



CMHDA-CADPAAC Medi-Cal Substance Use Disorder Waiver Recommendations

JOINTLY ADOPTED 2-13-14

- 1) **Expand California's Bridge to Reform Demonstration.** CMHDA and CADPAAC strongly support the expansion of California's Bridge to Reform Demonstration (Section 1115(a) Medicaid Demonstration Waiver) to test new and innovative organized service delivery system models that improve care, increase efficiency and reduce costs in the Drug Medi-Cal Program.
- 2) **Develop an Organized Delivery System to Respond to Significant Recent Changes.** The Drug Medi-Cal program provides substance use disorder treatment services to Medi-Cal beneficiaries. Funding for the program was realigned to the counties as part of 2011 Public Safety Realignment, but the delivery system remained unchanged. California's Budget Act for FY 13-14 significantly expanded the benefits available through the Drug Medi-Cal program, as well as expanded eligibility for the entire Medi-Cal program as part of California's implementation of the Affordable Care Act. Given these important changes, an organized delivery system is critically needed in a timely fashion to meet the needs of the tens of thousands of additional potential Medi-Cal beneficiaries seeking expanded substance use disorder treatment.
- 3) **Implement State's Behavioral Health Services Plan to Ensure Access to Benchmark Benefits.** As part of the special terms and conditions of the Bridge to Reform Demonstration, CMS required that California develop a detailed plan outlining the steps and infrastructure necessary to meet requirements of a benchmark plan and ensure strong availability of behavioral health services, including substance use disorder services. CMHDA and CADPAAC strongly support the expansion of the Bridge to Reform Demonstration to implement this detailed plan in order to ensure access to the substance use disorder services included in the benchmark plan.
- 4) **Address Local and State Correctional Challenges.** The Bridge to Reform Demonstration provides an important opportunity to create an organized substance use disorder service delivery system that can better coordinate with county public safety systems, improving the coordination of mental health and substance use disorder services to better support offenders in their re-entry back into the community.

substance use disorders requires assertive, proactive, culturally and linguistically appropriate outreach in a variety of settings by specialty and community providers who have the expertise in engaging individuals at the earliest possible point in an episode of mental illness and/or substance use.

- 7) **Mental health and substance use benefit packages must promote high quality, patient-centered and cost-effective care, and continue to support the existing safety net.** This includes, but is not limited to, services not traditionally provided in the medical arena and/or covered by Medicaid, such as many homeless outreach services, mobile response programs, services to children and youth in specialized foster care, supports for housing stability, recovery maintenance homes, field-based services, etc. These services are critical in addressing social determinants of health and are an integral component of California's specialty mental health and substance use disorder systems.
- 8) **Safety net funding for residually uninsured populations must be preserved.** As healthcare reforms take hold and insurance coverage gradually expands, we must ensure that a shifting or reduction in safety net funding does not diminish access to mental health and substance use disorder services for residually uninsured populations. In particular, approximately 11% (58,600) of today's uninsured Californians with mental health needs will not be eligible under the ACA due to immigration status³. This means increasing the efficiency of federal funds reimbursement, preserving realignment revenue and federal block grant funding for County mental health and substance use disorder services and ensuring that the State does not reduce Medi-Cal eligibility or benefits. The size and impact of the residual population, including those ineligible for programs due to placement in an Institute for Mental Disease (IMD), will likely be realized only over time once the ACA policies and programs are fully implemented. Any diversion of funds from these health care delivery systems before a full assessment of the near-term and longer-term impacts of the ACA are determined and analyzed would offer a recipe for undermining the very systems the State will need to rely on to service the expanded Medi-Cal and other publicly sponsored populations. Financing systems may need to be reformed to better align payment policies with care coordination and quality improvement goals and objectives.
- 9) **Support for policies that address the workforce composition, development and expansion to address the needs of the Medicaid expansion and Covered California populations is critical, including pathways to employment, competencies for peer support, etc.** This includes the utilization of non-licensed providers and peer support to most effectively and efficiently meet the needs of consumers/clients with mental health and substance use disorders.
- 10) **Coordination of mental health, substance use and primary care is essential to ensuring quality care and realizing cost savings.** The aim of the ACA is to ultimately reduce the cost of healthcare delivery to the entire population. In order to more effectively care for the whole person, there must be more seamless coordination between system partners. This includes reducing barriers to the exchange of information necessary to appropriately coordinate care, improve quality, and address confidentiality.

³ UCLA Center for Health Policy Research (November 2012), Health Policy Fact Sheet, "Half a Million Uninsured California Adults with Mental Health Needs Are Eligible for Health Coverage Expansions."

