DHCS Behavioral Health Forum
January Forum Meeting

January 7, 2015
9:30 a.m. to 5:00 p.m.
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Name</th>
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</thead>
<tbody>
<tr>
<td>9:30</td>
<td>Welcome &amp; Introductions</td>
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<tr>
<td>9:30 – 10:30</td>
<td>Fiscal Forum</td>
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<tr>
<td>10:30 – 11:45</td>
<td>Client and Family Member Forum</td>
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<tr>
<td>11:45 – 12:45</td>
<td>Lunch Break</td>
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<td>12:45 – 2:00</td>
<td>Integration Forum</td>
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<td>2:00 – 3:15</td>
<td>Strengthening Forum</td>
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<td>3:15 – 3:30</td>
<td>Break</td>
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<td>3:30 – 4:45</td>
<td>Data Forum</td>
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<tr>
<td>4:45 – 5:00</td>
<td>Next Steps and Wrap Up</td>
</tr>
</tbody>
</table>
INTRODUCTION OF CHAIRS
Behavioral Health Forum Leads

**Karen Baylor, Ph.D.**, Deputy Director  
Mental Health and Substance Use Disorder Services  
Department of Health Care Services

**Brenda Grealish**, Chief  
Mental Health Services Division  
Department of Health Care Services

**Dina Kokkos-Gonzales**, Chief  
Policy and Program Quality Assurance Branch  
Mental Health Services Division  
Department of Health Care Services

**Marjorie McKisson**, Special Advisor  
Substance Use Disorder Services  
MHSUD Deputy Director’s Office  
Department of Health Care Services

**Chuck Anders**  
Fiscal Management and Reporting Outcomes  
Mental Health Services Division  
Department of Health Care Services

**Marco Zolow, PhD**, Health Program Specialist I  
Prevention Treatment and Recovery Services  
Substance Use Disorders Division  
Department of Health Care Services
Behavioral Health Forum Leads

Efrat Eilat, PhD, Special Advisor
Health Care Delivery Systems and
Mental Health and Substance Use Disorder Services
Department of Health Care Services

Eileen Gillis, JD, MS, MFT, AGPA
Program and Grants Management Branch
Substance Use Disorder Services
Department of Health Care Services

Lanette Castleman, Chief
Program Oversight and Compliance Branch
Mental Health Services Division
Department of Health Care Services

Jennifer Taylor
Fiscal Management and Outcomes Reporting
Mental Health Services Division
Department of Health Care Services

Rachelle Weiss, Chief
Office of Applied Research and Analysis
Substance Use Disorder Services
Department of Health Care Services

Dionne Maxwell, PhD, Research Program Specialist III
Fiscal Management and Outcomes Reporting
Mental Health Services Division
Department of Health Care Services
OVERVIEW OF FORUM
DHCS BEHAVIORAL HEALTH FORUM

DHCS – PARTNERS BEHAVIORAL HEALTH SERVICES STEERING COMMITTEE
KAREN BAYLOR
MHSUD DEPUTY DIRECTOR
CHAIR

MEMBERSHIP:
• CMHDA & CADPAAC
• CSAC
• MHSOAC
• CA MH Planning Council
• Managed Care Plan representation
• Other key DHCS areas of jurisdiction
  (E.g. Elig./Benefits, Financing, Med. Dir., Health Care Del. Sys. etc.)

FUNCTIONS:
• Prioritize Issues
• Make policy recommendations
• Track progress and status of issues under consideration
• Oversee stakeholder engagement

STAKEHOLDER – CONSUMER / FAMILY MEMBER
“OPEN TO ALL” STAKEHOLDER FORUMS
(Frequency TBD)

“STRENGTHEN SPECIALTY MENTAL HEALTH AND DRUG MEDICAL COUNTY PROGRAMS AND DELIVERY SYSTEMS” FORUM
CHAIRS
MHSD – DINA KOKKOS-GONZALEZ
SUD - CD – MARJORIE MCKISSON

“DEVELOP A COORDINATED AND INTEGRATED SYSTEM OF CARE FOR MHSUD AND MEDICAL CARE” FORUM
CHAIRS
MHSD – SUD-PTRSD – MMCD –
LANETTE CASTLEMAN
EILEEN GILLIS
EFRAT EILAT,

“CREATE COORDINATED AND USEFUL DATA COLLECTION, UTILIZATION & EVALUATION OF OUTCOMES” FORUM
CHAIRS
MHSD – SUD-PTRSD –
DIONNE MAXWELL
RACHELLE WEISS

COST EFFECTIVE AND SIMPLIFIED FISCAL MODELS (FISCAL) FORUM
CHAIRS
MHSD - CHUCK ANDERS
SUD - MARCO ZOLOW

• Recommend prioritization of issues and work plan tasks
• Recommend policy and program actions
• Invite participation from other DHCS as well as other areas of jurisdiction (e.g. Managed Care, Benefits, Office of the Medical Director etc.)
• Invite Steering Committee members and/or stakeholders to meetings and/or solicit review and comment as needed
• Invite Legislative staff to meetings and/or solicit review and comment
• Report out as needed (internally and externally)

Version 10/02/14
Meeting Format

• All Forums meet quarterly

• Webinar/conference call and in-person

• Each Forum will meet for 1 to 1 ½ hours

• Meetings for the following Forums will occur consecutively on same day

• For consistency, DHCS will use a standardized agenda for all Forum meetings
Contact Information

Behavioral Health Forum Stakeholder Website:
http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx

Please e-mail questions, comments or concerns to:
MHSUDStakeholderInput@dhcs.ca.gov
DHCS Behavioral Health Forum
Fiscal Forum

January 7, 2015
9:30 a.m. to 10:30 a.m.
Introduction to Fiscal Forum

Chairs

Chuck Anders, Chief
Fiscal Management and Reporting Outcomes
Mental Health Services Division

Marco Zolow, PhD
Prevention Treatment and Recovery Services
Substance Use Disorders Division
Agenda

I. Welcome and Introductions

II. Fiscal Forum Charter

III. Presentations
   a. Funding Mental Health Services in California
   b. Substance Use Disorder Services Funding 101

IV. Discussion
FORUM CHARTER
Background and Purpose

The Fiscal Forum will specifically address key areas related to improving fiscal policy, reimbursement methodologies, and billing processes for MHSUD – Short Doyle Medi-Cal.
Objectives

- Develop longer term fiscal models to move forward in area of post realignment and health care reform worlds.
- Pursue solutions to provide counties with greater flexibility to manage fiscal & program risks as well as to implement different program and fiscal models.
- Develop process for state & counties to define roles & responsibilities to manage shared financial risk.
- Establish effective policy and processes for purchasing services.
- Streamline program oversight and reduce administrative burden that could detract from investing funds in direct services.
FY14/15 Priority Areas

• Improve Fiscal Policies/Statute/Regulations
• Improve Reimbursement Methodologies
• Improve the Billing System/Process
PRESENTATIONS
Funding Mental Health Services In California
Community Mental Health Services

- **1991 Realignment**
  - Part 2 – Bronzan-McCorquodale Act
  - Part 5 – Institutions for Mental Disease (IMD)
  - Division 9, Part 5, Chapter 6 – State and Local Fund Allocations

- **Mental Health Services Act (2004)**
  - Part 4.5 – Mental Health Services Fund
  - Part 3 – Adult and Older Adult Mental Health System of Care Act
  - Part 4 – Children’s Mental Health Services Act (CSOC)
  - Part 3.1 – Human Resources, Education and Training
  - Part 3.2 – Innovative Programs
  - Part 3.6 – Prevention and Early Intervention
  - Section 5847 - Capital Facilities and Technological Needs

- **2011 Realignment**
  - Part 2.5 – Mental Health Managed Care
  - Early and Periodic Screening Diagnosis and Treatment (EPSDT)
  - Government Code, Division 3, Chapter 6.3 – Local Revenue Fund 2011

- **Federal Financial Participation**
  - Specialty Mental Health Waiver
1991 Realignment

- Bronzan-McCorquodale Act
- Institutions for Mental Disease
- State and Local Fund Allocations
Bronzan-McCorquodale Act

• As part of 1991 realignment, the Bronzan-McCorquodale Act realigned the existing Short-Doyle Community Mental Health Services Program.

• Counties are expected to provide mental health services to the identified target population, to the extent resources are available (W&I Code, Section 5600.3)
Institutions For Mental Health Disease

- As part of 1991 realignment, Part 5 realigned the responsibility to pay for services provided in an IMD to counties.
State And Local Fund Allocations

- W&I Code, Section 17600 established the Local Revenue Fund with various accounts and subaccounts to fund 1991 realignment.
- Revenue received from a ½ cent sales tax and a portion of vehicle license fee is deposited into the Local Revenue Fund.
- Funds deposited into the Local Revenue Fund are allocated to the mental health account, social services account, and health account in each county’s local health and welfare trust fund pursuant to schedules established in statute.
Local Revenue Fund Account Structure

- Sales Tax Account
- Vehicle License Fee Account
- Vehicle License Fee Collections Account
- Sales Tax Growth Account
- Vehicle License Fee Growth Account
The Local Revenue Fund and 2011 Realignment

- Government Code, Section 30025 established the Local Revenue Fund 2011.

- Government Code, Section 30027.5 dedicates $93,379,252 per month to the Mental Health Account in the Local Revenue Fund beginning in 12-13.

- The Mental Health Account in the Local Revenue Fund also receives the first 5% of funds in the Behavioral Health Services Growth Special Account.
CALWORKS MOE Subaccount

• 2011 Realignment also established the CALWORKS MOE Subaccount within the Local Revenue Fund.

• Beginning in FY 2012-13, funding from the Sales Tax Account that would have otherwise been deposited into the Mental Health Subaccount is deposited into the CalWorks MOE Subaccount, not to exceed $1,120,551,000.
Mental Health Services Act

- Mental Health Services Fund
- Adult and Older Adult Mental Health System of Care Act
- Children’s Mental Health Services Act
- Human Resources, Education and Training
- Innovative Programs
- Prevention and Early Intervention
- Capital Facilities and Technological Needs
Mental Health Services Fund

• Revenue collected from a 1% tax on income in excess of $1 million is deposited into the Mental Health Services Fund.

• Revenue deposited into the Mental Health Services Fund is distributed by the State Controller’s Office to counties on a monthly basis.

• The distribution is pursuant to a scheduled developed by the Department of Health Care Services.
Systems Of Care

• The Adult and Older Adult Systems of Care and the Children’s System of Care (CSOC) programs were established as pilots in the 1980’s.

• The programs were historically funded with categorical State General Fund allocations.

• Funding for these programs were eliminated in the early 2000’s.

• Funds distributed to counties from the Mental Health Services Fund are now intended to finance the Adult and Older Adult Mental Health Systems of Care Act and the Children’s Mental Health Services Act (CSOC).
Human Resources, Education and Training

- Proposition 63 added Part 3.1 to Division 5 of the Welfare and Institutions Code.
- Counties received funding in 2005-06, 2006-07, and 2007-2008 for this purpose.
- These allocations must be spent within 10 years.
Innovative Programs

- Proposition 63 added Part 3.2 to Division 5 of the W&I Code.
- Counties are able to spend a portion of their annual allocation from the Mental Health Services Fund on innovative programs.
Prevention And Early Intervention

- Proposition 63 added Part 3.6 to Division 5 of the W&I Code.

- Counties may use a portion of the funds allocated from the Mental Health Services Fund on an annual basis to provide prevention and early intervention services.
Capital Facilities and Technological Needs

- Proposition 63 added Section 5847 to Division 5 of the W&I Code.

- Counties received funding from the Mental Health Services Fund in Fiscal Year 2005-06, 2006-07 and 2007-08 for Capital Facilities and Technological Needs.

- Counties have ten years to spend these funds.
2011 Realignment

• Local Revenue Fund 2011
Local Revenue Fund 2011

• Government Code, Section 30025 established the Local Revenue Fund (LRF) 2011

• Revenue collected from a ½ cent sales tax and some vehicle license fee revenue are deposited into the LRF 2011.

• Sales Tax Revenue is allocated among various accounts and subaccounts.
Local Revenue Fund 2011 Accounts and Subaccounts

- Mental Health Account (Local Revenue Fund)
- Support Services Account
  - Behavioral Health Services Subaccount
  - Protective Services Subaccount
- Local Law Enforcement Services Account
- Sales and Use Tax Growth Account
  - Support Services Growth Subaccount
    - Behavioral Health Services Growth Special Account
    - Protective Services Growth Special Account
  - Law Enforcement Services Growth Subaccount
Behavioral Health Services
Subaccount and Growth Special Account

• Government Code, Section 30025(f)(16)(B) identified the purpose for which funds deposited into the Behavioral Health Services Subaccount and Behavioral Health Services Growth Account may be used:
  – Residential perinatal drug services and treatment
  – Drug court operations
  – Nondrug Medi-Cal programs
  – Medi-Cal specialty mental health services (including EPSDT and managed care).
Federal Financial Participation

- Medi-Cal Specialty Mental Health Services Consolidation Waiver
• DHCS Contracts with a mental health plan in each county.

• The mental health plan assumes the responsibility to provide and/or arrange for the provision of specialty mental health services to Medi-Cal beneficiaries who meet medical necessity criteria in the county.

• All mental health plans are counties. Placer county is the mental health plan for Sierra County beneficiaries.
Reimbursement Process

- Certified Public Expenditures
- Interim claim
- Interim cost settlement
- Final cost settlement
Certified Public Expenditures

- The Department of Health Care Services uses expenditures incurred by and certified by the county mental health plans to draw down federal financial participation for Short-Doyle Medi-Cal specialty mental health services.

- Mental health plans must first incur a cost and certify that cost to DHCS before DHCS is able to draw down Federal Financial Participation and pay the mental health plan.
Interim Claim

- Mental health plans submit claims through the Short-Doyle Medi-Cal claiming system to receive interim payments for their certified public expenditures incurred to provide specialty mental health services.

- The claim represents a reasonable estimate of the amount of federal reimbursement due to the mental health plan.
Interim Cost Settlement

- Six months after the close of each fiscal year, mental health plans are expected to submit a cost report to DHCS.
- The cost report determines the actual amount of federal reimbursement due to each mental health plan.
- DHCS reconciles the interim payments made with the cost report.
- This reconciliation may result in an additional payment of federal funds or a recoupment of federal funds.
Final Cost Settlement

- DHCS audits the cost report as well.
- The audit may result in adjustments to the cost report.
- These adjustments may result in additional payments of federal funds or a recoupment of federal funds.
- The audit is the final cost settlement.
STAKEHOLDER DISCUSSION
Substance Use Disorders (SUD) Funding 101
Consumer

Service Facility – Provider
- Support Services
- Primary Prevention
- Secondary Prevention
- Nonresidential
- Narcotic Treatment Program (NTP)
- Residential Treatment
- Ancillary Services
- Driving Under the Influence

SAPT Block Grant Funding (SAMHSA)
- Allocated in monthly payments

Drug Medi-Cal Funding (Federal and State)
- Reimbursed via “fee for service” billing in Short Doyle Medi-Cal

County Contract
DMC and SAPT Funding

Direct Provider Contract
DMC Funding

Annual Cost Settlement
SAPT Block Grant

- The block grant describes the plan for provision of prevention and treatment programs in California. The Federal funds awarded through the block grant represent a major source of funding for substance abuse prevention and treatment services.

http://www.dhcs.ca.gov/provgovpart/Pages/SAPTBLOCKGRANT.aspx
State Fiscal Year 2014-15 Substance Use Disorder Funding Budget Act Allocation

- MHSUDS INFORMATION NOTICE NO.: 14-037

Exhibits:
A. Overview of Programs, Funding and Allocation Methodologies
B. Statewide Allocation of DMC State General Funds and SAPT BG Funds
C. SAPT BG Exchange Program
D. Funding Period for SAPT BG
E. Individual County Allocation Summary
F. Estimated County Share of SAPT BH Statewide Maintenance of Effort
G. County Share of Women’s Services Expenditure Requirement

Fiscal Year 2014-15 Budget Act Allocation

• Exhibit A
  Overview of Programs, Funding, and Allocation Methodologies

  SAPT Discretionary FFY 2015 Award - $141,784,785
  Prevention Set-Aside FFY 2015 Award - $47,162,776
  Friday Night Live/Club Live FFY 2015 Award - $1,056,000
  HIV Set-Aside – FFY 2015 Award - $12,454,346
  Perinatal Set-Aside FFY 2015 Award - $17,054,000
  Adolescent and Youth Treatment Program FFY 2015 Award - $7,132,304

Fiscal Year 2014-15 Budget Act Allocation
SAPT Block Grant Distribution

- SAPT Discretionary FFY 2015 Award $141,784,785
- Prevention Set-Aside FFY 2015 Award $47,162,776
- Perinatal Set-Aside FFY 2015 Award $17,054,000
- HIV Set-Aside – FFY 2015 Award $12,454,346
- Adolescent and Youth Treatment Program FFY 2015 Award $7,132,304
- Friday Night Live/Club Live FFY 2015 Award $1,056,000
Substance Abuse Prevention and Treatment Block Grant Exchange Program

• Exhibit C –

The SAPT BG Exchange Program was created because California’s least populous counties lack sufficient populations to result in an ongoing demand for specialized treatment services for Perinatal and Adolescent/Youth. Exchanging Perinatal and Adolescent/Youth treatment funds for Discretionary funds allows the least populous counties to best respond to treatment needs and reduces the return of unspent SAPT funds to the federal government.

DMC Billing

• Within the broader Medi-Cal program, DHCS-SUD administers the Drug Medi-Cal Treatment program also known as Drug Medi-Cal (DMC). DMC reimbursement is issued to counties and direct providers that have a contract with DHCS-SUD for approved DMC services provided to Medi-Cal beneficiaries.
## DMC Billing Rates

**PROPOSED DRUG MEDI-CAL RATES FOR FISCAL YEAR 2014-15 MHSUDS**

**INFORMATION NOTICE NO.: 14-021**

### Regular DMC Description

<table>
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<tr>
<th>Service Description</th>
<th>Unit of Service (UOS)</th>
<th>FY 2014-15 UOS Rate**</th>
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<tbody>
<tr>
<td>Narcotic Treatment Program (NTP) - Methadone</td>
<td>Daily</td>
<td>$10.80</td>
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<tr>
<td>NTP - Individual Counseling</td>
<td>One 10-minute Increment</td>
<td>$13.48</td>
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<tr>
<td>NTP - Group Counseling</td>
<td>One 10-minute Increment</td>
<td>$2.91</td>
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<tr>
<td>Intensive Outpatient Treatment</td>
<td>Face-to-Face Visit</td>
<td>$56.44</td>
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<tr>
<td>Naltrexone (NAL) (*)</td>
<td>Face-to-Face Visit</td>
<td>$19.06</td>
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<tr>
<td>Outpatient Drug Free (ODF) Individual Counseling</td>
<td>Face-to-Face Visit (Per Person)</td>
<td>$67.38</td>
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<td>ODF Group Counseling</td>
<td>Face-to-Face Visit (Per Person)</td>
<td>$26.23</td>
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### Perinatal DMC Description

<table>
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<th>Service Description</th>
<th>Unit of Service (UOS)</th>
<th>FY 2014-15 UOS Rate**</th>
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<tr>
<td>Narcotic Treatment Program (NTP) - Methadone</td>
<td>Daily</td>
<td>$11.79</td>
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<tr>
<td>NTP - Individual Counseling</td>
<td>One 10-minute Increment</td>
<td>$21.06</td>
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<td>NTP - Group Counseling</td>
<td>One 10-minute Increment</td>
<td>$7.03</td>
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<td>Intensive Outpatient Treatment</td>
<td>Face-to-Face Visit</td>
<td>$80.78</td>
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<tr>
<td>Residential Treatment</td>
<td>Daily</td>
<td>$99.43</td>
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<tr>
<td>Outpatient Drug Free (ODF) Individual Counseling</td>
<td>Face-to-Face Visit (Per Person)</td>
<td>$105.32</td>
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<tr>
<td>ODF Group Counseling</td>
<td>Face-to-Face Visit (Per Person)</td>
<td>$63.33</td>
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Questions?

Thank you for your attention.

Mental Health and Substance Use Disorder Services: Bulletins, Letters and Information Notices
http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-InfoNotices.aspx
DHCS Behavioral Health Forum
Client and Family Member Forum

January 7, 2015
10:30 a.m. to 11:45 a.m.
Client and Family Member Forum

Brenda Grealish, Chief
Mental Health Services Division
Department of Health Care Services

Jane Adcock, Executive Director
California Mental Health Planning Council
Integrated Care Client and Family Member Panel
Shannon Doermann
Douglas Smith
Susan Morris Wilson
STAKEHOLDER DISCUSSION
How can DHCS impact client and family members’ experience with integrated care?
Contact Information

Behavioral Health Forum Stakeholder Website:
http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx

Please e-mail questions, comments or concerns to:
MHSUDStakeholderInput@dhcs.ca.gov
LUNCH BREAK
11:45 a.m. – 12:45 p.m.
DHCS Behavioral Health Forum
Integration Forum

January 7, 2015
12:45 p.m. to 2:00 p.m.
I. Welcome and Introductions

II. Updates
   a. Substance Use Disorder (SUD) Memorandum of Understandings (MOU)
   b. Mental Health Memorandum of Understandings (MOU)
   c. Health Home Initiative

III. Presentations
   a. Section 1115 Medicaid “Bridge to Reform” Waiver Renewal
   b. MHSUD Integration Task Force Meeting

IV. Discussion
Integration Forum Chairs

**Efrat Eilat**, Special Advisor
Health Care Delivery Systems and Mental Health and Substance Use Disorder Services Department of Health Care Services

**Eileen Gillis**, JD, MS, MFT, AGPA
Program and Grants Management Branch Substance Use Disorder Services Department of Health Care Services

**Lanette Castleman**, Chief
Program Oversight and Compliance Branch Mental Health Services Division Department of Health Care Services
UPDATES
Updates

• Substance Use Disorder (SUD) Memorandum of Understandings (MOU)
• Mental Health Memorandum of Understandings (MOU)
• Health Home Initiative
PRESENTATIONS
Section 1115 Waiver Renewal
Concept Development

Wendy Soe
Senior Advisor for Policy Development
Department of Health Care Services
January 7, 2015
1115 Waivers

Allow states flexibility to design demonstration projects that promote the objectives of the Medicaid program

Demonstrations are typically approved for five years; states may submit request for renewal for 3 - 5 years

Must be budget neutral
2010-2015 Bridge to Reform
“Bridge to Reform” Waiver
2010 - 2015

Current Waiver demonstration sunsets October 31, 2015

Waiver renewal request must be submitted to the Centers for Medicare and Medicaid Services (CMS) at least 6 months before the end of the current Demonstration

<table>
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<tr>
<th>Six Primary Goals</th>
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<tr>
<td></td>
<td>Strengthen California’s health care safety net</td>
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<td>Maximize opportunities to reduce the number of uninsured individuals</td>
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<td></td>
<td>Optimize opportunities to increase federal financial participation and maximize financial resources to address uncompensated care</td>
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<td></td>
<td>Promote long-term, efficient, and effective use of state and local funds</td>
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<tr>
<td></td>
<td>Improve health care quality and outcomes</td>
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<td></td>
<td>Promote home-and community-based care</td>
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Successes of “Bridge to Reform”

- Low Income Health Program (LIHP)
- Delivery System Reform Incentive Pool (DSRIP) + Category 5 HIV Transition Projects
- Transition of Seniors and Persons with Disabilities (SPDs) into Mandatory Managed Care
- California Children’s Services (CCS) Pilots
- Health Families Program (HFP) Transition
- Rural Managed Care Expansion
- Indian Health Services Uncompensated Care claiming
- ACA Optional Medi-Cal Expansion
- Community-Based Adult Services (CBAS)
- Integration of Outpatient Mental Health Services
- Safety Net Care Pool / Designated State Health Programs
- Coordinated Care Initiative (CCI)
- Organized Delivery System Waiver for the Drug Medi-Cal (DMC) Program (pending)
- Full Scope Medi-Cal for Pregnant Women 109-138% FPL (pending)
2015 Waiver Renewal
Initial Concepts & Stakeholder Process
Objectives

Shared Goals with CMS

- To further delivery of high quality and cost efficient care for our beneficiaries
- To ensure long-term viability of the delivery system post-ACA expansion
- To continue California’s momentum and successes in innovation achieved under the “Bridge to Reform” Waiver

Strengthen primary care delivery and access

Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency

Address social determinants of health

Use California’s sophisticated Medicaid program as an incubator to test innovative approaches to whole-person care
Initial Waiver Concepts

- Federal-State Shared Savings
- Provider / MCO Incentive Programs
- Safety Net Payment Reform – DSH/SNCP
- FQHC Payment/Delivery Reform
- Successor DSRIP
- CCS Program Redesign
- Housing/Shelter for Vulnerable Populations
- Workforce Development
The Department is in the midst of a stakeholder process with workgroups dedicated to each initial concept. Workgroup members are comprised of subject matter experts in each respective area.

Behavioral/physical health integration strategies are a sub-topic of several of the workgroups.

Meetings are open to the public with time allotted to public comment.

Submission of Waiver Renewal to CMS anticipated for February/March 2015.

Development of Special Terms and Conditions and negotiations with CMS through Fall 2015.
Federal/State Shared Savings

- Under the Waiver, a per-beneficiary-per-month cost amount would be established based on predicted costs for those beneficiaries absent the waiver.
- The state would retain a portion of federal funding for the difference between actual expenditures and pre-established per beneficiary amounts.
- The savings serve as key component that will allow CA to implement many of the other waiver initiatives.
- Concept is not a per-capita cap that limits entitlement spending; any excess spending over the anticipated per-beneficiary cost would count against budget neutrality margin.
- **Stakeholder Process**: One all-day stakeholder meeting for the Department to present the savings model and solicit input from a broad, impacted stakeholder group.

**Related Objective**: Use California’s sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care.
Provider/MCO Incentive Programs

- CA would seek Waiver authority to create one or more incentive programs to achieve goals of the Triple Aim

- Focus on integration of behavioral health and substance abuse disorder services with medical care, as well as coordination across delivery systems

- Incentive payments would target total cost of care and allow for shared savings amongst impacted entities for meeting specified quality and outcome measures

- Payments could be targeted at both managed care plans and Medi-Cal providers

- **Stakeholder Process**: Three targeted workgroup sessions on incentive programs and financing strategies

**Related Objective**: Strengthen primary care delivery and access

**Related Objective**: Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency

**Related Objective**: Use California’s sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care
Successor DSRIP

- Would build on lessons learned from 2010 DSRIP and other states’ DSRIPs
- Lessons learned from the BTR DSRIP could inform program design for Non-Designated Public Hospitals (NDPHs)
- Successor DSRIP would be more outcomes and value-oriented and seek to demonstrate advancement of the Triple Aim more consistently across the public hospital systems
- **Stakeholder Process**: Five targeted workgroup sessions of impacted hospital associations and affiliated stakeholders

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**Related Objective:** Strengthen primary care delivery and access

**Related Objective:** Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency

**Related Objective:** Use California’s sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care
Safety Net Payment Reform – DSH/SNCP

• Aim for innovation in aligning incentives for safety net providers by transforming the traditional Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) reimbursement structures

• Explore concept of county-specific global or bundled payments that provide federal flexibility to integrate DSH and SNCP funding and serve as lever for whole-person coordinated care

• Support safety net providers in their efforts to provide comprehensive care for the remaining uninsured that includes primary care, in lower costs outpatient and clinic settings

• Stakeholder Process: Three targeted workgroup sessions with on payment and delivery system reform for the safety net/uninsured

Related Objective: Strengthen primary care delivery and access

Related Objective: Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency

Related Objective: Use California’s sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care
FQHC Payment/Delivery Reform

• Discussions on FQHC payment and delivery system reform occurring in separate workgroup efforts; under the waiver, the reforms will further support the goals of quality and value-based purchasing.

• Not seeking Waiver authority to waive PPS or Alternative Payment Methodology requirements

• Goal is to transform care at FQHCs from a volume-based model to a risk-based model and provide FQHCs with incentives and flexibilities to provide cost-effective, patient-centered care

 Related Objective: Strengthen primary care delivery and access

 Related Objective: Avoid unnecessary institutionalization and services by building the foundation for an integrated health care delivery system that incentivizes quality and efficiency

 Related Objective: Use California’s sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care
California Children’s Services

- Existing demonstration pilots will continue (HPSM, Rady Children’s Hospital)
- Separate stakeholder process administered by UCLA Center for Health Policy Research in conjunction with DHCS
- No predetermined delivery system identified, all options to be considered
- Key program principals will be maintained (e.g.: provider standards, whole child approach, maintaining regional provider network)
- Will include workgroups in key subject matter areas (e.g.: funding simplification, provider network, care coordination, patient centered medical care)

**Related Objective:** Use California’s sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care
Housing/Shelter for Vulnerable Populations

• Potential to test integrated whole-person care concepts that coordinate and facilitate access to housing and supportive services with the goal of better health outcomes for vulnerable populations and reduced total cost of care.

• **Stakeholder Process:** Four targeted workgroup sessions
  – Meeting 1: Kick-off to establish evidence, best practices, other states’ experiences
  – Meetings 2-4: identify existing local efforts and Waiver demonstration options (target populations, geographies, funding streams, etc.)

**Related Objective:** Address social determinants of health

**Related Objective:** Use California’s sophisticated Medicaid Program as an incubator to test innovative approaches to whole-person care
Workforce Development

- Address pressing need to transform and expand primary care delivery systems to serve the Medi-Cal population, given increased competition for providers post-ACA.
- Expand existing providers’ ability to deliver quality care to additional Medi-Cal members and users of CA’s safety net.
- Attract additional workforce to participate in the Medi-Cal program including new categories of health workers with expertise in physical-behavioral health integration and that have cultural and linguistic skill sets for broad community reach.
- Potentially drive value by leveraging these non-physician workforce.
- One concept is to support primary care providers’ capacity to serve Medi-Cal populations by offering malpractice insurance premiums for physicians who serve a significant portion of Medi-Cal patients.

**Stakeholder Process:** Three targeted workgroup sessions

**Related Objective:** Strengthen primary care delivery and access
Questions / Comments:

WaiverRenewal@dhcs.ca.gov
Practice Transformation Proposals for Physical Health, Mental Health & SUD Services Integration

Presentation to the Behavioral Health Forum
January 7, 2015

Efrat Eilat, MBA, PhD, DHCS

Context For This Work

- DHCS is committed to BH integration
- Yet BH integration requires real practice transformation
- Practice transformation is not an easy lift
- DHCS in various stages of planning for
  - Medicaid Health Home benefit
  - Section 1115 waiver renewal
  - Drug Medi-Cal Organized Delivery System waiver amendment
MHSUDS Integration Task Force Meeting (11/10/14)

- **Purpose:** Input on short- and long-term strategies to transform California’s BH programs into a high-performing, fully integrated system

- Convened CA thought leaders in relevant fields

- Participants asked to think broadly and strategically
Programmatic Proposals for Consideration

Input was received for:

a. Data system infrastructure
b. Comprehensive care coordination services
c. Multidisciplinary teaming
d. Psychiatric/PCP consultations
e. Peer providers
f. SBIRT expansion and training sustainability
g. Cross systems training
h. Measurements to enhance accountability
Building blocks for Integration

- Accountability (measurements)
- Data system infrastructure
- Coordination of services
- Multidisciplinary teams
- Psychiatry/PCP Consult
- Cross System Training
- SBIRT expansion
- Peer providers
Data Infrastructure and Enhancement

Behavioral Health Integration Requires:
1) Providers to share costs, clinical data and quality measurements via technology
2) Clinical information systems
3) High functioning of data system

Objective:
1) Invest in data infrastructure as a first priority
2) Ensure data feeds into EHR
3) Ensure technologies and software compatible among partners
4) Ensure information is transferable to consumers
5) Be aware of HIPAA and confidentiality laws, regs
Care Coordinators who offer Comprehensive Care Coordination Services

Behavioral Health Integration Requires:
  1) Coordination of care across payer and provider organizations for individuals with complex behavioral and physical health conditions
  2) The Care Coordinator “intentionally ensures the necessary degree of screening, referrals, tracking, outcome measurement, and care coordination needed to assure good health outcomes.” (Avery, 2014)

Objective:
  a) Hire Care Coordinators to serve as the single point of contact
  b) Ensure Care Coordination processes tailored to population served
Behavioral Health Integration Requires:

1) Collaboration between providers, which can include care coordinators, clinical social workers, community health workers, psychiatrists, pharmacists, counselors

2) Practices informed by evidence

Objective:

a) Enable providers to finance and implement a collaboration model that works for their circumstances while encouraging use of core evidence based practices
Psychiatric / PCP Consult

Behavioral Health Integration Requires:

1) Primary care access to psychiatric services
2) Coordination/Integration with primary care

Objective:

a) Increase access to psychiatric consultation using sustainable financing and tele-health where appropriate
b) Facilitate evidence-based practices such as systematic psychiatric caseload reviews and tele-mentoring
Peer Providers: Certification and Reimbursement

Behavioral Health Integration Requires:

1) Common definition of Peer Providers
2) Framework for the services/supports they provide
3) Certification
4) Reimbursement Strategy

Objective:

a) Adopt a common definition for California
b) Design and implement a services/supports framework
c) Certify and make services reimbursable
Behavioral Health Integration Requires:

1) Screening patients for SUDs at all points of care
2) Training for providers in appropriate screening practices

Objective:

a) Expand SBIRT Locations
b) Expand Screening services to include other populations
c) Expand professionals who can supervise SBIRT services
d) Expand training effort to include learning collaboratives and technical assistance. Emphasize sustainability
Cross Systems Training

Behavioral Health Integration Requires:

1) **Partnerships across systems of care**: primary care, BH, MCP, peer providers, social service providers

Objectives:

a) Offer cross system, multi-county learning collaboratives

b) Provide an overview of evidence-based practices: motivational interviewing, self-help, medication assisted treatment

c) Offer implementation learning collaboratives to sites

d) Offer intensive coaching to systems partners in individual counties that need more support than can be offered in a learning collaborative
## Accountability – Example Measures

<table>
<thead>
<tr>
<th>Condition/Area</th>
<th>Performance Measure</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• ED Utilization rates</td>
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<tr>
<td></td>
<td>• ED Utilization rates – mental health and SUD</td>
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<td>• Inpatient Utilization rates</td>
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<td></td>
<td>• Inpatient Utilization rates – mental health and SUD</td>
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<tr>
<td></td>
<td>• Follow-up after MH hospitalization*</td>
</tr>
<tr>
<td></td>
<td>• Successful Linkages to Integrated Care</td>
</tr>
<tr>
<td><strong>Access to Preventive/Ambulatory Health Visits</strong></td>
<td>• All-cause readmission (number of acute 30-day readmissions for any diagnosis)</td>
</tr>
<tr>
<td>Condition/Area</td>
<td>Performance Measure</td>
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<tr>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| Care Coordination   | • Timely Transmission of Transition Record (transition record sent to health home within 24 hours of discharge)*  
                     | • Medication Reconciliation Post-Discharge                                           
                     | • Release of Information for sharing protected health information (PHI) across providers  
                     | • Care Coordinator Assignment: Percentage of clients in the target population with an assigned care coordinator  
<pre><code>                 | • Common Care Plan: Percentage of clients in the target population with a physical and behavioral health care plan accessible by all providers and payers |
</code></pre>
<table>
<thead>
<tr>
<th>Condition/Area</th>
<th>Performance Measure</th>
</tr>
</thead>
</table>
| Patient Experience  | • Client experience with care  
                      • Client confidence  
                      • Satisfaction with coordination of care                                         |
| Recovery            | • Milestones of Recovery Scale (Improved mental health outcomes)  
                      • Housing stability  
                      • Employment  
                      • Food Access     |
Thank you!

Questions?
STAKEHOLDER DISCUSSION
Contact Information

Behavioral Health Forum Stakeholder Website:
http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx

Please e-mail questions, comments or concerns to:
MHSUDStakeholderInput@dhcs.ca.gov
DHCS Behavioral Health Forum
Strengthening Forum

January 7, 2015
2:00 p.m. to 3:15 p.m.
Agenda

I. Welcome and Introductions

II. Updates
   a. Katie A.
   b. External Quality Review Organization (EQRO)
   c. Out of County Placements
   d. Cultural Competence Plan Requirements
   e. DMC Waiver

III. Presentation
   a. Medi-Cal Specialty Mental Health Services Consolidation Waiver

IV. Discussion
Strengthening Forum Chairs

**Dina Kokkos-Gonzales**, Chief
Policy and Program Quality Assurance Branch
Mental Health Services Division
Department of Health Care Services

**Marjorie McKisson**, Special Advisor
Substance Use Disorder Services
MHSUD Deputy Director’s Office
Department of Health Care Services
UPDATES
Updates

- Katie A.
- External Quality Review Organization (EQRO)
- Out of County Placements
- Cultural Competence Plan Requirements
- DMC Waiver
PRESENTATION
OBJECTIVES

- Provide an overview of the following:
  - 1915(b) Waiver
    - Waiver Renewal Process
  - Requirements and Authority
  - Waiver Renewal Application
    - Areas of Focus
    - State and County Improvement Efforts
1915(b) WAIVER
Medicaid Waivers

Medicaid Waivers allow:

- The federal government to waive specified provisions of Medicaid Law (Title XIX of the Social Security Act).

- Flexibility and encourage innovation in administering the Medicaid program to meet the health care needs of each State’s populations.

- DHCS provides Specialty Mental Health Services (SMHS) under the authority of a 1915(b) waiver.
Section 1915(b) Waiver

- **Section 1915(b) Waiver Authority:**
  - Allows states to implement managed care delivery systems, or otherwise limit individuals’ choice of provider.
  - May not be used to expand eligibility to individuals not eligible under the approved Medicaid state plan.
  - Cannot negatively impact beneficiary access, quality of care of services, and must be cost effective.
Specialty Mental Health Services (SMHS) Waiver


  - **Freedom of Choice**: Each beneficiary must have a choice of providers.

  - **Statewideness**: Benefits offered to any individual must be available throughout the state.

  - **Comparability of Services**: Requires services to be comparable for eligible individuals—equal in amount, scope, duration for all beneficiaries in a covered group.
SMHS Waiver (cont.)

- Includes the following sections:
  - Section A: Program Description
    - Describes the delivery system, geographic areas served, populations served, access standards, quality standards, and program operations (i.e. marketing, enrollee rights, grievance system, etc.).
  - Section B: Monitoring Plan
    - Describes the monitoring activities planned for the upcoming waiver term.
  - Section C: Monitoring Results
    - Describes monitoring results for the most recent waiver term.
  - Section D: Cost Effectiveness
    - Projects waiver expenditures for the upcoming waiver term.
SMHS Waiver Renewal Process

- Current SMHS waiver term: July 1, 2013—June 30, 2015
- The next waiver renewal must be submitted to Centers for Medicare and Medicaid Services (CMS) by March 31, 2015.
- Upon receiving the waiver renewal application, CMS has 90 days to approve, disapprove, or request additional information (RAI).
  - CMS and DHCS work in partnership toward successful completion of Waiver submission and renewals.
SMHS Waiver Renewal Process (Cont.)

- If CMS does not act within 90 days, the application is deemed approved.
- If CMS issues an RAI, the state has 90 days to submit response to requested information.
- Upon receiving response to RAI, CMS has 90 days to approve or disapprove waiver renewal.
- Historically the waiver renewal period was 2-years; however, with the implementation of the Affordable Care Act States can request a waiver renewal period of up to 5-years.
- The State requested a 5-year waiver term for the current waiver, however, CMS granted a 2-year renewal term.
Authorities and Requirements

- Title 42 Code of Federal Regulations
- State Plan
- 1915(b) Freedom of Choice Waiver
- California Welfare and Institutions Code
- Title 9 California Code of Regulations
- MHP Contract
Title 42 Code of Federal Regulations

Title 42 CFR Part 438 Managed Care includes provisions on:

- Beneficiary information requirements
- Enrollee rights and protections
- Quality assessments and performance improvement
- Access and capacity standards
- Structure and operation standards
- Grievance systems
- Certification and program integrity protection

Medi-Cal State Plan

- The official contract between the Single State Medicaid Agency (DHCS) and CMS by which a state ensures compliance with federal Medicaid requirements to be eligible for federal funding.

- Developed by DHCS and approved by CMS.

- Describes the nature and scope of Medicaid programs and gives assurances that it will be administered in accordance with the requirements of Title XIX of the Social Security Act, Code of Federal Regulations, Chapter IV, and other applicable federal/state policy.

  http://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx
California Welfare and Institutions Code commencing with 14700 et. seq.
http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=wic

Title 9 California Code of Regulations, Chapter 11 Medi-Cal Specialty Mental Health Services commencing with 1810.100 et. Seq.
http://www.oal.ca.gov/CCR.htm
MHP Contract

- Contract required pursuant to state and federal law
- Delineates the MHP’s and DHCS’ responsibilities and requirements in the provision and administration of SMHS
- Conforms with federal requirements for Prepaid Inpatient Health Plans (PIHPs). MHPs are considered PIHPs and as a result must comply with federal managed care requirements (see Title 42, CFR, Part 438)
- Current MHP contract term: May 1, 2013-June 30, 2018

WAIVER

RENEWAL

APPLICATION
Areas of Focus

- During the monthly CMS monitoring calls and in ongoing communications, CMS has asked questions on specific areas of the Specialty Mental Health Services waiver.

- CMS reviews MHP triennial and EQRO reports and raised concern about the findings and continued non-compliance with specific waiver requirements.

- CMS believes that there needs to be significant improvement in identified areas and expects the state to closely monitor, ensure and provide evidence of compliance.
The following are the identified areas of focus:

- **24/7 telephone line with appropriate language access** ~
  Regulations for Medi-Cal Specialty Mental Health Services at Title 9, Section 1810.405(c) and (d) require that MHPs provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries in the county. Focus will be on ensuring the toll free line is always answered and has adequate linguistic capacity with no excessive wait times 24/7 and not just during business hours.
System in place to track timeliness of access across the plan
  ~ The MHPs must have an organized system to track the
timeliness of beneficiary access to services across the MHP,
specifically the time between an initial request for services to the
time services are actually provided to the beneficiary. The goal is
to produce uniform statewide standards specific to access of
SMHS.

TARs adjudicated in 14 days ~ Title 9, Section 1820.220
requires the MHP to approve or deny a Treatment Authorization
Request (TAR) within 14 calendar days. The goal is to establish
a specific metric for TAR adjudication as one of the statewide
standards.
Areas of Focus (cont.)

- **System in place to log grievances and appeals, name, date, and issue** ~Title 9, Section 1850.205(d)(1) requires that MHPs maintain a grievance and appeal log that contains the beneficiary’s name, date, and nature of the problem. This standard is also reviewed in the triennial system review.

- **System in place to ensure providers are certified and recertified** ~ Certification and recertification of Medi-Cal providers must be completed accurately and on time to ensure beneficiaries are provided with specialty mental health services that meet program requirements and that providers are qualified to provide services.

- **Disallowance rates** ~ CMS has expressed concern about the ongoing elevated inpatient and outpatient disallowance rates resulting from chart reviews.
Areas of Focus (cont.)

- CMS has requested that DHCS explore establishing a process to enact fines, sanctions and penalties, or corrective actions as a way to ensure compliance.
- As a result of CMS concerns, we anticipate the next waiver renewal will include additional information addressing efforts for compliance in the identified areas. Section B will likely include this additional information on current and future activities.
- Further communications with CMS will determine the level of detail included in the waiver renewal.
State and County Improvement Efforts

- State and county workgroup have collaborated to develop and recommend uniform statewide metrics, with a focus on timely access of service.

- In the coming year, DHCS will request MHPs submit updated Quality Improvement work plans, Implementation Plans and Cultural Competence Plans. DHCS will review these documents to ensure compliance with requirements, provide technical assistance and share best practices, as needed.

- DHCS plans to convene technical assistance calls to better assist MHPs in meeting regulatory and contractual requirements.
State and County Improvement Efforts (cont.)

- County Support staff are going on the triennial system reviews to learn more about the program, be part of the county review process and provide targeted technical assistance.

- DHCS County Support continues to provide follow up monitoring and technical assistance on triennial system review Plans of Correction and requests evidence of correction in priority areas.

- DHCS will ensure there is clear guidance provided to MHPs and if needed will issue policy guidance.
Stakeholder Involvement

- Current SMHS waiver term: July 1, 2013 — June 30, 2015
  [http://www.dhcs.ca.gov/services/MH/Pages/MCMHP.aspx](http://www.dhcs.ca.gov/services/MH/Pages/MCMHP.aspx)

- Stakeholders interested in providing comments based on what we have presented or on the current waiver may send questions and comments to [MHSUDStakeholderInput@dhcs.ca.gov](mailto:MHSUDStakeholderInput@dhcs.ca.gov)

- Pursuant to Welfare and Institution code 14100.3 the waiver renewal application will be posted online within 10 business days from the date the department submits waiver to CMS for approval.

- Once the waiver renewal has been posted, stakeholders can send comments on the renewal to [MHSUDStakeholderInput@dhcs.ca.gov](mailto:MHSUDStakeholderInput@dhcs.ca.gov)
Questions?
Thank you!
Contact Information

Behavioral Health Forum Stakeholder Website:
http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx

Please e-mail questions, comments or concerns to:
MHSUDStakeholderInput@dhcs.ca.gov
BREAK
3:15 p.m. – 3:30 p.m.
DHCS Behavioral Health Forum Data Forum

January 7, 2015
3:30 p.m. to 4:45 p.m.
Agenda

I. Welcome and Introductions

II. Updates
   a. Interagency Agreement – Identifying an Assessment to Evaluate Child and Youth Functioning
   b. MOU with CDSS – Katie A Data Sharing Project
   c. Performance Outcomes System Project Update

III. Presentations
   a. SUD Data Systems 101

IV. Discussion
Data Forum Chairs

Jennifer Taylor
Fiscal Management and Outcomes Reporting
Mental Health Services Division
Department of Health Care Services

Rachelle Weiss, Chief
Office of Applied Research and Analysis
Substance Use Disorder Services
Department of Health Care Services

Dionne Maxwell, PhD, Research Program Specialist III
Fiscal Management and Outcomes Reporting
Mental Health Services Division
Department of Health Care Services
Updates

- Interagency Agreement – Identifying an Assessment to Evaluate Child and Youth Functioning
- MOU with CDSS – Katie A Data Sharing Project
- Performance Outcomes System Project Update
PRESENTATIONS
Substance Use Disorder (SUD) Data Systems 101

An Overview of the SUD Services Division

January 7, 2015, Rachelle Weiss
SUD Overview

- The SUD is part of the Mental Health & Substance Use Disorders area within DHCS. SUD administers and coordinates state and federal funds and grant programs for SUD prevention, treatment, and recovery services.

- There are two divisions in SUD:
  - Compliance Division (SUD-CD)
  - Prevention, Treatment, and Recovery Services Division (SUD-PTRSD)
SUDCD Overview

SUDCD focuses on compliance with state and federal laws, regulations, and other governing requirements. The division oversees the licensing and certification functions, monitoring, and complaints for Driving Under the Influence programs (DUI), Drug Medi-Cal (DMC), Narcotic Treatment Programs (NTP), and outpatient and residential providers. The division also ensures compliance with the statewide criminal justice treatment programs and counselor certification.

SUDCD is comprised of the following branches:

- Licensing & Certification Branch (LCB)
- DUI, NTP, & Criminal Justice Branch (DNCJB)
- Compliance & Counselor Certification Branch (CCCB)

January 7, 2015, Rachelle Weiss
SUD-PTRSD Overview

SUD-PTRSD provides leadership and coordination in the planning, development, implementation, and evaluation of a comprehensive statewide SUD prevention, treatment, and recovery system. SUD-PTRSD plans, administers, oversees, monitors, and accounts for California’s network of publicly funded SUD services.

PTRSD’s core functions include:

- Administer the Substance Abuse Prevention & Treatment Block Grant (SAPT).
- Administer the Drug Medi-Cal (DMC) Program.
- Administer discretionary grants, including the Strategic Prevention Framework State Incentive Grant and Access to Recovery Grant.
- Conduct county-level performance assessments.
- Conduct research and evaluation related to SUD and publicly-funded SUD services.
Relevant Federal Laws

- SAPT Block Grant (45 CFR 96)
- HIPAA (45 CFR 160, 162, 164)
- Confidentiality for SUD Treatment (42 CFR 2, Subpart A):
  - Defines which SUD Programs are subject to 42 CFR 2
  - Defines circumstances under which disclosure is permitted with or without treatment client consent
- Federal data collection and reporting requirements (42 USC, Chapter 6A, Subchapter III-A, Part A)
- SAPT recipient requirements, including data collection and reporting requirements (42 USC, Chapter 6A, Subchapter XVII, Part B)
Relevant State Laws/Regulations

• Health and Safety Code (HSC), Division 10.5:
  o Includes various requirements for data collection, evaluation, and annual reporting
  o Permits SUD related research and task forces/committees to develop and document applications of research

• California Code of Regulations (CCR), Title 9:
  o SUD service administration
  o Program licensing and accountability
  o Counselor certification

• CCR, Title 22
  o Drug Medi-Cal

• County and Provider Contracts
SUD Data Systems

- California Outcomes Measurement System Prevention (CalOMS Pv)
- California Outcomes Measurement System Treatment (CalOMS Tx)
- Short-Doyle Medi-Cal Adjudication and Remediation Technology (SMART)
- PRIMe/SMART6i
- Drug & Alcohol Treatment Access Report (DATAR)
- Parolee Services Network (PSN)
California Outcomes Measurement System Prevention (CalOMS Pv)

• Collection tool for SAPT-required reporting on SUD primary prevention services.
• No PHI/PI collected by DHCS (though system is capable at the local level of collecting information on individual service-recipients for some services.
• Monthly collection of prevention service/activity data.
• Web-based system hosted by KIT Solutions, LLC.
• Used by counties in prevention planning and by DHCS to meet federal reporting requirements for SAPT.
• Owned by PPB in SUD-PTRSD.
California Outcomes Measurement System Treatment (CalOMS Tx)

• Collects SAPT-required data on clients receiving SUD treatment services in providers funded or monitored by DHCS.

• Monthly batch reporting of treatment admissions, annual updates, and discharges through ITWS.

• Used to meet federal SAPT and state reporting requirements, generate data on treatment clients, conduct needs assessments, analyze treatment program performance and client outcomes in seven life domains, and to support program monitoring and oversight.
Drug & Alcohol Treatment Access Report (DATAR):

- Web-based reporting system.
- Collects SAPT-required information on access to treatment services among certain populations (per SAPT mandated prioritization of SUD populations).
- Supports SAPT access requirements compliance reporting.
Drug Medi-Cal (DMC) Databases

- Short Doyle Medi-Cal (SD/MC) system: used in adjudicating claims for DMC services billed for by DMC providers.

- SD/MC Adjudication & Remediation Technology (SMART): DMC payment system.
PRIMe/SMART6i (former Master Provider File (MPF)):

• Replaced the former Master Provider File (MPF).
• SMART6i is a component of the Provider Registry Information Management enterprise (PRIMe) that identifies specific Drug Medi-Cal (DMC) provider information.
• Collects information on SUD prevention and treatment providers.
• Interfaces with CalOMSTX for data validation (e.g., is the provider authorized for CalOMSTx being reported by said provider).
Other SUD Databases


- Resource Center Information System (RCIS)

- Performance Assessment Tool (PAT): Internal tool which provides data from various sources on a single display for use in monitoring.

- Driving Under the Influence (DUI) Program provider information: Collects information on DUI providers.

- Parolee Services Network (PSN): Collected financial information from PSN providers.
SUD Data Uses

- Following are some examples of how SUD uses its various data sources:
  - SAPT Block Grant reporting/applications.
  - Program monitoring for compliance and performance evaluation.
  - Annual reporting: fact sheets and reports.
  - Site visits.
  - Audits.
  - Licensure applications, renewals, or other changes.
Examples of data products created by SUD:

- Data Indicator Reports; for program and county monitoring.
- Annual Indicator Report; HSC requirement.
- SUD Fact Sheets and annual SUD-related reports.
- Aggregate data tables for SAPT Block Grant Application, annual reporting, and needs assessment.
- Legislative Reports.
STAKEHOLDER DISCUSSION
Contact Information

Behavioral Health Forum Stakeholder Website:
http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx

Please e-mail questions, comments or concerns to:
MHSUDStakeholderInput@dhcs.ca.gov
BEHAVIORAL HEALTH FORUM
NEXT STEPS
Future Meeting Dates

Behavioral Health Forum Forums will be meeting on:

• April 6, 2015
• July 6, 2015
• October 5, 2015