DHCS-14-006E – Drug Medi-Cal Program Integrity
45-Day Public Comment Period and Public Hearing
List of Commenters

Number: 1
Name: Stan Sharma

Number: 2
Name: Christine Bierdrager-Salley, Ph.D.
Title: Director of Social Services Licensed Psychologist; President, Inland Empire Chapter of CAADPE **Association:** Inland Behavioral & Health Services, Inc.; California Association of Alcohol and Drug Program Executives

Number: 3
Name: David Martel
Title: Corporate Director
Association: Pacific Clinics

Number: 4
Name: Jennifer
Association: California Association of Alcohol and Drug Programs Executives, Inc.

Number: 5
Name: Robert Oakes
Title: Executive Director
Association: County Alcohol and Drug Program Administrators Association of California (CADPAAC)

EXHIBIT A
Name: John de Miranda
Title: Associate Director
Association: Door to Hope

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #1
Stan Sharma
7/16/14

Comment Topic and Summary
A. Contact Person
Who is the point person for contact on issues of Clarifications Questions Suggestions?

Department Response
The contact persons for this package are:

- Marcia Yamamoto, Chief of the Substance Use Disorder Prevention, Treatment and Recovery Services Division, Performance Management Branch at (916) 322-6643
- Jasmin Delacruz, Office of Regulations, at (916) 440-7688
- Lynette Cordell, Office of Regulations, at (916) 440-7695.

The Department responded directly to Mr. Sharma on 7/17/14 and provided the "Contact Persons" information in the Notice for this regulatory action.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #2
Christine Bierdrager- Salley, Ph.D.
Inland Behavioral & Health Services
President, Inland Empire Chapter of California Association of Alcohol and Drug Program Executives (CAADPE)
8/06/14

Comment Topic and Summary
A. Day Care Habilitative (DCH) Services Regarding the changes to DCH: The unit is a "day unit," not counseling sessions per se. We have historically submitted a weekly schedule to the State (ADP) to account for weekly programming. DCH is the cross between residential and outpatient. However, it appears that re-labeling DCH as "intensive outpatient" and these new regulations indicate a serious misunderstanding of what constitutes day treatment.

We have a perinatal day treatment program.

Department Response

While not stated, the Department believes that this comment refers to Subsections (d)(3) and (d)(4)(A), (B) and (C). There were no changes in these regulations that resulted in the re-labeling of DCH as "intensive outpatient." Furthermore, Subsections (d)(3) and (d)(4)(A), (B) and (C), which specify day care habilitative services and perinatal residential substance use disorder services, respectively, were unchanged.

Both day care habilitative services and perinatal residential substance use disorder services include individual and group counseling sessions and rehabilitative services. (See Subsections (b)(8) and (d)(3))

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #2
Christine Bierdrager- Salley, Ph.D.
Inland Behavioral & Health Services
President, Inland Empire Chapter of California Association of Alcohol and Drug Program Executives (CAADPE)
8/06/14

Comment Topic and Summary
B. Progress Notes
Hence, specifically, the emergency regulations now require us to list "date, start and end times, and topics for each counseling session." The day program includes daily check-in, groups, individuals, case management, wrap-up, lunch observation (nutrition, parent-child interactions), one-on-one parenting training, etc. Please can clarify whether we need to list all services as a "counseling session" for every day for every DCH client? Or are you only interested in the groups portion?

Department Response
While not stated, the Department believes that this comment refers to Subsection (h)(3)(B) which specifies the documentation requirements for progress notes for day care habilitative services and perinatal services. Language was added to Subsection (h)(3)(B) to further clarify that a progress note shall be recorded for each beneficiary participating in structured activities including counseling sessions. However, it does not require the therapist or counselor to list all services as a counseling session. Only a counseling session should be documented as a counseling session in a beneficiary's progress note.

Subsection (h)(3)(B)(ii) specifies the requirements for recording a beneficiary's attendance at each counseling session (either individual or group) in the progress notes. Language was added to Subsection (h)(3)(B)(ii) to require (in addition to the date) the start and end times and topic of each counseling session. However, the requirement that this provision apply to "each" counseling session (either individual or group) remained unchanged.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #3
David Martel
Corporate Director Pacific Clinics
9/8/14

Comment Topic and Summary
A. Age Appropriate Services RECOMMENDATION #1
Page 3 states ***A beneficiary that is 17 years of age or younger shall not participate in group counseling with any participants who are 18 years of age or older.***

We support rules and regulations that positively support age-appropriate services. However, the hard line drawn by this prohibition is a flawed solution to the goal of ensuring age-appropriate services that will result in negative consequences for both service providers and our beneficiaries.

The emergency regulation acknowledges that there is ***one*** circumstance where this is appropriate, school-based services where most students will be minors, and some may be age 18. However, there are many similar circumstances beyond school-based services where such an exception is appropriate. However, the new emergency regulation does not allow for such exceptions.

Department Response
This comment refers to Subsection (b)(11) that defines the term "group counseling." Prior to this provision, there were no parameters regarding the age of the individuals participating in group counseling sessions together. Based on observations during the Department's recent targeted field reviews, this amendment was necessary to protect the vulnerable and impressionable minor population by separating them from the adult population. This amendment was also necessary to remove an impediment to effective treatment for minors as discussed in the ISOR. (See page 5)

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #3
David Martel
Corporate Director Pacific Clinics
9/8/14

Comment Topic and Summary

In counties throughout California, there are entire systems of publically funded services targeted to **Transition Age Youth (TAY)** that is most commonly defined as ages 16-25 by California's Mental Health Services Act (MHSA). Integrating services funded by separate public systems of care (e.g. SUD, mental health, child welfare, juvenile justice, education, etc.) is already an exhausting burden for providers serving patients with complex needs (which is the norm), and this regulation makes it additionally challenging. There are many similarities in the TAY age range that make it beneficial to treat them as a group, including their physical, cognitive, emotional and social development, the greater prevalence of substance use than the general population, and the similarity in patterns of substance use. In fact, there are many more similarities between the 17 and 19 year old patients, than there are between the 19 and 30 year old patients, or the 22 and 65 year old patients. However this regulation makes no such distinctions, and puts California's largest system of SUD treatment out of alignment with most other systems of publicly funded care. This emergency regulation, as it is written, is a huge step backwards for all of these systems throughout California that serve Transition Age Youth, and are now forced to separate ages 16 and 17 from those that are 18-25, and it may have the unintended consequence of younger adults being placed in groups with middle-aged or even older adults.

We strongly recommend that DHCS consider "guidelines" for age appropriate services based on age ranges of:
12-17 adolescents
16-25 transition age youth 18-30 Young adults
25-55 Adults
55+ older adults.

Any age grouping will have some pros and cons for mixing the two, and unintended consequences if hard lines are drawn by regulation, which is why we recommend that these be implemented as "guidelines" rather than regulation.

Department Response
The Transition Age Youth age range (16-25 as referenced in California's Mental Health Services Act) is not an appropriate age range grouping for substance use disorder treatment services and does not protect minors. Furthermore, the age groups provided for in the regulations is consistent with federal reporting requirements for substance use disorder services.

This comment requests that the Department implement age ranges for group counseling sessions via guidelines. Since guidelines are unenforceable, it is necessary that this requirement be included in regulation.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #3
David Martel
Corporate Director Pacific Clinics
9/8/14

Comment Topic and Summary
B. Physical Exam Requirements RECOMMENDATION #2
Page 14 describes ***Physical exam requirements***. In principle, the idea of every beneficiary obtaining a physical examination is important and ***should be*** the goal. In practice, there are circumstances where this is not feasible, may become a barrier to treatment, or may be counter to patient-centered services.

We are in agreement with (a) and (b), and strongly recommend a change to (c) that allows providers to document when a patient is either unable or unwilling to obtain documentation of the physical exam and refuses to address this in their treatment plan. We support encouraging patients to obtain the physical exam and documentation, however, requiring a patient to set a goal that they do not agree with is counter to the notion of client- centered services, undermines the patient's autonomy, and undermines the value of the treatment plan, since it requires goals set by the State/provider, irrespective of the patient's opinion.

In addition, we serve many patients that receive services through the minor consent process. In many instances, requiring these 14-15-16 year olds to obtain documentation from their primary care provider will either require parent/care-giver involvement (which is counter to the concept of minor consent), may be unrealistic for the minor to obtain on their own, or will require a goal in the treatment plan that they have no intention of fulfilling, undermining the treatment process as described above.

For these reasons, we recommend that in part (c), DHCS allows that providers may document when/if a patient refuses to set a goal towards obtaining a physical exam (when there hasn't been one), or obtaining documentation (when there has been one in the past 12-months.

Department Response
This comment refers to Subsection (h)(1)(A)(iv) that specifies the physical examination requirements.
Paragraph (a) requires the provider, not the beneficiary, to obtain records of the beneficiary's recent physical examination. If a beneficiary (or a beneficiary's guardian) is unwilling to authorize release of the physical examination records, paragraph (a) requires the provider to "describe the efforts made to obtain this documentation in the beneficiary's individual patient record."

If paragraphs (a) or (b) cannot be met, then paragraph (c) requires a provider to include on a beneficiary's treatment plan, the goal of obtaining a physical examination. However, a beneficiary can disagree with treatment plan goals. If a beneficiary refuses to sign the treatment plan that includes a goal of obtaining a physical examination, "the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment." (Subsections (h)(2)(A)(ii)(b) and (h)(2)(A)(iii)(b).)

The Department believes there are no negative consequences arising from requiring the goal of obtaining a physical examination and there are significant benefits. Including a treatment plan goal to obtain a physical examination is consistent with professional standard of care practices. In addition, a physical examination can assist a physician in determining whether substance use disorder treatment services are

medically necessary for a beneficiary and assist the provider in determining the most appropriate treatment modality, as further described in the ISOR. (See page 11)

For services provided under minor consent, the doctor can release physical examination information to the provider (with a signed release of information from a minor who is at least 12 years old) without parental knowledge pursuant to Family Code Section 6929. Therefore, the minor consent process is not impacted.

The commenter's suggestion to amend Paragraph
(c) is not necessary since the regulations already provide that if a beneficiary refuses to sign their treatment plan because it includes a goal of obtaining a physical examination, "the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment." (Subsections (h)(2)(A)(ii)(b) and (h)(2)(A)(iii)(b.))

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #3
David Martel
Corporate Director Pacific Clinics
9/8/14

Comment Topic and Summary
C. Discharge Plan Timeframes
RECOMMENDATION #3
Discharge Plan (Page 23) states under section ***(6)(A)(ii) The discharge plan shall be prepared within thirty (30) calendar days prior to the date of the last face-to-face treatment with the beneficiary*.**

It is unclear if this is (1) the **only** time that the discharge plan can be done, or (2) if this is the only required time that it must be done, and there is flexibility to do more often. Therefore, we are requesting clarification and recommending that it may be done more frequently, as clinically appropriate. Previously, there were no restrictions or directions in Title 22 to prescribe when the Discharge Plan must be done. After attending technical assistance training with California Alcohol and Drug Program staff in 2010 our agency developed a practice of having patients complete discharge plans within the first 30-days of treatment. We find this to be very beneficial in getting patients to think about how they will maintain their progress after treatment. We also have them update their discharge plans shortly before they complete treatment, which seems to be in the spirit of the Emergency Regulatory Action (within 30-days prior to the last face-to-face).

Therefore we are seeking clarification regarding this regulation, and we are recommending (2) above, which is that the last 30-days is the only required discharge plan, but additional discharge plans may be done as clinically appropriate.

Department Response
This comment refers to Subsection (h)(6)(A)(ii), which requires a provider to complete a discharge plan for a beneficiary within the 30 day period prior to the beneficiary's last face-to-face treatment. The timeframe specified in Subsection (h)(6)(A)(ii) is the only period in which a discharge planning session can be billed as an individual counseling session. The regulation does not prohibit a provider from conducting additional discharge planning sessions outside of that time period but the Department shall not reimburse a provider for those sessions.

The Department's current and prior training materials do not endorse the practice of having patients develop a discharge plan within the first 30 days of treatment. However, a treatment plan shall be developed for a beneficiary within 30 calendar days from the admission to treatment date and shall be updated in accordance with Subsection (h)(2)(A)(iii)(a).

Providers can bill for individual counseling sessions to prepare and plan for a beneficiary's discharge from treatment. However, the Department auditors have noted that some providers billed for individual discharge planning counseling sessions that did not occur. In other instances, providers billed for individual discharge planning counseling sessions when the counseling session was not for the purpose of discharge planning, but rather an unauthorized purpose. (As specified in Subsection (d)(2)(B), individual counseling is allowed for intake, crisis intervention, collateral services, treatment planning, and discharge planning only.)

If providers were allowed to prepare discharge plans for beneficiaries outside the 30-day period specified in the regulations, as suggested, the regulations would not prevent providers from continuing to improperly bill for individual discharge planning counseling sessions.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
A. Emergency Authority
CAADPE also protests the issuance of these regulations under emergency authority.
CAADPE is a statewide association of community- based nonprofit substance use disorder treatment agencies, including co-occurring disorders. Its members provide substance use disorder treatment services at over 300 sites throughout the state and constitute the infrastructure of the state's publicly funded substance use disorder treatment network. It is the only statewide association representing all modalities of substance use disorder treatment programs.

Department Response

The comment is regarding the Department's issuance of these emergency regulations. The Department properly issued these regulations under emergency authority. The Department relied on the emergency authority provided through Welfare and Institutions Code Sections 14124.26 and 14043.75. (See Finding of Emergency) The Department believes that all provisions of the regulatory text fall within the scope of authority provided in the above noted statutes. The Office of Administrative Law reviewed the Department's authority for emergency regulations and approved the initial emergency filing on June 25, 2014.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
B. Definition of Face-to-face
There are valid reasons for telephone contacts, e.g., crisis intervention, and these contacts should be reimbursable. In addition, home visits have shown to be effective and should be reimbursable and they are in some other states. This is also allowable in the mental health system with excellent outcomes.

Department Response
This comment refers to Subsection (b)(10) that defines the term "Face-to-face." The definition clarifies the exclusion of telephone contacts, home visits and hospital visits as a face-to-face contact. This exclusion was previously included in the definition for "individual counseling" (Subsection (b)(12).) A separate definition for "face to face" was necessary for clarification.

Pursuant to Welfare and Institutions Code Section 14124.24(a), substance use disorder services offered by the DMC program shall be consistent with the California State Plan and State Plan Amendments (SPA). The exclusion of telephone contacts, home visits and hospital visits from the definition of "face-to- face" is necessary to be consistent with the most recently approved SPA 13-038. (Supplement 3 to Attachment 3.1-A, Page 6a and Supplement 3 to Attachment 3.1-B, Page 4a)

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary

C. Group Counseling Session Group Size Limit CAADPE objects to imposing a group size upper limit. We are not talking about psychotherapy, and within IOP services there is an array of various therapeutic group activities. IOP is not reimbursed by group or individuals session, it is a day rate for a minimum of 3 hours of services which are often a mix of therapeutic activities many of which justifiable well in excess of 12.

Department Response
This comment refers to Subsection (b)(11)(B) that specifies the size limitation of a group counseling session for day care habilitative services. For substance use disorder group counseling sessions to be effective there must be a limited number of participants.

Additionally, the lack of a group size limitation has been abused by some providers who have included up to forty participants in a group counseling session. This provision is necessary to prevent this practice, which falls below professionally recognized standards of care. (See ISOR page 6)

The limitation on group size applies only to group counseling sessions that are conducted as part of a beneficiary's receipt of day care habilitative services, which the commenter refers to as "IOP." Therapeutic services other than group counseling are not subject to the limitation.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
D. Definition of Relapse Trigger
Revise to say "that puts a beneficiary at risk of relapse"

Department Response
This comment refers to Subsection (b)(26) that defines the term "relapse trigger." However, CAADPE's comment was based on a draft version of the regulations that was initially shared with stakeholders prior to the Department initiating the emergency rulemaking process. (See ISOR page 3)

The commenter's suggestion to amend Subsection (b)(26) is not necessary since the regulations already incorporate the suggested language.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
E. Physical Exam Requirement Linked to Admission
CAADPE objects to a physical exam being linked to admission. To link to admission is to create a access barrier. Give at least 60 days to provide evidence of a physical. Access to physicals can take months, there must also be a provision beyond 60 days to demonstrate efforts to obtain there must also be reimbursed of the H&P in the event it cannot be obtain by primary care and must be conducted by the DMC medical director.

Department Response
CAADPE's comment was based on a draft version of the regulations that was initially shared with stakeholders prior to the Department initiating the emergency rulemaking process. (See ISOR page 3)

These emergency regulations, which specify the physical exam requirements under Subsection (h)(1)(A)(iv), do not require a beneficiary to have a physical exam prior to being admitted for treatment. Therefore, there is no link between obtaining a physical exam and admission to treatment that would cause an access barrier.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
F. Physical Exam Requirement
CAADPE objects to the requirement of a physical exam mandate. The levels of care simply do not justify this across the board requirement. It is not clinically justifiable, it will unnecessarily drive cost and impose access barriers. There isn't sufficient physician time available to meet this proposed mandate. A physical exam requirement should be based on identified medical need as indicated by presenting medical conditions identified in the self-history and assessment documents.

Any such requirement must be accompanied with a reimbursement for the added costs. Finally we should remember where we are trying to

get, and that is a system which allows other nonphysician clinicians of the healing arts to admit for DMC services.

Department Response
CAADPE's comment was based on a draft version of the regulations that was initially shared with stakeholders prior to the Department initiating the emergency rulemaking process. (See ISOR page 3)

These emergency regulations, which specify the physical exam requirements under Subsection (h)(1)(A)(iv), do not require a provider to perform a physical exam of a beneficiary. Since a physical exam is not required, there are no additional costs that should be reimbursed nor are there additional costs that would cause an access barrier.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
G. Timeframe to Conduct Physical Exam
CAADPE objects to the 30 day window, it cannot be met, more time is needed should this stand and there must be a process to show evidence of efforts to obtain. Many primary care clinics have 3, 4 and 5 month wait time for physical exams.

Department Response
CAADPE's comment was based on a draft version of the regulations that was initially shared with stakeholders prior to the Department initiating the emergency rulemaking process. (See ISOR page 3)

These emergency regulations do not require a provider to perform a physical exam of a beneficiary within a 30 day period. However, Subsection (h)(1)(A)(iii) requires a physician to review a beneficiary's personal, medical and substance use history within 30 days of the beneficiary's admission to treatment date. This was an existing requirement that was previously under Subsection (h)(1)(A)(iii)(b).

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
H. Face-to-Face Contact with Physician
CAADPE objects to the mandate for a face to face with the physician. Physician time is hard to come be, is costly and is not clinically justified in many cases. Why mandate unnecessary costly services. Again this should be tied to medical history and assessment. Example, patient has diabetes, liver disease, renal failure etc. this has added cost for MD time and for staff to coordinate follow up document etc, that must be reimbursed.

Department Response
CAADPE's comment was based on a draft version of the regulations that was initially shared with stakeholders prior to the Department initiating the emergency rulemaking process. (See ISOR page 3)

These emergency regulations do not require a beneficiary to have a face-to-face with a physician to determine medical necessity for services.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
I. Diagnosis by Licensed Professional of the Healing Arts
Or approve the diagnoses made by another qualified professional of the healing arts

Department Response
This comment refers to Subsection (h)(1)(A)(v) that specifies the requirements for diagnosis of a beneficiary.

The Department has proposed changes to this subsection to be consistent with the most recently approved State Plan Amendment, 13-038. (Supplement 3 to Attachment 3.1-A, Page 6a and Supplement 3 to Attachment 3.1-B, Page 4a.) and the commenter's request. The proposed changes are as follows:

Subsection (h)(1)(A)(v) has been amended to read "Diagnosis requirements" and includes Subsections (h)(1)(A)(v)(a) and (b).

Former Subsection (h)(1)(A)(v) was re-designated as Subsection (h)(1)(A)(v)(a) and specifies the diagnosis requirements for a physician.

Subsection (h)(1)(A)(v)(b) was added to clarify that a therapist, physician assistant or nurse practitioner may evaluate a beneficiary to diagnose whether the beneficiary has a substance use disorder. (Therapist as defined in Subsection (b)(29) includes licensed practitioners of the healing arts (LPHA).) However, it also requires a physician to approve each diagnosis that is performed by a therapist, physician assistant or nurse practitioner by signing and dating the beneficiary's treatment plan.

The Department made these additional changes available for a 15-Day Public Comment Period (from December 26, 2014 through January 9, 2015) and did not receive any additional comments.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
J. Diagnostic and Statistical Manual of Mental Disorders (DSM)
Or most currently available addition

Department Response
This comment refers to Subsection (h)(1)(A)(v) that specifies the diagnosis requirements including the version of the Diagnostic and Statistical Manual of Mental Disorders to be used.

The regulations did not change the version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) upon which physicians are to base their diagnoses. In order for the Department to transition providers to the latest version of the DSM, the Department must make changes to its infrastructure and engage in a significant outreach and education effort. The Department is working to transition the Drug Medi-Cal program to the most current version of the DSM but changing the DSM in these regulations would be premature.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
K. Timeframe of Physical Examination

See prior objections on exams, but this should read if older than 12 months

Department Response
This comment refers to Subsection (h)(5)(A)(ii) which specifies how a physician shall determine if it is medically necessary for a beneficiary to continue services. Specifically, Subsection (h)(5)(A)(2)(ii)(b) requires that documentation of a beneficiary's most recent physical exam should be considered when determining medical necessity.

The comment suggests that a physician's review include documentation of a physical exam if older than 12 months. However, this suggestion is inconsistent with Subsection (h)(1)(A)(iv)(a) that requires consideration of a physical exam if conducted within the 12 month period prior to the beneficiary's admission to treatment. Reviewing documentation of a physical exam conducted more than 12 months prior would not provide the physician with the current information needed to evaluate the beneficiary. (See ISOR page 11)

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
L. Face-to-Face Requirement
CAADPE objects to the face to face mandate for reasons already stated above

See prior objections on exams, but this should read if older than 12 months

Department Response
CAADPE's comment was based on a draft version of the regulations that was initially shared with stakeholders prior to the Department initiating the emergency rulemaking process. (See ISOR page 3) Subsection (h)(5)(A)(ii) in these emergency regulations requires a physician to determine whether continued services are medically necessary for each beneficiary and it does not require a physician to have a face-to-face meeting with a beneficiary. So, CAADPE's comment is not applicable.

It is unclear how this comment relates to this subsection, however, please see response above to Comment **K. Timeframe of Physical Examination.**

Commenter Name, Title, Organization and Date Comment Received

Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
M. Discharge Plan Timeframes
There must be time allowed for the discharge, we should give 30 days for transition and avoid an abrupt discharge which may be detrimental to the patient .

Department Response
This comment was made in relation to Subsection (h)(5)(A)(iii), which requires the beneficiary to be discharged from treatment if a physician determines that continuing services is not medically necessary. However, the discharge of a beneficiary is governed by Subsection (h)(6). Specifically, Subsection (h)(6)(iii) provides that a discharge plan shall be prepared within the 30 day period prior to the date of the last face-to-face treatment with the beneficiary. Therefore, the commenter's suggestion that the provider be given 30 days to prepare the beneficiary for discharge is already incorporated in the regulations.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter # 4
Jennifer on behalf of California Association of Alcohol and Drug Program Executives (CAADPE)
9/8/14

Comment Topic and Summary
N. Audit Documentation
CAADPE objects to adding this provision the facts are the facts and if they are presented after a site visit they need to be considered. There are sometimes very legitimate reasons for files to not be available.

Department Response
This comment refers to Subsection (l) which specifies that the Department shall review a sampling of beneficiary and other provider records as part of a post payment utilization review. Subsection (l) further provides that the Department shall not consider records provided to the Department after Department personnel have left the provider's premises. As stated in the ISOR (See page 20), this provision was necessary to prevent fraud through the fabrication of documents.

There is no legitimate reason why a provider has not kept its individual patient records up-to-date.
Providers should not need extensive time to find documents that they are required to keep in each beneficiary's individual patient record per

Subsection (g)(1). In addition, Post Service Post Payment (PSPP) reviews are scheduled in advance, (typically two to three weeks in advance) so providers have time to review their patient records before Department personnel arrive and locate any missing documents. Furthermore, PSPP reviews are typically conducted over a two to three day timeframe and providers can find documents not in a beneficiary's file while reviewers are on site.

In the past, providers have sent documents to the Department that were obviously fabricated after the reviewers left the provider's site. Therefore, the Department will not accept documents after the reviewers have left the provider site.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #5
Robert Oakes Executive Director
County Behavioral Health Directors Association of California
9/4/14

Comment Topic and Summary
A. Definition of Physician
Pg. 4, Section (13). Language was deleted requiring physicians to be licensed in California; however, the same language was retained in section (21) on page 5. This inconsistency needs to be corrected.

Department Response
This comment was made in relation to Subsection (b)(13) that defines the term "intake." Language was deleted from the definition of "intake" because it is duplicative to language used to define "physician" in Subsection (b)(21).

The definition of "physician" includes the requirement that a physician (or Osteopath) be licensed to practice medicine in the State of California. This definition applies every time the word physician is used in the regulations.
Therefore, the language deleted from Subsection (b)(13) "licensed to practice in the State of California" is not necessary since this requirement is included in the definition of physician in Subsection (b)(21).

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #5
Robert Oakes Executive Director
County Behavioral Health Directors Association of California
9/4/14

Comment Topic and Summary
B. Definition of Relapse
Pg. 6, Section (25). The definition of relapse as a "single" instance of drug use is unnecessarily restrictive. A client may have a period of relapse that entails multiple instances of drug use.

Department Response
This comment refers to Subsection (b)(25) that defines the term "relapse." The definition of relapse includes both "a single instance of a beneficiary's substance use" and "a beneficiary's return to a pattern of substance use." Therefore, the definition of "relapse" already incorporates the commenter's suggestion, because "a beneficiary's return to a pattern of substance use" would include multiple instances of drug use.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #5
Robert Oakes Executive Director
County Behavioral Health Directors Association of California
9/4/14

Comment Topic and Summary
C. Definition of Therapist
Page 6, Section (29). The definition of "therapist" should be expanded to include a Licensed Professional Clinical Counselor (LPPC).

Department Response
This comment refers to Subsection (b)(29) that defines the term "therapist." Licensed Professional Clinical Counselors are licensed to provide mental health services, but not substance use disorder services, and substance use disorder services are outside their scope of practice. (See Business and Professions Code Sections 4999.20(a)(2) and 4999.30)

In addition, pursuant to Welfare and Institutions Code Section 14124.24(a), substance use disorder services offered by the DMC program shall be consistent with the California State Plan and State Plan Amendments. (See ISOR page 8) The most recently approved State Plan Amendment, 13-038, (SPA) authorizes specified licensed/registered providers to perform the functions of a therapist. (See Supplement 3 to Attachment 3.1-A, Pages 5, 6 and 6a and Supplement 3 to Attachment 3.1-B, Pages 3, 4 and 4a.) Licensed Professional Clinical Counselors are not authorized in the SPA to perform the functions of a therapist and therefore, Licensed Professional Clinical Counselors are not included in the definition of therapist.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #5
Robert Oakes Executive Director
County Behavioral Health Directors Association of California
9/4/14

Comment Topic and Summary
Page 12, Section (g)(1)(B)(iii). Compliance with subsection (h)(4) requires a minimum provider beneficiary contact and that the program provide at least two (2) counseling sessions every thirty (30) days except where physician determines (a) fewer are appropriate; or (b) the beneficiary is progressing in the treatment plan. The regulations need to more clearly define "counseling sessions." Are they referring to individual or group counseling-- or a combination of both? Greater specificity is needed for counties to know if they are in compliance.

Department Response
This comment was made in relation to Subsection (g)(1)(B)(iii) which cross references to Subsection (h)(4) regarding minimum provider and beneficiary contact. The Department did not revise this section of the regulations because it has not been problematic. Counties and providers have appropriately implemented this portion of the regulations as two group counseling sessions, two individual counseling sessions or one of each, subject to the requirements and limitations applicable to each modality and as prescribed on each beneficiary's treatment plan.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #5
Robert Oakes Executive Director
County Behavioral Health Directors Association of California
9/4/14

Comment Topic and Summary
E. Physical Exam Requirements
Pages 14-15, Section (h)(1)(A)(iv)(a). The requirements for physical examination will increase the duties of physicians to assure that the physical health conditions of the beneficiary are addressed and the beneficiary is safe for treatment. There are also additional documentation requirements. This change will impose significant additional costs on counties and programs.

Department Response
This comment refers to Subsection (h)(1)(A)(iv), which specifies the physical exam requirements.

Prior regulations required either a physical exam (Subsection (h)(1)(A)(iii)(a)) or review of documentation of a beneficiary's physical exam (Subsection (h)(1)(A)(iii)(b)). These requirements have not changed but were relocated under Subsections (h)(1)(A)(iv)(a) and (b).

Prior regulations under Subsection (h)(1)(A)(iii)(b) also required a physician to complete a physical exam waiver if it was determined that a physical exam was not required. The current regulations do not require a physician to conduct a physical exam of a beneficiary; therefore the waiver option was eliminated. The elimination of the waiver requirement decreases the documentation requirements for a physician.

The current regulations provide that if the requirements under Subsections (h)(1)(A)(iv)(a) and (b) are not met, then the provider is required to include obtaining a physical exam as a treatment plan goal. Including a physical exam as a treatment plan goal would not increase counties and providers costs, as the development of a treatment plan is already required under Subsection (h)(2).

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #5
Robert Oakes Executive Director
County Behavioral Health Directors Association of California
9/4/14

Comment Topic and Summary
F. Role of an LPHA
Page 15, (v). CADPAAC and CMHDA propose specific changes to this subsection to assure that the regulations conform to the Drug Medi-Cal State Plan Amendment 13-038 – specifically the requirements outlined in Supplement 3 to Attachment 3.1-A, Limitation on Services 13.d.5 Substance Use Disorder Treatment Services. The regulations as written appear to establish a higher standard for physician direction than is specified in the approved Medi-Cal state plan. The state plan clearly indicates that an LPHA can diagnose a substance related disorder subject to physician approval. The regulations should reflect the same language as is in the federally approved state plan. This subsection should be amended to say:

The physician or licensed practitioners of the healing arts (LHPA) within their scope of practice shall evaluate each beneficiary to diagnose whether the beneficiary has a substance use disorder, within thirty (30) calendar days of the beneficiary's admission to treatment date. The diagnosis shall be based on the applicable diagnostic code from the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition, published by the American Psychiatric Association. The physician shall document or document approval for the basis for the diagnosis on the treatment or service plan in the beneficiary's individual patient record.

Department Response

This comment refers to Subsection (h)(1)(A)(v) that specifies the requirements for diagnosis of a beneficiary.

The Department has proposed changes to this subsection to be consistent with the most recently approved SPA, 13-038. (Supplement 3 to Attachment 3.1-A, Page 6a and Supplement 3 to Attachment 3.1-B, Page 4a.) and the commenter's proposal. The proposed changes are as follows:

Subsection (h)(1)(A)(v) has been amended to read "Diagnosis requirements" and includes Subsections (h)(1)(A)(v)(a) and (b).

Former Subsection (h)(1)(A)(v) was re-designated to Subsection (h)(1)(A)(v)(a) and specifies the diagnosis requirements for a physician.

Subsection (h)(1)(A)(v)(b) was added to clarify that a therapist, physician assistant or nurse practitioner may evaluate a beneficiary to diagnose whether the beneficiary has a substance use disorder. (Therapist as defined in Subsection (b)(29) includes licensed practitioners of the healing arts (LPHA.)) However, it requires a physician to approve each diagnosis that is performed by a therapist, physician assistant or nurse practitioner by signing and dating the beneficiary's treatment plan.

The Department made these additional changes available for a 15-Day Public Comment Period (from December 26, 2014 through January 9, 2015) and did not receive any additional comments.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #5
Robert Oakes Executive Director
County Behavioral Health Directors Association of California
9/4/14

Comment Topic and Summary
G. Discharge Plan Timeframes
Page 23, A(b)(ii). This subsection reads: The discharge plan shall be prepared within thirty (30) calendar days prior to the date of the last face-to- face treatment with the beneficiary. CADPAAC and CMHDA propose the following alternative language:

The discharge plan shall be initiated within the thirty (30) calendar days prior to the last expected face-to-face treatment with the beneficiary.

Rationale: (1) preparing a plan 30 days before discharge sends a message to the client they are done with treatment, thus decreasing their motivation to return; and (2) with this client population it is difficult to know the exact date of the last face-to-face treatment session, so changing the language allows the flexibility to get as close as possible to meeting this new requirement.

Department Response
This comment refers to Subsection (h)(6)(A)(ii) that specifies the timeframe for the development of a beneficiary's discharge plan.

Providers can bill for individual counseling sessions to prepare and plan for a beneficiary's discharge from treatment. Department auditors have noted some providers bill for discharge planning sessions that did not occur. In other instances, providers bill for individual discharge planning counseling sessions when the counseling session is not for the purpose of discharge planning, but rather an unauthorized purpose. (Individual counseling is allowed for intake, crisis intervention, collateral services, treatment planning, and discharge planning only.) The commenter's proposed language would perpetuate this abuse because providers would not have to produce a discharge plan.

The Department does not agree that having a beneficiary prepare a discharge plan 30 days before his/her anticipated discharge date creates a disincentive for the beneficiary to return to treatment. Currently, beneficiaries are supposed to be discharged when they have completed their treatment plan goals. Treatment plans include target dates for completion of treatment plan goals, so beneficiaries know approximately when they will be discharged. This has not created a disincentive for beneficiaries to continue in treatment, so having beneficiaries prepare discharge plans 30 days before their planned discharge should not create a disincentive.

The Department understands the commenter's second rationale for the proposed alternate language to be that it is sometimes difficult to know the exact date of the last face-to-face treatment session because some beneficiaries abandon treatment prior to completion. Subsection (h)(6)(A) states that if a provider loses contact with a beneficiary the requirement to prepare or complete a discharge plan does not apply, so it should address the commenter's concern.

Commenter Name, Title, Organization and Date Comment Received
Comment Letter #5
Robert Oakes Executive Director
County Behavioral Health Directors Association of California
9/4/14

Comment Topic and Summary
H. Audit Documentation
Pages 27-28, (l). Not allowing documents to be submitted once State auditors leave the premises is unreasonable.

Audits occur without advance notice. How is an agency to gather the requested data that may be stored (or is years-old) if the State leaves the premises?

Normal audit procedures allow for a response and supporting documentation to be provided shortly thereafter. This revised language implies

that State auditors are done and that disallowances stay once the auditors depart if documentation is not available, which will lead to many cases unnecessarily being appealed.

Department Response
This comment refers to Subsection (l) which specifies that the Department shall review a sampling of beneficiary and other provider records as part of a post payment utilization review.
Subsection (l) further provides that the Department shall not consider records provided to the Department after Department personnel have left the provider's premises. As stated in the ISOR (Page 20), this provision was necessary to prevent fraud through the fabrication of documents.

Providers should not need extensive time to find documents that they are required to keep in each beneficiary's individual patient record per Subsection (g)(1). While the Department is authorized to conduct unannounced visits, post service post payment (PSPP) reviews are scheduled in advance, (typically two to three weeks in advance) so providers have time to review their patient records and locate any missing documents before Department personnel arrive. While providers are required to retain individual patient records for three years, in practice, PSPP reviews focus on reviewing the prior fiscal year, so providers are not required to gather files that are older than a year.

Furthermore, PSPP reviews are typically conducted over a two to three day timeframe and providers can find documents not in a beneficiary's file while reviewers are on site.

For documents that have been stored at a different location other than the clinic site, the provider may arrange to bring the documents to Department personnel while on site within the two to three day review or the Department can relocate the review to the site where the documents are located.

In the past, providers have sent documents to the Department that were obviously fabricated after the reviewers left the provider's site. Providers have adequate time to find missing documents before and during the PSPP review. Therefore, the Department will not accept documents after the reviewers have left the provider site.

Commenter Name, Title, Organization and Date Comment Received
Exhibit A Comment Letter
Submitted at Hearing
John de Miranda Associate Director Door to Hope
9/5/14

Comment Topic and Summary
A. Physical Exam Requirement
The Medi-Cal expansion in California will take a major step in providing treatment for those in need but the emergency regulations now under consideration will place a significant financial burden on the organizations providing this service.

In the eleven years that Door to Hope has provided Outpatient Drug Medi-Cal services we have lost money each year. Despite this our volunteer Board of Directors, the Monterey County Behavioral Health Department and the executive leadership of our organization all support offering this service because of the demonstrated need (now increased with the Medicaid expansion), and because we are the only Outpatient Drug-free provider in Monterey County.

Last fiscal year we admitted 354 Drug Medi-Cal clients to our outpatient program. We expect that a greater number will be admitted this year because of the expansion.

The requirement to require a physical examination is quite understandable and entirely in keeping with appropriate care practices, but creates a financial burden on programs like ours that are already financially stretched.

At this point we cannot estimate what percentage of these clients will need a current physical examination nor what percentage of these clients will require a physical examination that we will provide. A guesstimate at this point may be 10- 15%. In order to pay a physician to provide this service we estimate that the cost for a very conservative 35-52 clients per year would be approximately $6,125 - 9,100 at $175.00 per examination.

If the regulations are to become permanent we would respectfully request the some rate increases occur to lessen the financial impact.

Department Response
This comment refers to Subsection (h)(1)(A)(iv). The regulations do not require providers to perform a physical examination of beneficiaries. Subsection (h)(1)(A)(iv)(b) states in part that "As an *alternative* to complying with paragraph (a)…the physician, a registered nurse practitioner or a physician's assistant *may* perform a physical examination of the beneficiary…." Therefore, a physical examination is not required and a provider can either review documentation of a beneficiary's recent physical examination or instead make obtaining a physical examination a treatment plan goal for the beneficiary.

Furthermore, the prior version of the regulations required a physician to perform a physical examination of each beneficiary upon admission to treatment, unless the physician determined it was not necessary and completed a physical examination waiver. If the physician determined that a physical examination was warranted, the program physician would conduct the physical examination.
If the program is estimating that it will perform a physical examination of 10-15% of beneficiaries entering treatment, there should be no additional costs as they should have been performing these physical examinations under the previous regulatory requirement as the physician would have had no basis for signing a physical examination waiver.

Therefore under these regulations, there should be no increase in provider costs related to providing a beneficiary a physical examination since the physical examination requirement is now optional and the physical examination can be performed by the beneficiary's primary care provider. Therefore, the regulations could in fact reduce the provider's costs.

Commenter Name, Title, Organization and Date Comment Received
Verbal Testimony by John de Miranda Associate Director Door to Hope
9/5/14

Comment Topic and Summary
Mr. Miranda's verbal comment matched his comment letter above with the addition of the following comment:

If the regulations are to become permanent we would respectfully request the some rate increases occur to lessen the financial impact, or the regulations make an explicit statement that the regulations that a provider will not be financially penalized if beneficiaries complete treatment without achieving the goal of having received a physical examination.

The regulations in that area are cloudy and vague, in my reading and our reading of it; and there is that opportunity to kind of avoid having to provide a physical examination by making it a treatment plan goal. Our fear is that those clients who do not achieve that goal prior to exiting treatment will result in financial liability and penalization to the program.

Department Response
Please see the prior response to Mr. de Miranda's written comments.

Currently and previously, DMC providers were required to develop treatment plan goals that address various problems that a beneficiary may be experiencing, as a result of, or which impact their substance use. Providers are not financially penalized when a beneficiary does not complete all of his/her treatment plan goals. The goal of obtaining a physical examination is no different than any other goal on a beneficiary's treatment plan and failure to complete it will not result in the provider being financially penalized.