



Date:  
Thursday, September 26, 2013

The Best of Walden House and  
Haight Ashbury Free Clinics

To: California Joint Oversight Hearing: Assembly Health and Accountability & Administrative Review Committees

From: Vitka Eisen, CEO, HealthRIGHT 360

Re: A Review of the Drug Medi-Cal Program

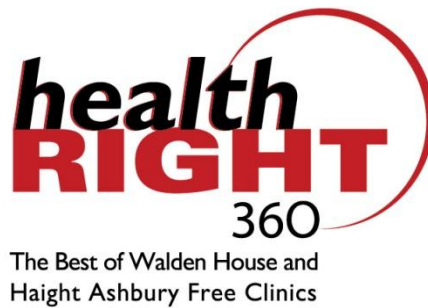
Poised at the dawn of a new day for those suffering from substance use disorders—a new day in terms of increased access to treatment for low-income and uninsured individuals—it makes good sense to explore some of the challenges in our current system of care as they are likely to increase with the expansion of MediCal.

I would like to thank the Committees for allowing me to share a provider's perspective. I represent—HealthRIGHT 360, a family of programs that includes Haight Ashbury Free Clinics, Walden House and now Asian American Recovery Services. We have over 20 different funding sources, from foundations to county, state, and federal dollars. We are an FQHC, and follow all of the HRSA as well as CMS regulations and guidelines. Our organization served over 49,000 clients last year, with a combined annual budget of over \$65MM. Despite the fact that we are a rather large substance use disorder service provider in California, HealthRIGHT 360's total volume of Drug MediCal revenue was \$75K—a little over 1/10 of 1% of our total revenue. This is due to the prior limitations on eligibility under the current MediCal system. So while we have some knowledge of the system, we are not a high volume DMC provider at this time. Nevertheless, in January 2014, that will begin to change rather dramatically as MediCal expands to include low-income single adults—by far the lion's share of our 49,000 clients. It is therefore important that we take the time to fix the problems and get this right.

We take our responsibility to operate with integrity very seriously for three big reasons:

1. Our clients are slow to trust as a result of prevalent histories of trauma and abuse. We work very hard to earn, maintain and protect that trust; it is vital to our effectiveness as a treatment provider.
2. I always say, as a non-profit provider of a social service (rather than a tangible product) all we have is our good name. We must strive to preserve that.
3. MediCal fraud can lead to criminal charges—and orange is not *my* new black—neither me nor my Board of Directors!

We as provider must take responsibility for assuring that we operate with absolute integrity. At HealthRIGHT 360, we meet weekly to review our data entry and process—scrubbing our charting, data collection and billing process for ways to improve the process and to make sure we are accurate and in compliance with the regs. We also have a Whistleblower Protection Policy and procedure for reporting fraud and abuse in our employee handbook. Reviewing that policy is a part of our new employee orientation process. We also check our employee roster—some 450



employees—monthly, against the Department of Health and Human Services Office of Inspector General’s Exclusion website to make sure that our employees are not barred from billing Medicare or Medicaid.

Below, I list some challenges and proposed solutions and I have attached answers to your questions as well.:

1. *DMC certification process:*

The current process for certifying providers is overly burdensome. It only serves to screen out potentially qualified providers and yet does not prevent unqualified vendors from being certified. In our experience, it has taken over 19 months from initial application to site visit, and we have yet to receive notification of certification (for example, items noted as missing were in fact included in the application; our application was rejected because our lease agreement for an entire building did not specify that the first floor would be used for the DMC program) Even a simple organizational name change requires a near do-over of the application process.

Proposed solution: Move the certification process to the county, modeled after the current county Mental Health MediCal certification process. Include an annual monitoring process in the county’s certification and oversight responsibility.

2. *Physician sign-offs on treatment plans:*

Currently, DMC Outpatient Drug Free Counseling (ODF) Services require an MD review and approval on treatment plans, despite the fact that ODF is specifically a non-medical service. This is a cost that is not supported by the DMC rate and it also does not produce an improved outcome. General Practice MDs are required to maintain a broad knowledge of healthcare and medicine; however they are not necessarily specialists in the treatment of addiction.

Proposed solution: Treatment plan review and approval by a licensed mental health professional is more relevant, cost effective and more likely to produce an improved level and quality of care.

3. *One service per day:*

ODF has two different service categories: Individual counseling and group counseling. A client may attend a treatment group on a particular day and the meet with their counselor for discharge planning however the provider is only allowed to bill for one service in a day. The only way for providers to recoup the cost of providing the service is to schedule the client to come a different day for the second service. This is not a good treatment practice and can be seen as a barrier to care. Similarly, a client may attend two different treatment groups on a particular day—for example a cognitive behavioral therapy group for managing emotional dysregulation associated with addiction and then a parenting group—and yet the provider is only allowed to bill for the cost of a single service. This serves as a disincentive to providers offering comprehensive services that is in accordance with clients’ needs and accommodates client schedules.



Proposed solution:

Allow providers to bill for multiple services in one day, with proper justification and documentation and in accordance with the client's treatment plan.

4. *Limit on individual counseling sessions;*

Current regulations limit individual counseling sessions to treatment planning, crisis intervention, and discharge planning. This regulatory limit is not in keeping with current best practices and standards of care in the treatment of SUD.

Proposed solution:

Allow for individual counseling sessions as determined by the client's assessment and in accordance with the client's treatment plan, with requisite documentation.

5. *IMD exclusion:*

Federal law prohibits the use of Medicaid to fund residential SUD treatment in facilities larger than 16 beds. This a major access-to-care barrier for low-income individuals. Although residential SUD treatment is included in the state's Alternative Benefit Plan as an option, at current DMC rates, a 16-bed residential SUD treatment facility does not have sufficient economies of scale to be viable. As a result, there are very few 16-bed SUD facilities across the state's system of care. There are, however, many 30+ bed facilities available—sufficient capacity to meet the state's need for residential SUD treatment for its low-income population. The IMD exclusion prevents the state from accessing that capacity (as well as accessing the FMAP available under the Affordable Care Act to cover the cost of residential care for the expansion population).

Proposed solution: California should join with other states in asking CMS for a redefinition of the IMD exclusion—one that separates the short-term episodic nature of acute SUD treatment, from the longer term challenges of treating chronic and persistent serious mental illness, and removes residential substance use disorder treatment from the IMD definition.

Other suggestions for improvement:

The state's current process for licensing and certifying its substance use disorder programs (non-DMC) is a reasonably good process. Certified outpatient and residential SUD programs are thoroughly reviewed on a biannual basis, including site visits, review of charting and documentation and a review of counselor certification. Certification should be required of all DMC programs. In closing, we have an opportunity to bring help and hope to those have had not previously had access, and to improve the health of our communities. It is in the best interest of our clients, first and foremost, and our stakeholders—that is our funders and the tax payers that support our work, that we have a system of care that is compassionate, empirically grounded, and run with the highest level of integrity; without those critical elements, we will never, as we like to say at HealthRIGHT 360, help people get better, do better, and be better.



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Thank you for this opportunity to share my thoughts.

Respectfully,

Vitka Eisen, MSW, EdD  
CEO  
HealthRIGHT 360