (MH State Plan)

- *Therapeutic or rehabilitative services provided in a non-institutional residential setting* in a structured program (3 months or less) as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis without need for nursing care.
- Includes a range of activities and services *to restore, improve, and/or preserve interpersonal and independent living skills, and to access community support systems.*
- Structured day and evening services are available *24/7*.
- The timing, frequency, and duration or the various types of services *depends on the acuity and individual needs* of each beneficiary.

Residential (SUD State Plan and SUD Managed Care)

- *Non-institutional, 24-hour non- medical, short-term residential program* that provides rehabilitation services to beneficiaries with a SUD.
- *Individualized* to treat the functional deficits identified in the ASAM Criteria.
- Daily regimen and structured activities *restore cognitive functioning and build behavioral patterns in a community.*
- Beneficiaries are supported to *restore, maintain and apply interpersonal and independent living skills and access community support systems.*
- Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.

Workgroup Discussion

- What are the opportunities and challenges for creating integrated service definitions?
- What elements of the existing definitions should be retained? Removed?
- What are the key considerations?
- Do you have specific recommendations for revisions?

Workgroup Focus Questions and Deliverables

Workgroup Focus Questions

- Is DHCS' proposal to change clinical documentation standards on the right track? If not, what alternatives do you propose?
- If current documentation standards are removed, how should counties and DHCS ensure quality of care?
- What should auditors review that would add value? What would ensure high standards without adding unnecessary burden?
- Should a provider be permitted to document patient refusal when a criteria is not met (e.g. H&P requirement in outpatient care)?
- Should DHCS remove the requirement for medical clearance prior to treatment?
- What are the opportunities and challenges for creating integrated service definitions?
- What elements of the existing definitions should be retained? Removed?
- What are the key considerations for integrating service definitions? Do you have specific recommendations for revisions?
- What, if anything, is missing from DHCS' list of integration priorities?
- What recommendations do you have about the timeline and proposed phases for integration by 2026?
- What else, if anything, should DHCS consider when these planning and implementing these changes?

Workgroup Expected Deliverables

- Policy recommendations based on workgroup focus questions
- Provide feedback and recommendations on proposed changes to medical necessity criteria for outpatient specialty mental health services and substance use disorder services
- Provide feedback and recommendations on proposed changes to medical necessity criteria for inpatient specialty mental health services
- Provide feedback and recommendations on standardizing level of care assessment tools for specialty mental health services and substance use disorder services
- Provide recommendations for communicating new medical necessity requirements to stakeholders

Workgroup Meeting Schedule

Date	*Time*	*Topic(s) / Agenda Items*
Thursday, Jan 30th	10:00 am to 3:30 pm	BH Integration
Tuesday, Feb 4th	10:00 am to 3:00 pm	Payment Reform
Wednesday, Feb 26th	10:00 am to 3:00 pm	Medical Necessity/ BH Integration
Thursday, Feb 27th	10:00 am to 12:00 pm	Payment Reform
Thursday, Feb 27th	1:00 pm to TBD (no later than 4:00 pm)	SMI/SED IMD Demonstration

Public Comment

Please limit comments to 2 minutes

Closing and Next Steps

Next Behavioral Health Workgroup Meetings: **February 4, 2020** (Payment Reform)

Any comments on the materials presented today can be submitted to CalAIM@dhcs.ca.gov by **February 6, 2020**.

Questions? CalAIM@dhcs.ca.gov