Policy & Fiscal Updates: Substance Use Disorder Prevention and Treatment Services in California

The Changing Landscape of SUD Services: Where Do We Go From Here?

The ACA requires health insurance plans to cover MH & SUD treatment as one of the 10 Essential Benefits

State Impacts of Health Care Reform

- Estimates of the influx of newly-covered individuals in California by 2014:
  - range from 1.5 to 2.5 million new Medi-Cal beneficiaries
  - over 3 million others subsidized by the California Health Benefit Exchange.
- SAMHSA estimates that the Medicaid expansion population in CA could be as high as 2.4 million, of which 15% (or 360,000) will need substance use disorder services. Estimates of those who will access services range from 147,000 – 195,000.

Implications for Counties

- Your county may have as much as a 50% increase in Medi-Cal enrollees in 2014.
- How well will your county and its network providers be able to address the whole health needs of...
  - The 5% of the population who use 50% of the resources, half of whom have a mental health or substance use disorder?
  - The 20% of the population who use 80% of the resources, 30%-40% of whom have a mental health or substance use disorder?

Drug Medi-Cal Reform

Current (Base) Benefits:

- Narcotic Treatment Program (NTP) – Outpatient treatment primarily utilizing methadone.
- Outpatient treatment utilizing the narcotic antagonist Naltrexone.
- Outpatient Drug Free – Mostly group counseling and some limited individual counseling.
- Day Care Rehabilitative – Intensive outpatient treatment, including group and individual counseling, eligibility for which is limited to pregnant and postpartum women and, as an EPSDT benefit, to children under 21.
- Perinatal Residential – Residential treatment provided to pregnant and postpartum women in facilities of 16 beds or less, not including beds occupied by children. (Room & board must be paid for by revenue other than D/MC.)

Drug Medi-Cal Reform (cont.)

Enhanced Benefits:

- Outpatient chemical dependency care, including day treatment programs, intensive outpatient treatment programs, individual and group chemical dependency counseling, medical treatment for withdrawal symptoms, methadone maintenance treatment for pregnant members during pregnancy and for 2 months after delivery at a licensed treatment center; and
- Transitional residential recovery services, including chemical dependency treatment in a nonmedical transitional residential recovery setting that provides counseling and support services in a structured environment.

Drug Medi-Cal Reform (cont.)

- **Note:** Inpatient detoxification, including hospitalization for medical management of withdrawal symptoms, room and board, physician services, drugs, dependency recovery services, education and counseling, will be offered as a Medi-Cal fee-for-service benefit to all eligible patients when medically-necessary, and will no longer be contingent upon other physical health conditions.

Drug Medi-Cal Reform (cont.)

- **Currently Eligible (eligible under current rules)**: All who are currently eligible for Medi-Cal, even if not currently enrolled.
- **Newly Eligible (eligible under new rules)**:
  (1) Single, childless adults with incomes below 138% FPL.
  (2) Families with children whose income and/or assets make them currently ineligible for Medi-Cal, but whose income falls below 138% FPL.

Drug Medi-Cal Reform (cont.)

Summary of Provisions:

- The state's benchmark plan benefits (Kaiser Small Group) will become the ***enhanced*** benefits for the Medicaid population, and will be added to the State Plan for Drug Medi-Cal beginning January 1, 2014.
- These enhanced benefits will ***supplement, not replace*** the current Drug Medi-Cal benefits.
- These benefits, like the current DMC benefits, will be available statewide. There is no county opt-in.
- The enhanced benefits will be an entitlement for ***all*** Drug Medi-Cal eligible, not just for the newly-eligible (the expansion population).

Drug Medi-Cal Reform (cont.)

- Drug Medi-Cal will remain a carve-out, with services and benefits administered by County Alcohol and Other Drug programs.
- For the ***enhanced*** benefits, the state will pay the non-federal share of cost for all DMC populations.
- For the ***current*** benefits, the counties will continue to pay the non-federal share of cost for current beneficiaries.

Drug Medi-Cal Reform

Federal, State, and County Drug Medi-Cal funding in 2014-2016

	Current Drug Medi-Cal Benefits			Enhanced Drug Medi-Cal Benefits		
Share-of-Cost	Feds	State	County	Feds	State	County
Current Eligibles	50%	0%	50%	50%	50%	0%
New Eligibles	100%	0%	0%	100%	0%	0%

Drug Medi-Cal Expansion

DMC Workgroups:

- **Coverage SPA (State Plan Amendment)**
  - Identifying medical necessity & acuity for each service
  - Outpatient service components
  - Residential settings/medical services at licensed "non-medical"
  - Do we need a process for authorization?
  - How will inpatient detox services be delivered?
  - What about social model detox?
- **Fiscal SPA**
  - Alternative cost-reimbursement structure for counties' Certified Public Expenditures (CPEs)
- **Reimbursement Rates**
  - Cost-based rate-setting process

Drug Medi-Cal Expansion (cont.)

- **Short-Doyle/Programming Changes**
  - I.T. System & billing changes/new service codes
  - Cost report guidelines for current & expansion populations
- **Delivery Systems**
  - State-County-Provider contracts
  - DMC provider certification – County involvement
  - Beneficiary assessments/service authorization
  - Utilization review, quality, oversight & monitoring
  - Program integrity
  - Access/capacity issues
- **Beneficiary Orientation & Notifications Outreach**
  - Strategies for beneficiary enrollment
  - Outreach to enroll new providers, expand services
  - Training & T.A. for providers and counties

Parking Lot Issues

- Improving DMC rates structure in order to provide better quality treatment.
- Prior authorization before payment is approved (prior to the claim being paid)
- The use of other FDA approved medications for substance abuse conditions.
- Eliminate the restrictions on individual counseling.
- Eliminate the restrictions on group size
- 3 days per week/3 hours per day v. 9 hours/week
- IMD limitations on residential programs
- Room and board costs

Parking Lot Issues (cont.)

- Same-day billing
- Youth treatment standards and costs
- Medi-Cal aid codes
- Rehab Option
- Medical & social model detox
- Direct Contracts?
- Beyond DMC, other state standards and guidelines that have impacts on DMC programs need to be reviewed and revised so as not to create impediments to the type and range of services provided to clients.

Trends & Developments in Medi-Cal

<u>Potential Impacts on Drug Medi-Cal</u>:

- Ramping up to serve the Medi-Cal expansion population will place additional responsibility on organizations providing SUD treatment to expand capacity.
- SUD programs will be more involved in their clients' health care.
- The health care system will experience demands for care from a caseload with which it has had little experience.
- There will be a resurgence of offender treatment as D/MC coverage becomes available to childless adults.

CHALLENGES

- **Treatment Capacity:**
  Given their intimate knowledge of local populations, the counties are uniquely qualified to develop new systems of substance use disorder services. The enhanced SUD benefit option is an opportunity for counties to develop capacity to deliver crucial services to some of their most vulnerable populations.
- **IMD Exclusion** will hamper the ability of counties to provide sufficient residential treatment capacity.
- **Workforce:**
  Treatment capacity expansion will require a better system of workforce development, with a single state certification body for SUD counselors.

Impacts of the ACA on the Public SUD Treatment System

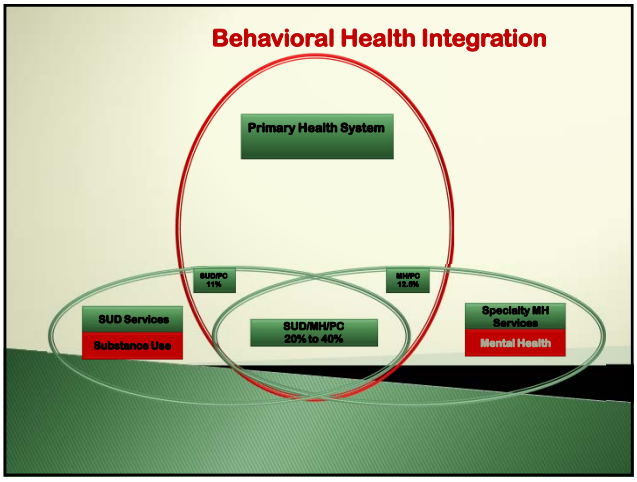
Requirements for Expanded SUD Coverage:
Along with the expansion of Medicaid eligibility, the ACA will greatly increase public support of SUD treatment services. These and other changes will have a significant impact on the types and relative importance of funding sources, the numbers and types of SUD treatment providers, the workforce, and the kinds of services offered.

Sources of Funding:

- Under health reform, Medicaid's share of total public funding for SUD treatment will increase, while the share from SGF spending will probably continue to decline.
- The other major source of non-Medicaid funding, the federal Substance Abuse Prevention & Treatment (SAPT) Block Grant, is also likely to decline in relative importance.

Impacts on the Public SUD Treatment System (cont.)

- Payment systems for SUD providers will need to be based on equitable reimbursement for services consistent with a medical model framework for levels of care, such as the patient placement criteria offered by the American Society of Addiction Medicine.
- The increased reliance on Medicaid as a funder of public SUD treatment systems may further challenge the role of residential programs, since Medicaid excludes medical assistance for people in institutions for mental diseases, and Medicaid funding does not extend to the room and board costs of residential facilities. Maintaining residential programs at existing levels will require continuing support from SGF and Block Grant funding at a time when both sources of funding are being increasingly reduced.



Realignment Account Structure: Behavioral Health Subaccount

The Behavioral Health Subaccount includes:

- 1. Medi-Cal Specialty Mental Health (including EPSDT and Managed Care)
- 2. Drug Medi-Cal
- 3. Perinatal Drug Services
- 4. Non- Drug Medi-Cal Services
- 5. Drug Courts

Growth Allocations Change Over Time

Support Services Growth Subaccount Allocations

	2012-13	2013-14	2014-15
Protective Services	82%	62%	45%
Behavioral Health	13%	33%	50%
'91 Mental Health	5%	5%	5%

Note: The percentages in 2014-15 assumes $200 million child welfare restoration is met. Once restoration is met, these would be the ongoing proportions for growth funds.

BH Account Base & Growth Proposals (CMHDA/CADPAAC)

- The total distributions to each county Behavioral Health Account by the SCO for FY 12/13 should become the set base for each county, and should not be subject to redistribution by the state in subsequent fiscal years. This will provide each county with the base funding stability and predictability needed to maintain the transferred programs, and the use of the annual growth distribution process to adjust to changes in utilization and beneficiary eligibility.
- The Medi-Cal entitlement programs specified in Government Code 30025 (f)(16)(B)(iv) and (v) will be prioritized for the annual county Behavioral Health Account growth distributions.

BH Account Base & Growth Principles (cont.)

- After the Medi-Cal entitlement growth has been addressed, the remaining Behavioral Health growth funds should be prioritized for distribution to small counties (population 100,000 and under), subject to a minimum base allocation formula for the Drug Medi-Cal program. This priority would remain in place until the agreed upon D/MC minimum base ($100,000 ?) was met for each eligible county.

Stating the Obvious

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We still have a lot of work to do…

About CADPAAC

The County Alcohol and Drug Program Administrators' Association of California (CADPAAC) is a non-profit association comprised of the designated county alcohol and drug program administrators representing the 58 counties within California. CADPAAC is dedicated to the reduction of individual and community problems related to the use of alcohol and other drugs.

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