COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PRVENTION AND CONTROL
HEALTH CARE REFORM READINESS PLANNING AND IMPLEMENTATION INITIATIVE

SUMMARY OF WORK GROUP MEETING

Group: Benefit Package/Continuum of Services/Standards of Care

Meeting Date: March 11, 2011

In Attendance: See attendance roster attached.

TOPIC OF DISCUSSION	DISCUSSION	TIMELINE	LEAD	ACTION NEEDED
OBSERVATIONS/CHALLENGES:	• Interpretation - field of Substance Use Disorders (SUD) was not included in the 1115 Waiver – more beneficial to Mental Health (MH). State/County not mandating SUD inclusion. • Los Angeles County (LAC) had the option to include SUD, but decided to exclude it, County and/or this workgroup should examine more closely how to include SUD as a minimum benefit in the 1115 waiver • Request: What is the minimum benefit cap that the county can develop under			

	1115 Waiver? • When will SUD come to the table– discussion – mental health community has recently been added to the discussions on Health Care Reform (HCR). SUD field must be ready to support efficacy, will be pivotal to the success of HCR. • Under the terms and conditions of the 1115 Waiver a Statewide Behavioral Health Needs Assessment (State Department of Health Care Services) is required; the assessment is due to the Centers for Medicare and Medicaid Services (CMS) March 2012. There is still time to provide additional information in terms of MH and SUD. • Department of Mental Health (DMH) – There is a notion that MH is in competition with SUD; this is not an accurate perception. • DMH and SAPC have enhanced collaboration (e.g., memorandum of understanding) and this should continue. • There should also be more emphasis			

	on developing mechanisms for care coordination (across systems) versus case management (within systems). Understanding that some case management activities will need to continue • There needs to be an understanding that persons with Co-Occurring Disorders (COD) can enter the SUD system at any level of care – COD transcends the fields of SUD and MH. • Need to recognize funding limitations for the homeless population, (e.g., General Relief – benefits extremely limited). • Department of Public Social Services (DPSS) clarified that there is no limit on General Relief (GR) benefits for persons with disabilities (including MH) that prevent them from entering the workforce; treatment is limited to a maximum of one year (12 months). • There have been discussions between DPSS and Department of Public Health (DPH) regarding the possibility of utilizing general relief funding for County match to fulfill 1115 waiver			

	requirement discussions continue to weigh the benefits and challenges for the County. • Counties will need to provide funding to draw down federal match. Under 1115 Waiver, monies must be generated and classified as net county funds, in order to qualify for federal match dollars. • The new system requires appropriate assessment and referral function for all clients – there was discussion that the Community Assessment Services Centers (CASC) may fulfill this requirement. • Statewide Assessment requirement – recommendation is to implement a Los Angeles County assessment. The benefit package should be based on assessment not assumptions. • Expectations are to include the full Continuum of Care. An agency does not need to provide the full continuum, but can chose to provide specialized service/functions within the continuum. SUD community should formulate relationships with			

	different partnerships – (e.g. FQHCs and Public Private Partnerships [PPPs] Independent Practice Associations [IPAs]). • Benefit - under HCR – SUD is included as part of the benefit package, but not specified. • Critical for smaller SUD entities to partner/collaborate with larger organizations, there are many issues that will need to be resolved – e.g. Electronic Health Records and how the information exchange is managed between agencies. • Information on the confidentiality and consent requirements was discussed. More information will be shared at the next meeting. • Increased need for SUD field to understand the need to shift to a market driven system under HCR. Smaller entities will need to specialize/become experts particularly in a specific SUD niche, and provide better outcomes, or same outcomes with less funding.			

	• Kaiser Foundation website has a short video explaining HCR. There is a link to the video on Substance Abuse Prevention and Control (SAPC) website under HealthCare Reform. • How will HCR influence SUD services given the role of commercial/private Insurance market – SUD programs that are currently publically funded should be looking at ways to interface with the commercial/private markets in the implementation of HCR. The role of competition in this new marketplace needs to be well understood (e.g., outcomes based services, fee-for service vs. capitated rates). • Excluded populations – how will HCR deal with exclusions. Focus on special populations including those involved in the criminal justice system (CJ) as part of benefit package. • Competition – major factor in this arena, dollars will be available to provide benefit package for continuum of care under HCR. Behavioral health services must be sensitive and responsive to the need for outcome driven /quality services to take full			

	advantage of HCR. • LAC – workgroup should remain abreast of what is being considered by State and CAADPAC, to deliberate and collaborate.			
• Role of medical necessity and physician direction	a. Medical necessity – level of care at a specified cost. Restricted level of care. b. Criteria – medicalization of medical necessity c. Look at developed protocol on medical websites, such as Megellan, Value Options, and HealthNet d. Medical necessity not just level of need for SUD, but more encompassing in other areas of individual health. Look at the individual/patient as a whole – e.g. health, dental, MH. e. The needs of children involved in the dependency system also needs to be included as part of the discussion. Care must be given to develop the communication			

	relationship between legal system and the health care delivery system developed under HCR e.g. interactions with Department of Children and Family Services (DCFS), Family Courts. Currently youth may voluntarily enter treatment without parental consent. f. Under the new system, SUD needs to be considered a health problem and move away from using SUD treatment as a punitive measure. Treatment should be based on medical necessity, and used as positive reinforcement. g. Under the new system, the use of medical necessity will allow for a more sophisticated way of measuring efficacy of treatment. h. Based on historical data and SUD information, programs will be expected to develop a trajectory of patient needs/treatment requirements. i. SUD programs will need to strike the right balance between not			

	enough information and too much information, based on agency's program needs. j. Workgroup must remember this is a continuum of care, and involve outside groups. Improving quality outcomes and reduced costs as part of system reform. k. Implementation of reform system – system has to have a third party administrator to review costs and standards of care. l. Reform system – under managed care cost structure will not be Fee-For-Services (FFS). Reimbursement will be outcome oriented. m. Current system will shift to a capitation cost structure. n. A benefit is only a benefit if administered in the way it was intended. Implication – figure out how to manage your own utilization management. o. Utilization management – shift thinking to ways of providing			

	services away from current model. p. There is a need for paradigm shift in looking at SUD as a chronic disease that encompasses various levels of acuity at different times. q. Case management vs. Care Coordination – success under a capitated system is determined by strong care coordination. r. Where does Recovery support fit in Continuum of Care. s. Under the new HCR system, peer recovery personnel could perform a number of vital functions, such as care coordination, Recovery support and case management. Portion of this may be an infrastructure requirement for your program and a portion of this can be a billable function. t. Workgroup must differentiate what is Recovery support and treatment as part of building the benefit package. Determine what level of credentialing will be required to perform each function. Housing may be considered as part			

	of treatment component, as it may be mandated by the feds. u. www.eclinicalworks.org			
• Possible impact of DSM V in gauging severity/need.				
• Expanded role of Evidence Based Practice's (EBP's) with corresponding demands on program staffing.	a. EBP's will become standard practice and a requirement of the Primary organization.			
TOPIC OF DISCUSSION	DISCUSSION	TIMELINE	LEAD	ACTION NEEDED
• Private sector demands – accreditation, staff				

licensure				
Next meeting	Discussion of Evidence Based Practices (EBP's)/Private sector demands – accreditation, staff licensure/consider confidentiality/Quality service agreements/Electronic Health Records – whether it's to be included/.	April 21, 2010 10:00 a.m. Location – SAPC headquarters G-2		