Probably the most important part of the infrastructure to change is the Medicaid (MediCal in California) system. Everywhere I go the number one issue people want improved is Medicaid/MediCal. Unfortunately, it is also one of the most difficult parts to access and one of the most prone to influence by Washington politics usually insensitive to our needs. To make things worse Medicaid is administrated by a multilayer system of auditors, rule makers and interpreters, and payment authorizers none of whom really have the power to improve the system, but all of whom have the power to destroy a program. It is also infected with fraudulent claims.

We had a delegation from Washington tour the Village so I wrote this letter trying to get them to do something about MediCal.

Mark Ragins' MediCal/Medicaid Thoughts

(2006)

We're not so much interested in you exploring the details of our particular situation to help us individually since we've found a number of ways of thriving and frankly many of our solutions aren't generalizable. What we are interested in is ways MediCal/Medicaid inhibits recovery work generally and how it could be changed globally to facilitate recovery.

For example, if we were to design a "recovery option" for Medicaid, what would it look like? Or if we were to design a mental health carve out managed care program to promote recovery what would it look like? And who would be eligible?

Here's a list of issues our daily experience would suggest are relevant:

1) Presently eligibility is diagnostically based. This makes it very difficult to use MediCaid for the numerous people who don't believe they have a mental illness as well as those with complex, unclear diagnoses. A change that would address this would be to change eligibility to be "disability/need/adverse events" based.

2) Presently the level of service approved is based on acuity of illness. This is problematic for people who have severe problems with skills and supports even when their symptoms aren't acute. It is also problematic for people whose symptoms have been reduced coercively who aren't engaged in ongoing treatment. This could be addressed by including stage of recovery in the process of service authorization.

3) Presently only a limited set of services and a limited set of service locations are approved. Very valuable and cost effective treatments ranging from crisis residential treatment to jail outreach to passes from the hospital to arrange a place to live and link with community providers are excluded. This could be addressed by expanding the list of services or converting to a capitated system.

4) Presently only a limited set of providers can provide services. Quite a number of services can be provided competently by people without licenses (For example, peer support, psychoeducation, street

outreach, and substance abuse treatment). There are also widespread shortages of various licensed personnel. This could be addressed by expanding the ways of demonstrating competency to deliver specific services.

5) Presently services must be directed towards symptom reduction (or - in a substantial improvement in the rehab option - towards reducing symptom barriers in the way of goals). We still cannot bill for services that directly assist with goals without addressing symptoms (for example getting a birth certificate, taking someone to a job interview, or finding them an apartment). This could be addressed by allowing services to be directed towards goal attainment (there could be a set of approved quality of life goals). This shift runs the political risk of moving our services from medical services to poorer funded social services. To avoid that, goal oriented services must be approved within the overall integrated treatment context, not as an isolated fee-for-service treatment.

6) Presently, community based services are authorized on an individual basis and each contact must be laboriously documented. When services are offered as a coordinated, integrated package each one must be documented, justified, and billed for separately - a process that consumes almost one third of staff time. This could be addressed by approving packages of services or levels of service and requiring summary documentation.

7) Accountability in our present system is only for process - what did we do and for how long and why - rather than for outcomes. This leads to effective and ineffective interventions being supported equally, and leads to an incredible array of rules and audits trying to reduce fraud and create accountability while actually only insuring the creation of lengthy chart notes. Programs could be instead held accountable for aggregate outcomes using either quality of life measures and/or Milestones of Recovery. Maintaining continuity of care, avoiding drop outs, and working proactively and preventatively instead of working in a reactive crisis mode would be indirectly rewarded by this approach.

8) Presently the documentation requirements - including comprehensive intake assessments, service plans, informed consent – are only really appropriate for the subset of people who are "self-responsible", but not for those who are "unengaged", or "engaged, but poorly self-coordinating," although a preponderance of people with serious mental illnesses are in the latter two categories. This could be addressed by having sets of requirements tailored to the person's level of participation in treatment.

At some point Medicaid is going to need to make changes like these to facilitate the recovery vision. We would be interested in collaborating on practical work on these issues.

Thank you.

It turned out even though they were from Washington, the delegation didn't have any power over MediCal. (It later turned out that even SAMHSA had a liaison to Medicaid for a decade and didn't get anywhere either.) But they did tell me that the people at the Community Health Clinic working with diabetics had the same complaints we did, which got me to thinking that the issue could be framed as

moving from treating acute illnesses to chronic illnesses without running the usual risks of separating ourselves from the rest of medicine (this eventually led to "We treat chronic Illnesses, Don't We?"). I think that a MediCal policy that had a separate set of rules for people for acute and chronic illnesses has promise.

The Washington people also told me that very little is actually in the Federal laws – it's the negotiation between the feds and the state that's crucial, along with trying to avoid the narrowing of interpretation of the rules "just to be safe" that occurs as it moves down from feds to state to counties to programs. I now think that the most promising approach to reforming Medicaid is to create a high profile state negotiating team in California to work with the feds to design a "Recovery Option MediCal" that could also be a model for other states.