




# DMC-ODS at the Starting Blocks

Insights from Phase I Counties

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A study for the **California Senate Office of Research**  
on the expansion of substance use treatment under California's Medi-Cal 2020 waiver



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## Table of Contents

<b>I. EXECUTIVE SUMMARY</b>	<b>5</b>
<b>II. ABOUT THIS REPORT</b>	<b>11</b>
PREFACE	11
STUDY OBJECTIVES	11
METHODS	12
TERMINOLOGY	13
<b>III. SUBSTANCE USE AND THE MEDICAID POPULATION</b>	<b>14</b>
SUBSTANCE USE DISORDERS IN THE U.S. AND CALIFORNIA	14
SUBSTANCE USE DISORDERS AMONG MEDICAID BENEFICIARIES	14
SUBSTANCE USE TREATMENT AND THE HEALTH CARE DELIVERY SYSTEM	14
<b>IV. MEDI-CAL 2020 AND THE DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM</b>	<b>16</b>
THE PATH TO REFORM	16
OUTLINE OF DRUG MEDI-CAL WAIVER PROVISIONS	19
WAIVER GOALS	19
SUMMARY OF WAIVER PROVISIONS	19
IMPLEMENTATION PROCEDURES AND TIMELINES	21
PHASED ROLLOUT	21
IMPLEMENTATION PREREQUISITES	22
<b>V. THE DMC-ODS TRANSFORMATION</b>	<b>24</b>
OPPORTUNITY TO IMPROVE SUD CARE	24
OFFERING AN EVIDENCE-BASED CONTINUUM OF CARE	25
MANAGING CARE VIA AN ORGANIZED DELIVERY SYSTEM	30
OVERVIEW OF CHALLENGES	33
<b>VI. STRUCTURAL BARRIERS TO WAIVER SUCCESS</b>	<b>37</b>
NAVIGATING FINANCIAL RISK	37
SUCCESSFUL IMPLEMENTATION DEPENDS ON ADEQUATE SERVICE PAYMENTS.	38
UNCOVERED COSTS EXACERBATE FINANCIAL UNCERTAINTY.	41
ENSURING NETWORK ADEQUACY	45

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DIFFICULTY RECRUITING AND RETAINING SUD PROVIDERS MAY LEAVE GAPS IN THE CARE CONTINUUM.	45
SHORTER LENGTHS OF STAY IN RESIDENTIAL TREATMENT CREATE AN URGENT NEED FOR RECOVERY RESIDENCES.	49
MANY COUNTIES ARE UNABLE TO OFFER SUD TREATMENT TARGETED TO YOUTH.	51
<b>ALIGNING POLICY WITH CLINICAL PRACTICE</b>	<b>54</b>
DMC DOCUMENTATION REQUIREMENTS DO NOT REFLECT CLINICAL BEST PRACTICES.	54
STANDARDIZED INTAKE INTO AN ODS MUST PRESERVE TREATMENT ON DEMAND.	56
MULTIPLE FUNDING STREAMS AND MANAGED CARE STRUCTURES MAY UNDERMINE CARE INTEGRATION.	57
<b>VII. CONSIDERATIONS FOR MONITORING SYSTEM PERFORMANCE</b>	<b>59</b>
<b>MECHANISMS FOR MONITORING DMC-ODS PERFORMANCE</b>	<b>59</b>
SUMMARY OF ASSESSMENT ACTIVITIES	59
STATUS OF EQR AND PROGRAM EVALUATION	61
<b>CONSIDERATIONS FOR MONITORING AND OVERSIGHT</b>	<b>62</b>
NEED FOR DEFINED STANDARDS FOR TIMELY ACCESS TO CARE	62
ALIGNMENT WITH SMH EQRO PROCESS	65
<b>VIII. STRATEGIES TO SUPPORT FULL IMPLEMENTATION</b>	<b>66</b>
REDUCE FINANCIAL UNCERTAINTY & INCREASE CAPACITY	66
ENHANCE COORDINATION ACROSS MEDI-CAL PROGRAMS	69
FACILITATE CONTINUOUS FEEDBACK	72
<b>APPENDIX A: KEY INFORMANTS</b>	<b>73</b>
<b>APPENDIX B: ASAM DIAGNOSTIC CRITERIA &amp; CONTINUUM OF CARE</b>	<b>75</b>
<b>APPENDIX C: SUMMARY DEFINITIONS OF SUD TREATMENT SERVICES</b>	<b>77</b>
<b>APPENDIX D: FREQUENTLY USED ACRONYMS</b>	<b>79</b>
<b>ENDNOTES</b>	<b>82</b>

## I. Executive Summary

There are roughly 1.2 million Medicaid beneficiaries in California with substance use disorders (SUDs), but 10% or fewer receive appropriate treatment.<sup>1</sup> In August of 2015 California received federal approval via Section 1115 waiver for a landmark expansion and reorganization of Medicaid SUD services. This report examines the rollout of the state's Drug Medi-Cal Organized Delivery System (DMC-ODS).<sup>2</sup> It is an early implementation study that employs regulatory analysis, literature review, and key informant interviews to:

- Illustrate the delivery system transformation that must occur in counties that opt into the DMC-ODS pilot.
- Describe how certain structural barriers within Drug Medi-Cal will impact waiver implementation.
- Explore strategies to address these barriers and support waiver success.

The San Francisco Bay Area is the first of five regions that will implement the waiver. Consequently, this study focuses on the experiences of Bay Area counties. Ideally, the insights captured here will prove useful to policymakers tasked with overseeing and administering Drug Medi-Cal.

## The Drug Medi-Cal Organized Delivery System Transformation

### DMC-ODS Provisions at a Glance

Requirements for opt-in counties, adapted from Medi-Cal 2020 Special Terms and Conditions and CA DHCS publications

- **Evidence-based continuum of care**
  - New covered benefits & use of ASAM diagnostic and treatment framework
- **Increased local control and accountability**
  - Counties responsible for selective contracting, provider oversight, county-specific interim rates
- **Managed care via an organized delivery system**
  - Utilization controls, beneficiary protections, standardized practices, coordinated care transitions
- **Enhanced coordination/integration with other systems of care**
  - Consistent, documented collaboration with physical & mental health providers
- **New mechanisms for quality assurance and oversight**
  - Standardized quality improvement processes, formal program evaluation, external quality review
- **Special considerations for criminal-justice involved population**
  - Longer lengths of stay, guarantees of eligibility

The DMC-ODS is intended to “demonstrate how organized SUD care improves outcomes for DMC beneficiaries while decreasing other system health care costs.”<sup>3</sup> Counties that opt-in will implement the above provisions during the initial five-year waiver period. **This report highlights two changes counties must undertake that represent true transformations in the way SUD care is delivered and require significant investments of time, money, and resources.** These are:

1. **Offering an evidence-based continuum of care.**
2. **Managing care via an organized delivery system.**

**Offering an evidence-based continuum of care.** Under the waiver, counties may receive federal matching funds for services and activities not covered under California’s existing Medicaid State Plan. Beneficiaries in opt-in counties will be entitled to an expanded menu of SUD treatment services based on an industry-standard diagnostic and treatment framework developed by the American Society of Addiction Medicine (ASAM). Beneficiaries in opt-out counties will continue to receive State Plan services.

The table below illustrates DMC services guaranteed under California’s State Plan, services guaranteed under the DMC-ODS, and the corresponding levels of care within ASAM’s treatment continuum. (See Appendix C for summary definitions of each service type.)

<b>DMC State Plan</b>	<b>DMC-ODS: Opt-In</b>	<b>ASAM Levels of Care</b>
Outpatient Drug Free Treatment	Outpatient Services	1.0
Intensive Outpatient Treatment	Intensive Outpatient Services	2.1
Naltrexone Treatment (oral for opioid dependence or with treatment authorization for other)	Naltrexone Treatment (oral for opioid dependence or with treatment authorization for other)	N/A: component of multiple levels
Narcotic Treatment Program	Narcotic Treatment Program	Includes MAT & outpatient counseling
Perinatal Residential SUD Services (IMD exclusion)	Residential Services (not restricted by IMD exclusion or limited to perinatal)	3.1, 3.3, 3.5 (one level required)
Detoxification in a Hospital (with treatment authorization)	Withdrawal Management	1-WM, 2-WM, 3.2-WM (one level required)
	Recovery Services	N/A
	Case Management	component
	Physician Consultation	N/A
	❖ Partial Hospitalization (optional)	2.5
	❖ Additional Medication Assisted Treatment (optional)	component

\*Table adapted in part from a graphic by Harbage Consulting: “CHCF Legislative Staff Briefing on DMC-ODS Pilot Program,” Harbage Consulting, (Sacramento, CA: Presentation to California Legislative Staff, December 2015).

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**Managing care via an organized delivery system.** Within many California counties, safety net SUD program operations are largely de-centralized and non-standardized. A client's path through treatment is highly dependent upon how, and where, he accesses care. There may be little communication between SUD care providers, or between SUD providers and physical and mental health providers. This must change under the waiver. County SUD treatment programs will act as Medicaid managed care entities and administer SUD health benefits via organized delivery systems. Each opt-in county must:

- **Standardize processes for client intake/assessment, treatment planning, and care transitions**, e.g. by operating a 24-hour beneficiary access line and ensuring all SUD clients are screened using ASAM's diagnostic criteria.
- **Establish utilization controls**, e.g. treatment authorization requests will be required for clients to enter residential treatment.
- **Ensure coordination of care** between SUD levels of care and with non-SUD treatment providers.
- **Function as unified, data-driven systems** by regularly reviewing access and quality-related data at the county level and participating in external quality reviews and a formal program evaluation.

**At the time of this report, no California counties had begun to deliver or bill for DMC-ODS services.** Nine counties had signaled intent to opt-in to the waiver by submitting implementation plans for approval by the California Department of Health Care Services (DHCS) and the federal Centers for Medicare and Medicaid Services (CMS). In addition to plan approval, prerequisites for full implementation include DHCS approval of county-specific interim service payment rates and the execution of state-county managed care contracts.

## Structural Barriers to Waiver Success

Key informants agreed that to succeed under the waiver the state must overcome what one provider called "a history of benign neglect" of SUD treatment within its health care safety net. SUD services have been underfunded at the state level. Access to treatment has been dependent on each county's ability to offer services paid for with non-DMC funding sources. **To move beyond Drug Medi-Cal's historical limitations, the state, its counties, and SUD stakeholders must address barriers to success that are deeply rooted in the structure and financing of Medi-Cal.** They must:

1. **Navigate financial risk.**
2. **Ensure network adequacy.**
3. **Align policy with clinical practice.**

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### Key Findings: Navigating Financial Risk

- **Successful implementation depends on adequate service payments.** Counties view the opportunity to negotiate county-specific interim payment rates as a chance to reverse a long history of overly low rates and establish parity of reimbursement for mental health and substance use services. Failure to approve adequate rates will negatively impact the ability of counties to retain DMC providers and meet demand for SUD services.
- **Uncovered costs exacerbate financial uncertainty for counties.** The limited administrative overhead payments counties may claim through Drug Medi-Cal will not cover the expenses necessary to transition into providing managed care through an organized delivery system. (These include start-up costs for new providers, compliance/expansion costs for existing providers, costs associated with administrative and infrastructure improvements, and the room and board portion of residential treatment). Administrators from counties where SUD services have been historically well-funded by non-DMC sources are more confident that their counties will be able to cover necessary costs and provide the non-federal share of DMC-ODS payments.

### Key Findings: Ensuring Network Adequacy

- **Difficulty recruiting and retaining SUD providers may leave gaps in the care continuum.** Opt-in counties trying to expand provider networks must contend with a nationally recognized shortage of SUD treatment professionals. Training and development of the existing workforce is critical but will only be a good investment if SUD staff retention improves. Practitioners expect provider organizations to continue a trend toward consolidation, but fear that the loss of small community providers will exacerbate existing challenges with delivering culturally inclusive care.
- **Shorter lengths of stay in residential treatment create an urgent need for recovery residences.** The waiver limits residential lengths of stay to 90 days. Clients are then meant to “step down” into recovery residences if they do not have another source of stable housing. Historically, many clients in safety net residential treatment have been homeless. Longer residential stays have substituted for more permanent housing. California’s housing crisis will make it extremely difficult to meet the needs of this population.
- **Many counties are unable to offer SUD treatment targeted to youth.** Medi-Cal-eligible youth are entitled to all medically appropriate care within the SUD continuum. However, most counties have few SUD treatment programs targeted to the unique needs of young people. Notably, very few counties offer residential treatment for youth. Youth-specific services must be expanded to meet waiver requirements.



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## Key Findings: Aligning Policy with Clinical Practice

- **DMC documentation requirements do not match clinical best practices.** Current DMC documentation requirements are not well-aligned with the ASAM continuum of care and do not reflect an understanding of SUD as a chronic condition. At best, providers face increased administrative burden. At worst, compliance begins to dictate patient care.
- **Standardized intake into an ODS must preserve treatment on demand.** SUD providers are concerned that steering clients through centralized intake hubs to standardize screening and placement may delay access to treatment. Counties are conscious of the importance of facilitating treatment on demand and will adopt different strategies for client intake based on their existing system characteristics.
- **Multiple funding streams and managed care structures may undermine care integration.** The waiver creates a third managed care structure within Medi-Cal. California's carve outs of SUD and SMI complicate efforts to improve care integration under the DMC-ODS and within Medi-Cal generally. Lack of I.T. capabilities and concerns about data privacy regulations governing the exchange of SUD health information are also barriers to waiver integration goals.

## Mechanisms for Monitoring DMC-ODS Performance

Mechanisms for monitoring DMC-ODS performance under the waiver include:

- Ongoing county monitoring and quality improvement activities.
- Annual external quality reviews by an independent review organization.
- Triennial compliance reviews by DHCS.
- Statewide program evaluation by researchers with UCLA's Integrated Substance Abuse Programs.

For those who will participate in these activities—and for policymakers wishing to engage in waiver oversight—important considerations include:

1. **Need for defined standards for access to care.** The waiver does not specify statewide standards for timely access to SUD services. DHCS should prioritize the establishment of statewide benchmarks for access and quality and sanction counties that fall short. Meanwhile, the external quality review process must be used effectively to detect whether counties are tracking timeliness and meeting self-imposed access standards.
2. **Alignment with the external quality review process for county mental health plans.** DHCS has prioritized streamlining the external quality review processes for county Specialty Mental Health (SMH) and Drug Medi-Cal managed care plans in order to minimize administrative burden. But as long as county mental health and SUD departments operate under separate financing and administrations, it will be difficult to combine the reviews.

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## Strategies to Support Full Implementation

The threats to waiver implementation explored in this report are “known issues” within Drug Medi-Cal that may ultimately impede statewide waiver performance. **Policymakers and administrators who wish to support the success of the DMC-ODS can seek feasible, incremental strategies to begin eroding entrenched regulatory and financial obstacles. Recommendations revolve around three key strategies:**

### 1. Reduce financial uncertainty & increase capacity.

- Raise the ceiling for county-specific interim payment rates.
- Fast-track efforts to set a permanent base for the Behavioral Health Subaccount.
- Fund DHCS personnel requests, particularly for SUD clinical positions.
- Steer foundation funding to high-impact areas like provider training, I.T. capacity-building, and service gap assessment.
- Explore options for state funding of county-level personnel and data infrastructure development.

### 2. Enhance coordination across Medi-Cal programs.

- Convene health care and housing stakeholders for collective problem-solving around housing for homeless Medi-Cal beneficiaries.
- Explore options to pilot combined funding for Specialty Mental Health and Drug Medi-Cal.
- Promptly apply “lessons learned” from SMH oversight to DMC oversight.

### 3. Facilitate continuous feedback.

- Continue to use foundation resources to engage diverse community stakeholders.
- Incorporate county, provider, and beneficiary testimony into legislative hearings on DMC-ODS funding, access, and quality.

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## II. About This Report

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### Preface

This report examines the rollout of California’s Drug Medi-Cal Organized Delivery System (DMC-ODS). The DMC-ODS is one of several demonstration projects authorized under the state’s recently renewed Section 1115 Medicaid waiver, known as “Medi-Cal 2020.”<sup>4</sup> Because Medicaid is jointly funded by the federal and state governments, states must receive federal approval for the health benefits they make available through Medicaid. Medicaid waivers are “vehicles states can use to test new or existing ways to deliver and pay for health care services”<sup>5</sup> consistent with the goals of the Medicaid program. Waivers are typically budget-neutral for the federal government and are time-limited.<sup>6</sup>

The DMC-ODS portion of Medi-Cal 2020 was approved by the federal Centers for Medicare and Medicaid Services (CMS) in August 2015, and will be implemented within opt-in counties on a rolling basis (see Section IV of this report for detail). As of May 2016, counties were engaged in strategic planning and preliminary implementation tasks. No county had yet begun to deliver services billable under the waiver.

As such, this study is a very early look at the delivery system transformation that must occur under the waiver. It is not a program evaluation or a comprehensive overview of Drug Medi-Cal policy. Rather, it is an implementation study that employs regulatory analysis, literature review, and key informant interviews to describe the changes that must occur if California is to meet its goals under the waiver. It outlines challenges opt-in counties are likely to encounter as they strive to improve care for Medi-Cal beneficiaries with substance use disorders (SUDs). Ideally, the insights shared by key informants will prove useful to policymakers tasked with overseeing and administering Drug Medi-Cal.

### Study Objectives

- **Illustrate the delivery system transformation that must occur in counties that opt into the DMC-ODS pilot.**
- **Describe how certain structural barriers or “known issues” within Drug Medi-Cal will impact waiver implementation.**
- **Explore strategies to address these barriers and support waiver success.**

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## Methods

**This analysis was shaped by interviews with a variety of DMC-ODS stakeholders** and subject matter experts, including representatives from:

- The California Department of Health Care Services (DHCS)
- County behavioral health/substance use departments (Alameda, San Mateo, San Francisco, Santa Clara and Santa Cruz)
- Substance use disorder treatment providers
- The County Behavioral Health Directors' Association (CBHDA)
- University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP)
- Behavioral Health Concepts, Inc. (BHC-EQRO)
- Harbage Consulting
- The California Health Care Foundation

**For a complete list of key informants, see Appendix A.**

**It also draws on Drug Medi-Cal documentation and related literature,** including

- Medi-Cal 2020 waiver terms and conditions (STCs)
- County waiver implementation plans
- Technical assistance materials from DHCS and Harbage Consulting
- Surveys and webinars from UCLA ISAP and BHC-EQRO
- Historical reports and needs assessments for California's substance use disorder treatment programs

**The focus on Bay Area counties** in this study stems from the phased rollout of the DMC-ODS. The Bay Area is the first of five California regions expected to implement the waiver. Consequently, the counties interviewed for this report were among the farthest along in their planning and preparations, and so well-positioned to offer insights about challenges that are likely to also affect later-phase counties. Obstacles encountered by these relatively wealthy, urban counties are also likely to be present—and possibly magnified—in less-resourced regions.

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## Terminology

**Medi-Cal** is the name for California’s statewide Medicaid program, which offers publicly funded health coverage to children and adults with incomes at or below 138% of the federal poverty level. **Drug Medi-Cal (DMC)** refers to substance use-related benefits for Medi-Cal beneficiaries with substance use disorders (SUDs).

Drug Medi-Cal and the Medi-Cal 2020 waiver are administered by **California’s Department of Health Care Services or DHCS**, referred to as **“the state” or “the Department”** in some contexts within this report. Prior to 2013, DMC and substance use services were administered by California’s Department of Alcohol and Drug Programs (ADP), which was subsequently rolled into DHCS.

This report uses **“behavioral health”** as a blanket term that encompasses both mental health and substance use disorders, and distinguishes between mental health and substance use disorders as necessary. This is consistent with language used by the federal Centers for Medicare and Medicaid services (CMS) and Substance Abuse and Mental Health Services Association (SAMHSA). The use of **“substance use disorder” or SUD** (as defined in Section III below) reflects terminology used widely within clinical practice, Medicaid, and federal and state health policy. Other terms like “substance *abuse*” or “addiction” are generally avoided, as they have specific historical and/or clinical connotations.

California’s 58 counties are responsible for administering local Medi-Cal programs, including Drug Medi-Cal and the DMC-ODS waiver. Individual counties organize their public departments of health and health services differently. In a majority of counties, Drug Medi-Cal and substance use disorder services are the responsibility of county behavioral health departments. Behavioral health departments typically oversee public mental health services as well as SUD services; they are often distinct from the department that oversees Medi-Cal’s physical health benefits. Because counties use a variety of titles for the departments and administrators that manage their SUD programs, **this report refers to them generically as “county SUD programs and administrators” or simply “county administrators.”**

**For a list of frequently-used acronyms, please refer to Appendix D.**

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### III. Substance Use and the Medicaid Population

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#### Substance use disorders in the U.S. and California

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines substance use disorder (SUD) as “the recurrent use of alcohol and/or drugs, [causing] clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.”<sup>7</sup> In 2014, the most recent year for which data is available, the National Survey for Drug Use and Health (NSDUH) estimated that 8.1% of Americans aged 12 and older—roughly 1 in 12—could be classified as having had a substance use disorder within the past year. This number includes alcohol, all illicit drugs, and those with both alcohol and drug disorders. In fact, 6.4% of Americans age 12 and older had an alcohol use disorder; the percentage for illicit drug use was 2.7%.<sup>8</sup>

California’s rates of SUD are largely comparable to national rates for both youth and adult populations, as well as for different types of substances. For example, in 2012-13, 2.9% of Californians aged 12 or older reported dependence or abuse of illicit drugs, compared with 2.7% nationally.<sup>9</sup>

Fatalities associated with substance use have been trending up in recent years. In 2014, more than three times as many people died from illicit drug overdoses as in 2001—a greater than 200% increase in little more than a decade.<sup>10</sup> Drug overdose was the leading cause of injury death for Americans aged 25-64 in 2013.<sup>11</sup> Higher rates of prescription opioid and heroin use are driving these increases, prompting the Obama administration’s 2016 proposal of 1.1 billion in funds for opioid disorder prevention and treatment.<sup>12</sup>

#### Substance use disorders among Medicaid beneficiaries

It has been estimated that the Medicaid-eligible population experiences SUDs at higher rates than does the population as a whole. Between 2008 and 2011, the NSDUH classified 10.3% of Americans 18-64 years old as having substance use disorders, while 11.9% of those with current Medicaid coverage met the definition. Among the population who would be eligible for Medicaid under the Affordable Care Act’s coverage expansion (those with incomes less than 138% of the federal poverty level, or FPL), 13.6% had an SUD.<sup>13</sup>

#### Substance use treatment and the health care delivery system

Most individuals with substance use disorders do not receive treatment. In 2014, only an estimated 11.6% of those defined through the NSDUH as *needing* treatment for a substance use disorder actually received it. This proportion remained relatively steady between 2002 and 2014. Low treatment rates are due in large part to a lack of perceived need for treatment. 93.6% of people with SUDs who did not receive treatment in 2014 did not feel they needed treatment. Similarly, even among those who thought they needed treatment, 41.2% reported that they did not receive that treatment because they were “not ready to stop using.”<sup>14</sup>

However, the next-most-cited reason for not attaining treatment among those who felt they needed it—and the top-ranking reason among those who made an effort to get care—was “no health coverage and could not afford cost.”<sup>15</sup> As access to coverage has increased post-ACA, it would be reasonable to expect the numbers of

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people seeking treatment to increase as well. California, however, did not see a sustained increase in overall admissions to treatment in the year following its coverage expansion.<sup>16</sup> This may have to do with low Medicaid take-up rates for the expansion-eligible substance use population,<sup>17</sup> and/or a lag in the time it takes SUD treatment providers to respond to an increase in demand.<sup>18</sup>

This data points to the need for increasing access to substance use disorder treatment, as California intends to do via the Drug Medi-Cal Organized Delivery System waiver. The state's 2015 Statewide Needs Assessment and Planning (SNAP) report for federal SUD block grant funds noted that "there are at least 2.2 million Californians who are estimated to need, but are not receiving, SUD treatment services."<sup>19</sup> Meanwhile, substance use takes a toll on health care resources. In 2009, 2.5 million emergency department visits nationwide were attributed to drug misuse and abuse.<sup>20</sup> Of the 467.7 billion dollars spent on substance use and addiction by all levels of government in 2005, 58% of state and federal dollars went to health care costs. Of that amount, less than 2%—or 1.9 cents on the dollar—went to prevention and treatment. The vast majority of the spending was for "medical consequences" of substance use.<sup>21</sup> In the words of one treatment provider interviewed for this report, "SUD is a chronic condition that affects every other aspect of a person's health. What we do here has a huge impact on the rest of the system."

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## IV. Medi-Cal 2020 and the Drug Medi-Cal Organized Delivery System

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### The path to reform

In August 2015, California became the first state in the nation to receive approval from the federal Centers for Medicare and Medicaid Services (CMS) to expand and reorganize substance use disorder treatment services for Medicaid beneficiaries through a waiver authorized by Section 1115 of the Social Security Act.<sup>22</sup> The SUD treatment program California will implement under the terms of this waiver is known as the Drug Medi-Cal Organized Delivery System (DMC-ODS). Waiver provisions are discussed in greater detail in the following sections of this report; this segment highlights elements of the policy history that led to its approval.

On July 27, 2015, a letter went out from CMS to state Medicaid directors. It read, in part:

*The purpose of this letter is to inform states of opportunities to design service delivery systems for individuals with substance use disorder (SUD), including a new opportunity for demonstration projects approved under section 1115 of the Social Security Act (Act) to ensure that a continuum of care is available to individuals with SUD. . . . Section 1115 demonstration projects allow states to test innovative policy and delivery approaches that promote the objectives of the Medicaid program. States may receive federal financial participation (FFP) for costs not otherwise matchable, such as services delivered to targeted populations, in limited geographic areas, or in settings that are not otherwise covered under the Medicaid program . . . . CMS supports state efforts to reform systems of care for individuals with SUD, such as by enhancing the availability of short-term acute care and recovery supports for individuals with SUD, improving care delivery, integrating behavioral and physical care, increasing provider capacity and raising quality standards . . . . Medicaid demonstration projects authorized under section 1115 [will] test Medicaid coverage of a full SUD treatment service array in the context of overall SUD service delivery system transformation . . . .*<sup>23</sup>

At the time, CMS was already engaged in negotiations with California's Department of Health Care Services (DHCS) for a Section 1115 demonstration project that fit this description. California's November 2014 waiver proposal had articulated a series of improvements to the state's Drug Medi-Cal (DMC) program that would "demonstrate how organized substance use disorder (SUD) care increases the success of DMC beneficiaries while decreasing other system health care costs."<sup>24</sup>

The programmatic approach endorsed by CMS in its letter mirrored that which had been proposed by California (additional discussion below). All states granted 1115 waivers for SUD demonstration projects would be expected to offer a full continuum of SUD treatment services that incorporated evidence-based practices like the diagnostic and treatment framework developed by the American Society for Addiction Medicine (ASAM), while also improving integration of physical and behavioral health services, managing utilization, and engaging in standardized quality assurance activities. Within a month of disseminating the above letter, CMS approved California's waiver program for a five-year period.

California's waiver request itself was a product of overlapping federal policy changes, most notably the Affordable Care Act (ACA), 2008's Mental Health Parity and Addiction Equity Act (MHPAEA), and recent



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regulations explicitly applying MHPAEA provisions to Medicaid. These reforms are driving a nationwide expansion of SUD treatment under Medicaid and California's 1115 waiver proposal is one manifestation.<sup>25</sup>

Key DMC policy goals that spurred California to request waiver authority for reform included:

- **Expanding residential SUD treatment by removing the IMD exclusion.** Federal law prohibits the delivery of residential mental health or substance use treatment in facilities with more than sixteen beds, known as Institutions for Mental Disease or IMDs.<sup>26</sup> 90% of California's existing residential treatment facilities fell under this exclusion and were ineligible for participation in Medicaid and receipt of federal dollars.<sup>27</sup> Consequently, California's existing residential treatment benefit was restricted to pregnant/postpartum women in facilities with less than 16 beds.<sup>28</sup>

In applying for the DMC waiver, California was following a mandate to eliminate the IMD exclusion and make residential SUD treatment available to all Medi-Cal beneficiaries. In 2013, California Senate Bill 1 implemented a host of federal provisions contained in the Affordable Care Act. It affirmed that adults newly eligible for Medicaid under the ACA's coverage expansion (adults with incomes at or below 138% of the federal poverty level) would be entitled to all existing Medi-Cal benefits. It also required Medi-Cal to cover all mental health and substance use disorder services included in the Essential Health Benefits package adopted by the state under the ACA, and required the state to seek federal approval as necessary to offer these services.<sup>29</sup> In addition to residential treatment, enhanced SUD services were to include intensive outpatient care and an elective detoxification benefit.

In practice, some California counties were already using non-Medicaid funding sources to offer residential treatment to the non-perinatal population. But these (along with detoxification) services were not accessible to many/most Californians; availability varied greatly by geography. The waiver offered an opportunity for the state to use federal Medicaid dollars to fulfill its mandate to offer these services.

- **Granting selective contracting powers to counties.** In August 2014, the California state auditor filed a report detailing substantial fraud within Drug Medi-Cal. The audit identified nearly 94 million dollars of potentially fraudulent DMC payments for more than 2.6 million outpatient SUD treatment services over a four year period.<sup>30</sup> The audit followed a wave of negative national publicity. The Center for Investigative Reporting, in collaboration with CNN, had produced a series of reports that depicted SUD treatment "providers" in California successfully billing Medi-Cal for services allegedly provided to deceased beneficiaries and clients who attested they did not need or did not actually receive the services, services provided on holidays and days when the facilities in question were closed, and more.<sup>31</sup>

At the time these incidents occurred, the state had the authority to contract with DMC providers directly, effectively bypassing the county behavioral health/drug and alcohol departments. DHCS had shared responsibility for provider certification, re-certification, and claims oversight with the California Department of Alcohol and Drug Programs (ADP), which was absorbed into DHCS following California's 2011 Public Safety Realignment.<sup>32</sup> The audit found that the two agencies were unable to fulfill these responsibilities. A package of emergency regulations for DMC was put into effect.<sup>33</sup> But the waiver was one tool for crafting a more permanent solution by formally returning authority to counties. As proposed,

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participating counties would be expected to contract with and oversee their own networks of treatment providers, while adhering to specified oversight and quality assurance procedures.

- **Offering a robust “continuum of care” for SUD beneficiaries.** California’s waiver proposal was in part a response to state and federal laws that required or incentivized expansion of Medicaid SUD treatment. In addition to removing the IMD exclusion that limited access to residential treatment, the waiver could help the state receive federal financial participation for services that previously had not been reimbursable under Medicaid but were considered clinically essential to meet the full-spectrum health and treatment needs of individuals with SUDs.

Examples of such services include case management and recovery supports. Case management, in a health care context, is work done to coordinate a variety the health and social services needed by an individual beneficiary, particularly those whose physical, behavioral, or substance use-related conditions make it difficult for them to navigate service delivery systems independently. Case management is a relatively straightforward strategy for improving the health outcomes of beneficiaries whose complex needs incur large costs to Medicaid as a whole.<sup>34</sup> However, the inability for DMC providers to bill for time spent on these activities disincentivizes them. Similarly, recovery services include health promotion practices that can help an individual with SUD meet his/her recovery and treatment goals, but often take place outside of clinical settings through support groups, 12-step programs, etc. Leveraging federal dollars to make such benefits more widely available to DMC clients could help to improve the health of clients with SUDs while decreasing cost elsewhere in the health system.

California is a populous state that has often positioned itself at the leading edge of health care policy and reform.<sup>35</sup> Roughly 13.5 million people—one third of the state’s population of 39,256,000—are now enrolled in Medi-Cal.<sup>36</sup> The challenge now before the state is to successfully implement the DMC-ODS waiver: to comply with its terms and conditions, and meet its goals to improve SUD treatment for Medi-Cal beneficiaries. Because the waiver is the first of its kind, there is something of a national spotlight on these efforts. **The success or failure of the DMC-ODS will help shape not only the future of SUD treatment for low-income Californians, but also the national conversation about Medicaid’s role in providing these services and fostering health care delivery system innovation.**

## Outline of Drug Medi-Cal waiver provisions\*

### Waiver Goals

In an October 2015 presentation to DMC-ODS stakeholders,<sup>37</sup> DHCS shared the following waiver goals:

#### DMC-ODS Goals/Objectives

- **Test** a new paradigm for the organized delivery of health care services for Medi-Cal enrollees with substance use disorders.
- **Demonstrate** how organized SUD care improves outcomes for DMC beneficiaries while decreasing other system health care costs.
- **Promote** both systemic and practice reforms to develop a continuum of care that effectively treats the multiple dimensions of substance use disorders.
- **Design** a SUD benefit that guarantees a full continuum of evidence-based practices to address the immediate and long-term physical, mental, and care needs of the beneficiary.

### Summary of Waiver Provisions

#### DMC-ODS Provisions at a Glance

Requirements for opt-in counties, adapted from Medi-Cal 2020 Special Terms and Conditions and CA DHCS publications

- **Evidence-based continuum of care**
  - New covered benefits & use of ASAM diagnostic and treatment framework
- **Increased local control and accountability**
  - Counties responsible for selective contracting, provider oversight, county-specific interim rates
- **Managed care via an organized delivery system**
  - Utilization controls, beneficiary protections, standardized practices, coordinated care transitions
- **Enhanced coordination/integration with other systems of care**
  - Consistent, documented collaboration with physical & mental health providers
- **New mechanisms for quality assurance and oversight**
  - Standardized quality improvement processes, formal program evaluation, external quality review
- **Special considerations for criminal-justice involved population**
  - Longer lengths of stay, guarantees of eligibility

\* Except where otherwise specified, all information in the “Outline of Drug Medi-Cal waiver provisions” and “Implementation procedures and timelines” portions of Section IV is drawn from the Medi-Cal 2020 Special Terms and Conditions (STCs) and supporting documentation published by DHCS (e.g. information notices), all available at [www.dhcs.ca.gov](http://www.dhcs.ca.gov).

DMC-ODS Special Terms and Conditions (STCs) contained within the larger Medi-Cal 2020 waiver agreement delineate distinct duties and responsibilities for DHCS, as well as for California counties and SUD treatment providers that elect to participate. **This study emphasizes the activities that must be undertaken—and the challenges that must be overcome—by participating counties and providers, while touching on DHCS’ role as relevant.** The following paragraphs summarize important aspects of the waiver.

**Medi-Cal 2020 is time-limited.** As part of the larger Medi-Cal 2020 Section 1115 waiver, the terms of the DMC-ODS were approved for a five-year period and will be subject to federal renewal or termination in 2020.

**County participation is not mandatory.** Counties may opt into the waiver at any time during the five-year period. Once they do, they are subject to all terms and conditions. Alternately, a county may opt-in on a provisional basis by specifying a plan for meeting all waiver requirements within one year. DMC beneficiaries in counties that choose not to participate will continue to be entitled to DMC services as specified under California’s Medicaid state plan amendment.<sup>38</sup> Beneficiaries in counties that opt into the waiver will be entitled to enhanced Drug Medi-Cal benefits.

DMC-ODS operational requirements can be summarized as follows. For detailed discussion of the evidence-based continuum of care and organized delivery system provisions and their implications, as well as further comparison of benefits in opt-in vs. opt-out counties, see Section V. Mechanisms for quality assurance and oversight are examined in Section VII.

- **Evidence-based continuum of care.** Opt-in counties will be expected to provide all SUD treatment service types or “modalities” included in the American Society of Addiction Medicine’s (ASAM) continuum of care. This includes residential treatment for the entire beneficiary population, with no restriction on the number of beds in a treatment facility, as well as intensive outpatient services, and detoxification or “withdrawal management.” Opt-in counties will offer and receive DMC reimbursement for previously uncovered services: case management, recovery supports, physician consultation, expansion of medication assisted treatment or MAT (optional), and partial hospitalization (optional). Diagnoses and treatment plans must reflect use of ASAM’s diagnostic criteria and continuum (see Appendix B). Individual providers must adopt at least two evidence-based treatment practices from a specified list, e.g. motivational interviewing and trauma-informed treatment.

The American Society of Addiction Medicine (ASAM) is a professional society of addiction medicine practitioners, founded in 1954 and dedicated to “increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.” ([www.asam.org](http://www.asam.org))

Diagnostic criteria and a corresponding treatment framework (known as the “ASAM continuum of care”) developed by ASAM are recognized as industry standards, and have been endorsed by both SAMHSA and CMS. **SUD treatment services within the ASAM continuum include:**

- Screening and early intervention
- Outpatient services
- Intensive outpatient/partial hospitalization
- Withdrawal management
- Residential treatment
- Medically monitored or managed intensive inpatient services.

For a list of DMC-ODS services, see Table 4 in Section V. For additional information on the ASAM continuum, see Appendix B.

- **Increased local control and accountability.** Counties will be responsible for contracting and monitoring a network of providers who meet waiver criteria to deliver DMC services. Counties will develop and

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propose county-specific interim payment rates for DMC services. Rates are subject to DHCS approval and federal expenditures will be reconciled to cost via a CMS-approved protocol.

- **Organized delivery system to manage care.** Counties that opt into the waiver will act as managed care entities or “Prepaid Inpatient Health Plans” (PIHPs) under federal law. Beneficiaries will be entitled to all managed care protections under 42 CFR Part 438. Counties must function as organized delivery systems with county Behavioral Health and/or Substance Use departments at the helm. Related requirements include operation of a 24-hour beneficiary call line, adherence to grievance and appeal procedures, participation in the quality assurance activities described below, use of utilization controls to ensure beneficiaries receive appropriate and medically necessary care, monitoring of network adequacy, and standardized processes for client intake, assessment, and treatment planning.
- **Increased coordination with other systems of care.** County SUD delivery systems must demonstrate and document enhanced integration and cooperation with physical and mental health providers. Counties must have a Memorandum of Understanding (MOU) with the local Medicaid managed care organizations (MCOs) responsible for the physical health and mild-to-moderate mental health needs of most Medi-Cal beneficiaries that describes how counties/MCOs will collaborate to deliver care to their joint beneficiaries.<sup>39</sup> Counties must document procedures for care transitions, while DHCS, as part of CMS’ Innovation Accelerator Program, will develop and disseminate an approach to improve integration of SUD and physical health services.
- **New mechanisms for oversight/quality assurance.** Participating counties must convene quality improvement committees to engage in quality assurance activities and performance improvement projects (PIPs) specified under waiver terms. Activities include regular review of data points related to network adequacy and beneficiary access. County delivery systems will also be subject to annual reviews by an external quality review organization (EQRO) and triennial compliance reviews by DHCS, as required under federal managed care regulations. A team from the University of California, Los Angeles’ Integrated Substance Abuse Programs (UCLA ISAP) will conduct a formal evaluation of statewide performance under the waiver.
- **Special considerations for the criminal-justice involved population.** Counties are responsible for educating their staff that probation/parole status does not disqualify an otherwise eligible beneficiary from DMC services. Counties may also choose to provide extended lengths-of-stay in residential or withdrawal treatment facilities for this population as appropriate, with some restrictions on FFP.

## Implementation procedures and timelines

### Phased Rollout

Waiver implementation will occur in a phased rollout, with counties around the state grouped into four regions plus California’s Tribal Partners. Each group of counties will receive intensive, introductory technical assistance (TA) from DHCS, and may then signal intent to opt into the waiver by submitting an implementation plan. At the time of this report, DHCS had finished delivering initial TA to Phase 3 counties and was ready to embark on Phase 4 for northern California.<sup>40</sup>

**Table I**

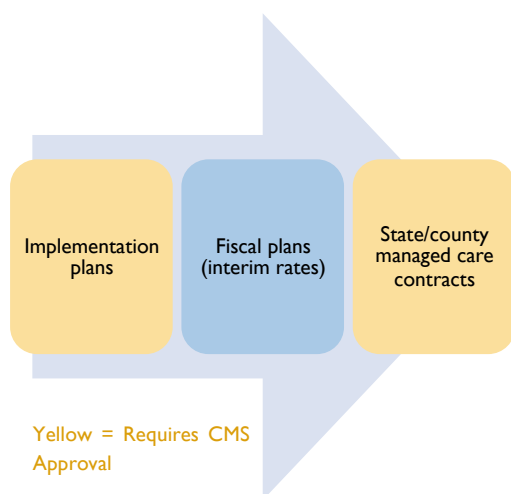
<b>Phased Rollout for DMC-ODS Waiver<sup>41</sup></b>			
<b>Region</b>	<b>Counties</b>	<b>% Population</b>	<b>Estimated Implementation Dates</b>
<b>1) Bay Area</b>	Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Clara, Solano, Sonoma	21.3	July 2016
<b>2) Southern California</b>	Kern, Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Ventura	60.8	January 2017
<b>3) Central California</b>	Calaveras, Eldorado, Fresno Inyo, Kings, Madera, Merced, Mono, Placer, Sacramento, Stanislaus, Yolo, San Joaquin, Sutter, Tuolumne, Yuba	13.8	July 2017
<b>4) Northern California</b>	Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Siskiyou, Tehama, Trinity	2.7	January 2018
<b>5) Tribal Partners</b>	N/A		2018

### Implementation Prerequisites

Opt-in counties may not begin billing for services under the waiver until several prerequisites are in place. These include:

- **Implementation plans.** Counties must develop and submit to DHCS plans that describe in detail how they will implement waiver activities. To meet federal managed care requirements, implementation plans must include information about each county's network adequacy and standards for timely access to DMC services. Plans are reviewed concurrently by DHCS and CMS officials, with a target of 60 days time for feedback and revisions. Plans must be approved by both agencies.





- **Fiscal plans.** Counties will propose interim payment rates for DMC-ODS services. Rates are also subject to approval by DHCS. They are referred to as “interim” rates because counties will ultimately be expected to follow a federally approved protocol to report costs incurred to provide DMC services. Overpayments or underpayments of federal funds will be reconciled. The cost-reporting procedure, known as the certified public expenditure (CPE) protocol, must be developed by DHCS and approved by CMS before interim rates can be finalized.

- **State/county contracts.** As managed care entities, county behavioral health/SUD departments must execute state/county contracts detailing their agreement to provide care for Drug Medi-Cal beneficiaries. Contracts must be approved by the county’s Board of Supervisors, DHCS, and CMS.

At the time of this report, no county had begun delivering and billing for SUD treatment services under the waiver. Nine counties had submitted implementations plans; only San Mateo’s had been approved. Three counties had proposed interim rates, but none had been approved because DHCS/CMS had yet to finalize the CPE protocol. Managed care contracts will not proceed until these other pieces are in place.

**Table 2**

Opt-In Counties, May 2016 <sup>42</sup>		
County	Implementation Plan Submitted	Implementation Plan Approved
San Francisco	Nov. 20, 2015	
San Mateo	Nov. 21, 2015	April 8, 2016
Riverside	Dec. 7, 2015	
Santa Cruz	Dec. 9, 2015	
Santa Clara	Feb. 3, 2016	
Marin	Feb. 5, 2016	
Los Angeles	Feb. 11, 2016	
Contra Costa	Apr. 15, 2016	
Napa	Apr. 20, 2016	

# V. The DMC-ODS Transformation

## Opportunity to improve SUD care

To understand the challenges facing counties that opt into the DMC-ODS, it is important to understand what SUD treatment is meant to be under the waiver—and how that ideal differs from the current state of the world in most counties. County SUD program administrators and treatment providers interviewed for this report expressed equal parts terror and optimism about their participation in the waiver. They portrayed the DMC-ODS as an incredible opportunity to improve care for DMC beneficiaries that will require sustained, systemic, and dramatic changes in county operations.

*“Creating a system that can really deliver treatment on demand is a career-long goal, the opportunity of a generation.”*

*--County Administrator*

Many of the descriptions in this section are stylized. **The tables and graphics draw on documents and interviews cited at the end of the report *do not* literally depict particular county delivery systems.** They are intended to represent and illuminate changes that must occur in opt-in counties.

The following table offers a snapshot of some of the differences between the approach to DMC services that will be adopted under the waiver and the approach to SUD treatment under Drug Medi-Cal historically. The “before” column is representative, to varying extents, of what is still happening in many counties pre-waiver.

Table 3

BEFORE	AFTER
<ul style="list-style-type: none"><li>SUD treated as acute condition</li><li>Uneven access to limited service types. Services guaranteed under state plan not available in all counties (or are paid for by non-DMC funds)</li><li>Loose confederation of providers</li><li>Vulnerable to provider fraud</li><li>Underfunded</li><li>Statewide service payment rates</li><li>Silos between SUD, mental health, &amp; primary care</li><li>Highly individualized quality assurance</li><li>Coordination with criminal justice system dependent on funding</li></ul>	<ul style="list-style-type: none"><li>SUD treated as chronic condition</li><li>Timely access to evidence-based continuum of care</li><li>Organized delivery system</li><li>Increased local control/accountability</li><li>Additional opportunities for federal dollars</li><li>County-specific interim rates</li><li>Strong linkages between SUD, mental health, and primary care</li><li>Standardized quality assurance/oversight</li><li>Medi-Cal safety net encompasses criminal-justice involved populations</li></ul>



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Two of the changes counties must undertake to comply with waiver requirements and realize the DMC-ODS vision are particularly momentous. **In many counties, these elements represent true sea changes or transformations in the way SUD care is delivered.** They also require significant investments of time, and monetary and non-monetary resources, and as such relate closely to the implementation barriers discussed later in this report. They are:

Offering an  
evidence-based  
continuum of care

Managing care via  
an organized  
delivery system

## Offering an evidence-based continuum of care

In its July 2015 letter urging state Medicaid directors to seek 1115 waiver authority to transform Medicaid SUD treatment in their states, CMS notes that states will be expected to undertake systemic reforms that include:

- *Promoting a definition of substance use disorders as a primary, chronic disease requiring long-term treatment to achieve recovery with relapse potential.*
- *Introducing a comprehensive continuum of care based on industry standard patient placement criteria, including withdrawal management, short-term residential treatment, intensive outpatient treatment, medication assisted treatment and aftercare supports for long-term recovery such as transportation, housing, and community and peer support services.*
- *Adding coverage of evidence-based and promising practices shown to effectively treat youth and adults for SUD that are not available through traditional Medicaid 1905(a) authority.<sup>43</sup>*

**California's waiver calls for precisely these transformations.** Practice changes that must occur in order to realize these reforms include:

**Use of ASAM diagnostic criteria and corresponding continuum of care.** The SUD diagnostic criteria and treatment framework endorsed by the American Society of Addiction Medicine (ASAM) will be the organizing principle of the new DMC-ODS. Each DMC beneficiary will be screened for SUD using ASAM's multi-dimensional diagnostic criteria, then placed into the corresponding "level of care." ASAM levels of care (numbered 0.5-4.0) refer to both the type of SUD service offered (Level 1.0 corresponds to Outpatient Services, Level 4.0 to Medically Managed Intensive Inpatient Services), and to differing approaches to/intensities of treatment within those service modalities (e.g. Level 3, Residential/Inpatient Services, is broken down into 3.1, 3.3, 3.5, and 3.7, in increasing order of intensity). DMC clients will be expected to transition between levels of care as their individual needs change over time.

Beginning to screen all clients using ASAM's criteria, incorporate the ASAM levels of care into each client's treatment plan, and document these processes will be a major change for most counties. In a survey administered by UCLA's Integrated Substance Abuse Programs (UCLA ISAP) in fall 2015, researchers estimated that only 10 of 48 respondent counties (21%) were currently collecting data related to the ASAM criteria from their providers. For county SUD program administrators, teaching providers to use and document ASAM assessment and placement processes topped a list of training priorities.<sup>44</sup> This sentiment was echoed in county implementation plans, with several counties listing ASAM training for providers when asked about technical assistance needed from DHCS. Fortunately, DHCS has prioritized ASAM training for providers in opt-in counties and will offer training at no cost to counties through a technical assistance contract with the California Institute for Behavioral Health Solutions (CIBHS).<sup>45</sup> Nonetheless, adopting ASAM constitutes a big lift for most counties. One administrator interviewed for this report said "The TA we really need is someone to sit with providers and hold their hands while they re-learn how to document everything."

*"The TA we really need is someone to sit in the room and hold providers' hands while they re-learn how to document everything."*

--County administrator

**See Appendix B for additional information on ASAM's diagnostic criteria and continuum of care framework.**

**Expansion of covered DMC services.** In addition to ensuring that clients are placed into service types and levels according to ASAM's model, opt-in counties must offer a complete continuum of care. All services types included within ASAM's levels of care must be available to DMC beneficiaries. In some cases where multiple levels of care exist within a service type, counties will be able to add additional levels over time, but must offer at least one at the time the opt-in. Partial hospitalization (optional under the waiver), recovery services, and case management are services that are already allowable under Medicaid state plans, so do not require waiver authority per se. However, they are currently not included in California's state plan and so not reimbursable under DMC in California (targeted case management in some counties is an exception).<sup>46</sup> The mandate to offer these services represents a significant expansion of benefits in opt-in counties.

The table below illustrates the DMC services previously guaranteed under California's state plan, the services guaranteed under the DMC-ODS, and the corresponding ASAM levels of care. **See Appendix C for summary definitions of each service type.**

**Table 4**

<b>DMC State Plan</b>	<b>DMC-ODS: Opt-In</b>	<b>ASAM Levels of Care</b>
Outpatient Drug Free Treatment	Outpatient Services	1.0
Intensive Outpatient Treatment	Intensive Outpatient Services	2.1
Naltrexone Treatment (oral for opioid dependence or with treatment authorization for other)	Naltrexone Treatment (oral for opioid dependence or with treatment authorization for other)	N/A: component of multiple levels
Narcotic Treatment Program	Narcotic Treatment Program	Includes MAT & outpatient counseling
Perinatal Residential SUD Services (IMD exclusion)	Residential Services (not restricted by IMD exclusion or limited to perinatal)	3.1, 3.3, 3.5 (one level required)
Detoxification in a Hospital (with treatment authorization)	Withdrawal Management	1-WM, 2-WM, 3.2-WM (one level required)
	Recovery Services	N/A
	Case Management	component
	Physician Consultation	N/A
	❖ Partial Hospitalization (optional)	2.5
	❖ Additional Medication Assisted Treatment (optional)	component

\*Table 4 adapted in part from a graphic by Harbage Consulting: “CHCF Legislative Staff Briefing on DMC-ODS Pilot Program,” Harbage Consulting, (Sacramento, CA: Presentation to California Legislative Staff, December 2015).

Recovery services, case management, and physician consultation have not previously been reimbursed by Drug Medi-Cal and have not been offered in all counties. Consequently, these services must be developed during the DMC-ODS rollout. DHCS must help answer questions like “What activities are billable under the label ‘recovery services’?” and “What is the unit of service for physician consultation billing?” For counties, determining how to provide these services and training providers on definitions and documentation are significant systemic changes.

**Some counties hoping to opt into the waiver must contend with existing gaps in services.** It is difficult to access accurate and current data on SUD treatment capacity in order to estimate how many counties are already offering all or most of the service types called for under the waiver. Much publicly available data pre-dates 2014’s ACA expansion, which enlarged both the Medi-Cal eligible and insured populations and may have attracted new providers. Pre-2014 data also does not account for shifts in the number and distribution of DMC providers that followed a massive re-certification and deactivation effort undertaken by DHCS in response to the DMC fraud discussed in Section IV.<sup>47</sup> Finally, because DMC services have historically been reimbursed at very low payment rates (see Section VI) and restricted by service type and population, many safety net SUD treatment providers have not participated in DMC. Instead, they contracted directly with counties and were paid through other funding sources (e.g. federal Substance Abuse Prevention and Treatment block grants). The question of which counties can most readily offer the full continuum of care does

not turn on numbers of currently certified DMC providers, but on the numbers of existing providers who plan to attain DMC certification and participate in the DMC-ODS.

With these caveats, a few available numbers support one basic premise. Some counties wishing to opt into the waiver are currently unable to offer even the more minimal array of services required under the DMC state plan, or at least not to an extent that would allow access for many/most DMC beneficiaries. The Bay Area and the Los Angeles area are believed to have the greatest existing capacity to provide the DMC-ODS continuum of care. Accordingly, these are the first and second regions in the phased rollout.

**As an illustration, the figures below are 2013 provider counts by service type and county** (inclusive of safety net SUD providers, DMC certified or not). Note that when this data was collected, nearly all waiver Phase 1 counties were already able to offer the four primary DMC service types, but many Phase 3 counties were not. The precise counts in these figures should not be considered representative of today's numbers, but the trends likely hold true. I.e., the majority of counties who had no residential or NTP providers in 2013 have probably *not* closed those gaps. For example, in May 2016 DHCS indicated that there are currently 28 counties without NTP services and 30 counties with NTPs.<sup>48</sup> Counties that lack NTPs are concentrated near the state's northern and eastern borders.

## Notes on Service Capacity in Bay Area Counties

**Bay Area counties that have submitted waiver implementation plans are already offering many/most of the services that makes up the ASAM continuum of care.** However, they do not necessarily expect to be ready to meet the full-spectrum needs of all beneficiaries on day one. In addition to developing new DMC benefits like recovery services, examples of areas in which Phase 1 counties must build additional service capacity include:

**Residential treatment.** Counties already offer residential treatment but maintain wait lists in the face of high demand; clients are sometimes offered less intensive outpatient services when they cannot immediately access residential. Counties are working to improve access. For example, **Marin** expects to pursue contracts with out-of-county providers. **Santa Cruz** and its residential providers are exploring options to contract for additional DMC beds with existing providers and re-license beds with licenses that have lapsed.

**Withdrawal Management.** Withdrawal management, or detox, may occur in an inpatient or outpatient setting depending on the severity of withdrawal. **San Mateo** expects to offer ASAM level 1-WM, Ambulatory Withdrawal Management by the end of implementation year 1 (a single level meets DMC-ODS requirements). The county will undertake an RFP process to recruit providers for residential detox. **Marin** plans to offer residential withdrawal management by the end of demonstration year 1, and ambulatory withdrawal by the end of year 2. **San Francisco** will add ambulatory detox to the menu of programs at its Howard Street hub for DMC services and referrals.

**Recovery Residences.** Recovery residences are not reimbursable through DMC but are considered an essential part of the treatment continuum. Counties described a need to expand recovery residences, given DMC-ODS limits on length of stay in residential treatment (see Section VI). **Marin** has undertaken an RFP process to add recovery residences and hopes to offer services by the end of Year 2. **Santa Cruz** notes that recovery residences will be offered "within the limits of available funding." **San Mateo** is developing standards for contracting residences. **Santa Clara** and **San Francisco** also offer recovery residences, but in interviews noted they anticipate challenges meeting demand.

**Youth Treatment:** See section VI for further discussion of gaps in the availability of specialized SUD treatment for youth. Historically, only Santa Clara and Alameda have offered youth residential treatment. County implementation plans (with the exception of Santa Clara) describe the need to collaborate with other Bay Area counties in order to connect youth with residential treatment.

**Table 5**

Phase I	ODF	Residential	IOP	NTP	Total
Alameda	43	19	22	9	93
Contra Costa	22	11	12	3	48
Marin	18	5	13	1	37
Monterey	6	2	1	2	11
Napa	16	2	7		25
San Benito	2	1	2		5
San Francisco	21	14	2	15	52
San Mateo	22	12	19	1	54
Santa Clara	62	13	26	4	105
Santa Cruz	19	7	4	2	32
Solano	22	6	15	1	44
Sonoma	13	8	17	2	40

**FY 2012-13 SUD Provider Counts:  
Phase I and Phase 3 DMC-ODS Counties**

Data: DHCS, *CA Substance Use Disorder Block Grant Needs Assessment & Planning Report, 2015*

BLUE = DMC-ODS opt-in counties as of May 2016

Phase 3	ODF	Residential	IOP	NTP	Total
Calaveras	2	1	2		5
El Dorado	14	7	2		23
Fresno	76	8	7	5	96
Inyo	3		2		5
Kings	13	2	2		17
Madera	6		2		8
Merced	11	2	3	1	17
Mono	1		1		2
Placer	19	5	5	1	30
Sacramento	69	14	18	5	106
Stanislaus	17	2	4	2	25
San Joaquin	9	4	2	5	20
Sutter	2		3		5
Tuolumne	1		1		2
Yolo	6	3	1		10
Yuba	3	1	1	2	7

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The numbers above are neither current nor precise. Overall provider counts don't address the number of providers per capita or the capacity of individual providers, critical data for estimating county service capacity as a whole. Instead, these numbers are rough indications that many counties must significantly expand their service capacity in certain areas—particularly residential treatment and NTPs—to participate in the waiver.

Additional evidence: in UCLA's September 2015 survey of county administrators, 48% of respondents (23 counties) named residential treatment as the most challenging service modality to expand, followed by NTPs (21%, or 10 counties) and detoxification (19%). Roughly one quarter of counties (27%) reported that NTPs were not available in their county and would not be in the next 12 months. Similarly, 23% of respondents did not expect withdrawal management to be available in their counties within 12 months; 33% described residential treatment services as only "partially available."<sup>49</sup>

**In short, transforming a service continuum that many key informants described with words like "sparse" or "bare-bones" into a robust system that can truly meet client needs at all levels of care is not a trivial task.**

## Managing care via an organized delivery system

A second sea change facing opt-in counties under the waiver is the imperative to function as managed care providers and organized delivery systems. Managed health care models rest on the assumption that the use of a centralized authority to oversee care utilization will keep costs down by reducing unnecessary or inappropriate care and improving quality and coordination. The DMC-ODS is intended to realize these assumptions: "The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs."<sup>50</sup>

Acting as an organized delivery system under the waiver means that each opt-in county must:

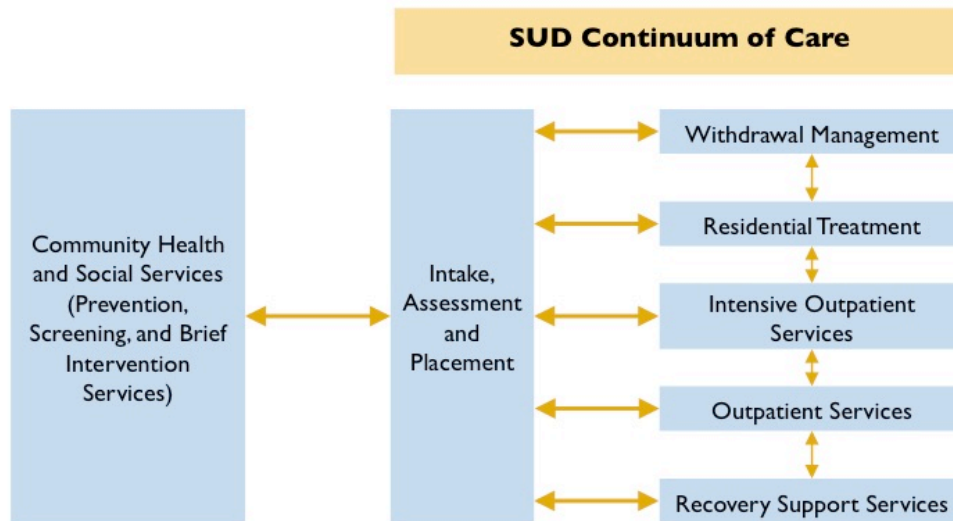
- **Standardize processes** for client assessment/intake, treatment planning, and care transitions, e.g. by operating a 24-hour beneficiary access line and ensuring all SUD clients are screened using ASAM's diagnostic criteria.
- **Establish utilization controls**, e.g. treatment authorization requests will be required for clients to enter residential treatment.
- **Ensure coordination of care** between SUD levels of care and with non-SUD treatment providers.
- **Function as unified, data-driven systems** by regularly reviewing access and quality-related data at the county level and participating in external quality reviews and UCLA's program evaluation.

The following diagrams illustrate the transition many counties must make from operating as loose confederations of providers with limited central management to functioning as organized delivery systems.



**Figure 1**

## **FUTURE: Organized Delivery System**



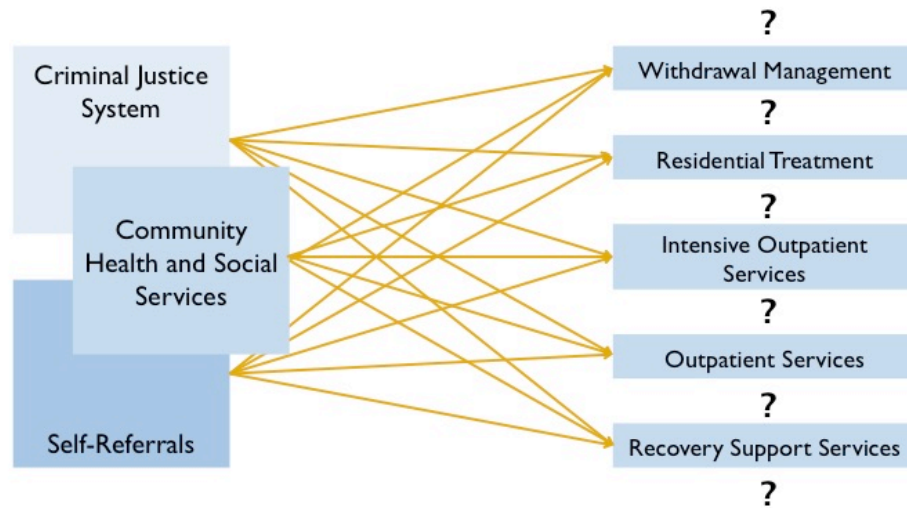
\* Diagram adapted from UCLA Integrated Substance Abuse Programs, 2015 *Evaluation, Training, and Technical Assistance for Substance Use Disorder Services Integration (ETTA) Report*, Appendix 2, p.118.

Notable features of the DMC-ODS depicted here include the bi-directional arrows, which indicate seamless transfers between levels of care, to and from the “intake, assessment and placement” processes, and with non-SUD providers. Also important is the idea that clients will undergo the same intake, assessment, and placement procedure before entering treatment, regardless of the “door” through which they originally enter. In practice, this may not mean that all beneficiaries are directed through the same gateway into treatment. I.e., not every client will access care by first placing a call to the 24 hour beneficiary line. Some may still present directly to SUD providers. But as soon as a client has been identified as DMC-eligible, counties must document that they have undergone a screening based on ASAM’s diagnostic criteria and document their diagnosis and medical necessity determination in a standardized fashion.

This does not describe current practices in many counties. The way a beneficiary proceeds into treatment often depends upon how they are referred. Are they connected with an SUD treatment provider via referral from primary care? Or after they or a family member contact a provider directly? The mechanism by which clients are diagnosed may vary significantly depending on the provider they initially encounter. Similarly, procedures for referrals between levels of care may be highly dependent upon existing relationships between providers rather than being standardized or managed by a central authority. And many otherwise-eligible beneficiaries do not access care paid for by DMC or delivered by DMC-certified providers. Instead, their treatment is paid for by other county funds, with each provider acting as an independent contractor.

**Figure 2**

**PRESENT: Confederation of Providers**



Along with the absence of county-wide, standardized diagnostic criteria, the diagram above shows little two-way communication between community health providers and SUD treatment providers. How, and how often, clients move between SUD service types is largely unknown. This is an exaggerated, worst-case scenario. In reality, operations within most counties (even the best prepared, those currently offering most required DMC services) lie somewhere on a spectrum between these “Present” and “Future” systems.

Some supporting evidence: most counties currently have at least some centralized/organized processes for referring patients into care. UCLA ISAP’s fall 2015 administrator survey found 50% of respondent counties already operate a toll-free, 24-hour beneficiary access number. 82% reported using a centralized system for screening and placing clients into at least some SUD treatment services. For example, a county may manage access/wait lists for a certain number of county-contracted residential treatment beds. However, adopting utilization management strategies was named fourth among the top five most challenging aspects of the waiver to implement. Sharing/tracking/monitoring of client data along the continuum of care was number one. Only 7 counties (15%) reported that utilization management tools were fully available within their delivery systems. Utilization management was also rated the second highest priority topic for training of staff and providers.

There is also data indicating that a smaller-than-optimal proportion of SUD treatment clients statewide actually transition between levels/types of care as clinically appropriate. For example, many clients who initially enter relatively intensive levels of care like residential treatment or detoxification/withdrawal management might be expected to stay in those environments long enough to stabilize their conditions, then



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“step down” into a less intensive form of treatment like intensive outpatient. But an analysis of statewide trends during 2014 (inclusive of DMC and non-DMC clients for whom data was reported via the state’s California Outcomes Measurement System, or CalOMS Tx) found that fewer than 13% of clients who received non-NTP detoxification services, and fewer than 6% of clients who entered residential treatment facilities, transitioned into another level of care within fourteen days of discharge.<sup>51</sup>

In a 2015 report to DHCS, researchers from UCLA ISAP described Santa Clara county as “the closest county in the state to having an ASAM-based system like that envisioned by the DMC-ODS waiver.”<sup>52</sup> Santa Clara began its transition to operating as an organized delivery system roughly twenty years ago. In contrast to statewide trends above, 2014 numbers for Santa Clara county showed 60% of detox clients being admitted into another type of treatment within fourteen days. For an extensive profile of Santa Clara’s organized delivery system and observations about what the rest of the state can learn from that county’s experience, refer to UCLA ISAP’s 2015 report to DHCS, “Evaluation, Training, and Technical Assistance for Substance Use Disorder Services Integration [ETTA],” available at [www.uclaisap.org](http://www.uclaisap.org).

Still, most counties must make significant operational changes before their systems begin to function as ODS’s.

## Overview of challenges

**Nearly three-quarters of counties responding to UCLA’s fall 2015 survey indicated they would opt into the DMC-ODS.** However, the survey preceded certain details about the waiver’s fiscal provisions, as well as the introductory TA sessions for counties in phases 2, 3 & 4. Counties that did not expect to opt in, or were uncertain, listed complex waiver requirements, lack of county resources, lack of access to residential treatment, uncertainty regarding reimbursement rates, and their small sizes as reasons they may not participate.

For opt-in counties, the system transformations described above are two of the most significant tasks ahead. There are also a host of additional waiver provisions that require counties to develop new policies, procedures, and practices. Challenges range from attaining DMC certification for new providers, to developing county-specific interim payment rates, to contending with a lack of interoperable electronic health records and expertise in data analytics.

County administrators responding to UCLA’s survey ranked the following five implementation requirements as most challenging:

1. Sharing/tracking/monitoring client data along the continuum of care.
2. (Expanding) withdrawal management services.
3. (Expanding) residential treatment services.
4. Utilization management.
5. (Recruiting and retaining) Licensed Practitioners of the Healing Arts (LPHAs).<sup>53</sup>

Table 6 summarizes implementation challenges discussed in the administrator survey, county implementation plans available at the time of this analysis, and key informant interviews.

**Table 6**

<b><u>Waiver Provisions</u></b>	<b><u>Associated Challenges for Counties</u></b>
Evidence-based service expansion	<ul style="list-style-type: none"> <li>• Adopting ASAM criteria, training providers</li> <li>• Adding missing services/levels of care (youth, residential, detox)</li> <li>• Ensuring fidelity of evidence-based practices</li> <li>• Housing: securing interim/recovery and permanent housing for DMC clients</li> <li>• History of low reimbursement rates</li> </ul>
Increased local control and accountability	<ul style="list-style-type: none"> <li>• Interim rate development</li> <li>• Provider recruitment &amp; certification</li> <li>• Uncovered start-up costs (for counties and providers)</li> <li>• Financial risk/uncertainty</li> </ul>
Organized delivery system to manage care	<ul style="list-style-type: none"> <li>• Implementing 24-hour beneficiary access line</li> <li>• Adopting standardized intake and treatment planning processes</li> <li>• More uncovered costs (counties)</li> </ul>
Increased coordination with other systems of care	<ul style="list-style-type: none"> <li>• Navigating 42 CFR and data privacy requirements</li> <li>• Sharing/tracking data for referrals</li> <li>• Separate funding streams = silos, lack of financial parity</li> </ul>
New mechanisms for oversight/quality assurance	<ul style="list-style-type: none"> <li>• County/DHCS staffing inadequate to meet administrative burden</li> <li>• Documentation requirements not well aligned with ASAM/clinical practice</li> </ul>
Special considerations for those involved with the criminal justice system	<ul style="list-style-type: none"> <li>• Aligning and coordinating justice system programs that have previously been unreliably funded by non-DMC sources with the new DMC-ODS</li> </ul>

Table 7 offers another representation of waiver-related challenges and the different baseline levels of preparedness that exist in counties today, as administrators decide whether or not to opt in.

**Table 7**

	<b>County A (MOST prepared)</b>	<b>County B (average)</b>	<b>County C (LEAST prepared)</b>
<b>DMC Population &amp; Utilization</b>	Higher utilization and/or penetration rates	Medium to large population  Low penetration or unpredictable utilization	Small DMC population  Or, large population with low/unknown penetration
<b>Existing Providers &amp; Services</b>	Most service types exist  More providers-per-capita	Some service gaps  Relatively more reliant on smaller, or fewer, providers	Several missing service types (e.g. residential, NTPs)  Extremely difficult to attract new providers (e.g. rural areas)
<b>Financial Risk</b>	Robust funding from non-DMC sources  Can absorb county start-up costs (& maybe offer support to providers)	Sizeable BH subaccount and SAPT allocations, but:  Less support from other county sources, or less resourced county in general, than County A	Underfunded from all sources  Least able to absorb start-up costs and combat financial uncertainty, but most dramatic changes needed
<b>ODS Infrastructure</b>	Existing call line & some centralized functions  Strong county/provider relationships  Sophisticated data capabilities	Little centralized function  Less advanced in quality improvement and data analytics than County A  Many providers without electronic records	Sparse staff at county level; inadequate for waiver start-up requirements (rate development, provider training, quality assurance)  Reliant on small network of less sophisticated or out-of-county providers
<b>Bottom Line</b>	Likely to opt-in  Likely to improve or maintain quality & access	Likely to opt-in  May struggle to meet all waiver requirements	Likely to opt-in only as part of a regional system of care with neighboring counties

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While these are composite profiles and do not precisely reflect any single county, the five Bay Area counties interviewed for this report had many of the characteristics in columns A and B. No county interviewed could be said to be strong in every dimension listed here. Meanwhile, many of the smaller Phase 3 and Phase 4 counties likely fall somewhere between columns B & C. Accordingly, key informants reported that at least one group of northern California counties is planning to opt-in as a regional collective, something that is permitted under the waiver.

As previously noted, this study focused on Bay Areas counties with the expectation that relatively wealthier and more urban systems will begin the five-year waiver term better-positioned to succeed, with more DMC-ODS components already in place than their less wealthy or more rural counterparts. **Ultimately, the challenges that rose to the surface in interviews with Bay Area administrators and providers were not particular to a given county's geography, population, or other variable factors. Instead, they were problems that stem from longstanding, structural features of Medi-Cal and Drug Medi-Cal.** These "known issues" will impact waiver implementation in every county. As such, they take on new significance. The remainder of this study considers several structural barriers counties face in their efforts to successfully implement the DMC-ODS, the waiver's mechanisms for monitoring the effects of these challenges on service delivery and patient care, and some incremental strategies that may increase counties' chances for success.

## VI. Structural Barriers to Waiver Success

County SUD program administrators, treatment providers, and DHCS staff interviewed for this study were unanimous in their belief that the waiver offers an unprecedented opportunity to use federal funds to transform Drug Medi-Cal. Yet even in the Bay Area, where most agreed that the existing SUD treatment infrastructure is stronger than in many other regions, interviewees expressed apprehension about what it will take to realize the waiver's long-term vision of a robust and efficient organized delivery system. In the words of one county administrator, "DMC has been so underfunded and benefits so bare-bones, it threatens to limit our vision for a full continuum of care and our ability to leverage federal dollars."

**To move beyond these historical limitations, the state, its counties, and SUD stakeholders must address barriers to success that are deeply rooted in the structure and financing of Medi-Cal. They must:**

1. **Navigate financial risk.**
2. **Ensure network adequacy.**
3. **Align policy with clinical practice.**

The threats to waiver implementation discussed here are "known issues" within Medi-Cal and California's SUD safety net. As such, it can be tempting for policymakers to dismiss them as intractable. **This report details how these structural problems will impact efforts to implement specific waiver provisions, and may ultimately impede statewide performance.** With all eyes on California's pioneering reforms, it may be time to undertake policy changes to remedy Drug Medi-Cal's historical shortcomings and support long-term success.

### Navigating financial risk

#### Key Findings

- **Successful implementation depends on adequate service payments.**

Counties view the opportunity to negotiate county-specific interim payment rates as a chance to reverse a long history of overly low rates and establish parity of reimbursement for mental health and substance use services. Failure to approve adequate rates will negatively impact the ability of counties to retain DMC providers and meet the need for SUD services.

- **Uncovered costs exacerbate financial uncertainty for counties.**

The limited administrative overhead payments counties may claim through Drug Medi-Cal will not cover the expenses necessary to transition into providing managed care through an organized delivery system. (These include start-up costs for new providers, compliance/expansion costs for existing providers, costs associated with administrative and infrastructure improvements, and the room and board portion of residential treatment costs). Counties where SUD services have been historically well-funded by non-DMC sources are more confident that their counties will be able to cover necessary costs and readily provide the non-federal share of DMC-ODS payments.

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**Two fiscal variables with which counties must contend are DMC-ODS payment rates and uncovered expansion costs.** In a fall 2015 survey, county administrators were asked about the most significant challenges they faced in expanding SUD services. At least 21 counties reported that low reimbursement rates were a challenge in expanding residential, detoxification, intensive outpatient, and outpatient services. Reimbursement rates were ranked as the number one challenge for three of these four service types. Another identified challenge was “high upfront investment/financial risk.” 28 counties reported that upfront costs were a factor in expanding residential treatment and 23 believed costs would affect efforts to expand detoxification services.<sup>54</sup>

Questions of financial risk under the waiver center on the way Medicaid is funded: program costs are shared by the state and federal governments.<sup>55</sup> Under California’s 2011 Public Safety Realignment policy, counties are responsible for providing the non-federal share of Medicaid payments using dollars allocated annually from designated state-level revenue sources<sup>56</sup> (with limited assistance from state general funds<sup>57</sup>). The federal government share of cost for the ACA expansion population began at 100% but will phase down to 90% by 2020. At that point California will be responsible for 10% of expansion population costs, as well as the typical 50% of costs for the population whose eligibility pre-dates the ACA.<sup>58</sup>

The novelty of the ACA expansion combined with the novelty of covering a full array of SUD services under Medi-Cal makes it challenging to predict how many beneficiaries will utilize DMC services—and makes it hard for counties to predict their non-federal shares of DMC costs. The Behavioral Health Subaccount from which counties draw the Realignment funds used for DMC is allocated annually using a formula that considers both county population and behavioral health program caseloads. However, it is the only Realignment account that does not have a permanent methodology for setting the base allocation. And of course the state sales tax revenues that fund the account can vary. Consequently, counties cannot count on a specific, minimum amount of funding year over year. This variability adds to a perception of financial risk. The state is working to finalize a methodology for setting the BH Subaccount base allocation,<sup>59</sup> which should help mitigate one source of financial anxiety.

**Given these uncertainties, county SUD program administrators interviewed for this report had differing perceptions of the level of financial risk their counties face under the waiver.** San Francisco and Santa Clara counties have historically enjoyed relatively robust financial support for safety net SUD treatment from non-DMC sources. They’ve used sizeable allocations of federal block grant dollars, other public and private grant funds, and even county general funds. Administrators from those counties were generally more confident in their county’s ability to predict utilization based on past trends, cover the necessary non-federal share of costs, absorb start-up costs, and perhaps help their SUD treatment providers do the same. But Santa Clara, with an operable organized delivery system already in place, and San Francisco, also among the wealthiest counties in California, should be considered exceptional cases. Administrators from Alameda, Santa Cruz, and San Mateo counties were relatively less sanguine about the financial risks of waiver participation. Most counties will have to carefully weigh the costs and benefits of opting into the DMC-ODS to guard against excess financial risk.

### Successful implementation depends on adequate service payments.

**Historically low DMC payment rates.** In recent years, Drug Medi-Cal payments have been capped under a statewide maximum allowance. Payment rates are based on cost reports, but there is consensus among DMC

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stakeholders that the numbers used are under-reported, often out-of-date, and not applicable statewide due to dramatically different costs of doing business in different California counties.<sup>60</sup>

Overly low payment rates are not unique to DMC. California providers and advocates have long maintained that low rates are the primary cause of well-documented beneficiary access problems throughout Medi-Cal.<sup>61</sup> But as California has gained the largest Medicaid population in the nation, the state has been hesitant to commit more money to the entitlement program.<sup>62</sup> The relatively low (50%) Medicaid matching percentage (FMAP) California receives from the federal government due to relatively higher per capita income means the state carries significant financial risk on behalf of this population.

The issue has been acknowledged by state lawmakers. During the summer of 2015, California Governor Jerry Brown called a special legislative session with the goal of finding sustainable, non-general fund revenue sources for Medi-Cal.<sup>63</sup> However, state officials noted that even were new funds to be allocated they would not be used for across-the board rate increases. Higher rates would be targeted to service types where DHCS data indicates they are most needed to support improved access.<sup>64</sup> At the time of this report, the state had not yet enacted any rate increases.

**Opportunity for county-specific interim rates.** County administrators interviewed for this report believe the ability to meet waiver requirements is contingent upon service payments that truly cover costs. They attribute past DMC provider shortages to the fact that “no one could do business on those rates,” and view higher payments as a critical tool to incentivize provider participation. These longstanding concerns prompted a waiver provision that allows DMC-ODS counties to propose county-specific interim payment rates, subject to DHCS approval.<sup>65</sup> They are “interim rates” because the federal share of Medicaid payments awarded per these rates will be reconciled annually against the county’s actual costs to correct over- or under-payments of federal dollars.

Securing adequate rates depends on two factors: 1) counties must predict their own costs and utilization with reasonable accuracy, and 2) the state must approve rates proposed by counties without instating caps that limit the ability to reconcile federal payments to real costs. Counties concerned their local funds may not cover the non-federal share of DMC costs must strike a balance by proposing rates that can support the DMC-ODS expansion without creating unnecessary financial risk.

**Rate development challenges.** Developing and proposing service payment rates poses an early implementation hurdle for counties. Data to support cost estimates and rates may be drawn from past-year cost reports on previously available DMC services, utilization estimates from providers, charges to third-party payers for services previously not covered by DMC, and approved medical inflation factors.<sup>66</sup> Nonetheless, these calculations may be challenging because:

- It is difficult to estimate either costs or utilization for services a county has not previously provided (or has not provided in a standardized manner).<sup>67</sup>



- As DMC becomes the payer for a greater array of services, rates will need to match what providers were previously being awarded through other payers/contracts simply to maintain existing levels of service (much less to expand access or capacity).
- Providers vary greatly in their capacity for sophisticated financial and data analysis and may be more or less able to accurately represent their costs for incorporation into rate estimates.<sup>68</sup>
- The numbers of SUD clients seeking treatment could increase under the waiver as the public becomes educated about available services.<sup>69</sup>

**Rate approval and fiscal parity with mental health services.** To the extent that counties are able to propose accurate interim payment rates that support DMC expansion, it is critical that the state approve them. As previously discussed, low payment rates are considered a primary driver of provider shortages. UCLA ISAP recommended increases in DMC reimbursement rates in its 2015 Evaluation, Training, and Technical Assistance report to DHCS.<sup>70</sup> Raising rates was also among the recommendations of a statewide workgroup that began in 2013 to examine strategies for developing the SUD workforce.<sup>71</sup>

*“Reimbursement rates must adequately account for the costs to build this improved system of care while also moving it into closer alignment with the mental and physical health systems.”*

--Los Angeles County waiver implementation plan

**Another argument for increased DMC payments raised by several key informants is the historic lack of parity between reimbursement rates for mental health services and those for SUD treatment.** Medi-Cal’s EPSDT benefits for youth under 21 (see subsection on youth treatment) and the 1915(b) waiver to provide specialty mental health (SMH) services to clients with serious mental illness are large entitlement programs that draw from the same pool of Realignment funds (the Behavioral Health Subaccount) used for Drug Medi-Cal.<sup>72</sup> Mental health programs have historically been funded more generously than SUD programs at the state level through policies like the Mental Health Services Act of 2004<sup>73</sup> and 2013’s Mental Health Wellness Act.<sup>74</sup> Medi-Cal’s mental health rates are calculated using a different protocol and different scale for units of service than those used for SUD treatment rates. The state’s mental health network has long relied on licensed clinicians to deliver most billable services, while SUD services have often been provided in “social model” environments by certified drug and alcohol counselors or lay people rather than professionals with advanced practice licenses. These are among the factors that have produced a longstanding imbalance between mental health and SUD reimbursements.

Under the waiver, SUD treatment providers will be required to hire more licensed clinicians. This will increase treatment costs; successful service expansion will depend on being able to pay licensed clinicians enough to incentivize their participation. But mental health and SUD systems must in effect draw from the same pool of behavioral health clinicians. Comparatively low rates disincentivize California’s behavioral health providers from specializing in SUD treatment or obtaining Drug Medi-Cal certifications. This lack of parity also complicates efforts to improve care coordination for beneficiaries with both SUD and mental health conditions



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(known as “co-occurring disorders”). As such, it is counterproductive to the enhanced integration with mental health that is another goal of the waiver.

**At the time of this report, the adequacy of DMC-ODS payments—and their impact on service expansion—is an open question.** Only 3 counties have proposed fiscal plans/interim rates, and none has been approved by DHCS. (DHCS, in turn, is awaiting CMS approval of the Certified Public Expenditure protocol counties will use to claim DMC costs.) The Department faces conflicting incentives in negotiations with counties. Counties manage Realignment dollars and feel responsible for meeting DMC non-federal share obligations with the funds they are allocated. But technically, it is the state that must ensure entitlements are met. In a worst-case scenario, the state would be forced to act as a back-stop for counties and cover non-federal DMC costs. One surefire way to protect the state’s budget is to keep DMC payment rates low. Yet the state does not want to discourage participation in the waiver. If rates truly do not support the cost of doing business counties might choose to opt out, even if it means leaving federal dollars on the table.

### Uncovered costs exacerbate financial uncertainty.

Counties and providers will incur significant start-up costs as they build the administrative capacity, infrastructure, and provider networks necessary to comply with waiver terms. The limited administrative costs that may be claimed post-implementation<sup>75</sup> will not be enough to underwrite these initial expenses. Administrators weighing the decision to opt into the waiver must gauge whether their counties have sufficient financial resources outside of DMC to make the necessary up-front investments.

Categories of uncovered implementation costs cited most frequently by key informants were:

- Start-up costs for new providers.
- Compliance/expansion costs for existing providers.
- Administrative overhead to support county-level activities.
- Room and board portion of residential treatment costs.

**Start-up costs for new DMC providers.** Many counties anticipate a need to add providers to their DMC networks to offer a full continuum of care and ensure access for beneficiaries. County administrators interviewed for this study discussed the challenges of bringing new providers on board: a lengthy RFP process, siting issues related to community opposition and zoning regulations, and high rental rates/real estate costs in the Bay Area. The waiver does not permit retroactive billing for DMC services, creating an imperative for counties to support or act as a primary payer for new providers until they demonstrate their qualifications, obtain certification, and begin billing DMC. One county that recently added a residential provider described a process that can last for two or three years and cost the county upwards of \$150,000 (apart from the provider’s own substantial investment). To the extent that a provider has previously done business in the county and has an existing client base supported by other payers, this scenario won’t occur. But some counties have not met the need for certain services the past and will need to bring providers online from the ground up. The issue is magnified in counties like San Mateo with relatively small per capita Medi-Cal populations. Providers may be reluctant to contract with the county because they cannot expect to treat consistently high numbers of DMC beneficiaries.

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A small number of counties will be readily able to cover such interim expansion costs, given previously high levels of investment in SUD services and the promise of additional federal dollars. But an inability to do so may leave others with inadequate networks and impede waiver participation and access to services.

**Compliance and expansion costs for existing providers.** SUD treatment providers who wish to participate in the DMC-ODS will be required to employ a medical director who is a physician licensed in the state of California. The DMC medical director requirement pre-dates the waiver, but is notable because many providers who previously did not participate in Drug Medi-Cal under the state plan (e.g. virtually all providers of residential treatment) will need medical directors in order to become certified to deliver DMC-ODS services. Provider organizations will also need to increase their staff of Licensed Practitioners of the Healing Arts (LPHAs). LPHAs include MDs, NPs, PAs, RNs, Pharm.Ds, LCPs, LCSWs, LMFTs, and LPCCs. Waiver terms and conditions state that a medical director or LPHA must make the initial medical necessity determination for DMC-ODS services “through a face-to-face review or telehealth,” and subsequently sign off on each client’s treatment plan.<sup>76</sup>

This represents a shift for SUD treatment providers who may previously have relied more heavily on non-licensed staff. Licensed staff must be paid more than other personnel. Larger, more established provider organizations are likely to have the LPHAs they need or the resources to hire them. The burden of “staffing up” falls most heavily on small, independent community providers, often referred to by county administrators as “mom’n’pop” clinics. San Francisco has offered grant money to help a few of its smaller providers hire medical directors. Most counties will not be able to do this, but will need to move away from non-DMC contracts with providers as they expand DMC. Providers who care for the safety net population but cannot attain DMC certification may not be able to stay in the field, or may need to merge with larger providers.

**Administrative overhead for transition to organized delivery system.** Counties also emphasized the increased administrative burden on county SUD departments under the waiver—and the resulting costs. New activities that must be undertaken to comply with waiver terms and conditions include:

- Developing waiver policies and procedures, interim rates, and contracts with providers, MCOs, and the state.
- Training and assisting providers with DMC certification, use of ASAM criteria, evidence-based practices, and DMC data collection and documentation.
- Building data infrastructure to support better coordination between DMC modalities and with MH and primary care.
- Organizing waiver-specific quality improvement (QI) activities, including the formation of a designated quality improvement committee if DMC duties cannot be added to the workload of an existing QI team.
- Engaging in the program evaluation and external quality review processes described in Section VII of this report.

In a case-study of Santa Clara County's existing organized delivery system, UCLA researchers wrote that "for a system of care to truly function as a system, its operations need to be consistently informed by real-time data. Utilization, performance, and cost data are the lynchpins of system design."<sup>77</sup> Most counties and their network providers have a long way to go to achieve this level of functionality. A 2013 behavioral health needs assessment conducted as part of the previous Section 1115 waiver noted that substance use providers exhibit disparities in I.T. and EHR capabilities when compared to both physical and mental health providers. The report went on to say that the state's Medi-Cal delivery system lacked "sufficient resources to significantly increase HIT/HER and health information exchange on its own over the next few years."<sup>78</sup> Estimates that only about 50% of behavioral health providers have operable electronic health records<sup>79</sup> are part of a landscape of I.T. challenges that have made health information technology one of the state's strategic priorities for its SUD system.<sup>80</sup>

These and other waiver requirements demand a significant investment of resources. Under-resourced public health care systems may try to supplement Medicaid or other public funding with private grants, additional government grants, or other sources of so-called nontraditional funds. But it is worth noting that few of these nontraditional funders will pay for staffing, infrastructure, or administrative overhead. Continued lack of public investment in these ongoing needs will almost certainly leave the DMC-ODS (along with other Medi-Cal programs) operating in a manner that can only be described as suboptimal.

### Notes on SUD Treatment Funding in CA

In addition to limited participation in Drug Medi-Cal, counties have historically financed SUD treatment with a patchwork of funding sources, including:

- **Behavioral Health Subaccounts (2011 Realignment)\***
- **Federal SAMHSA Substance Abuse and Prevention Block Grants (SAPT BG)**
- **State general funds\***
- **County general funds (rare)\***
- **Criminal justice system funds (e.g. AB 109)**

*\*Asterisks = possible sources of Drug Medi-Cal non-federal share.*

**BH Subaccount:** California's 2011 Public Safety Realignment policies shifted responsibility for public mental health and substance abuse services from the state to counties, a process begun in 1991. The resulting Behavioral Health Subaccount draws on a designated percentage of state sales tax revenue. Counties receive an annual allocation to provide publicly funded behavioral health services including DMC and SUD treatment programs; Medi-Cal's mental health managed care plans for those with serious mental illness (aka Specialty Mental Health services); and the EPSDT benefit for Medi-Cal beneficiaries under 21.

**SAPT BG:** SAMHSA's block grants are noncompetitive, annual awards from the federal government to states for public substance abuse prevention and treatment activities.

**State general funds:** The state of California may not mandate programs that impose costs on counties without allocating funding for those programs. As such, the state is responsible for the non-federal share of certain expanded DMC services under 2013's SB 1. The DMC-ODS waiver is an opt-in program that does not trigger an additional state obligation. However, the state does intend to offer supplemental state general funds to participating counties subject to annual appropriation. Counties may claim these dollars for qualifying expenses quarterly or annually up to a maximum allowance during at least year one of the waiver. (See MHSUDS Information Notice 16-009, available at [www.dhcs.ca.gov](http://www.dhcs.ca.gov).)

**County general funds:** Counties may use their own general funds to offer SUD services and supply DMC non-federal share, though most counties rely on other sources and use little, if any, general fund.

**Criminal justice system funds:** Historically, many safety net SUD treatment services have been reserved for the criminal justice population, and funded separately under legislation like AB 109 (another Realignment policy) or Proposition 36 (aka SACPA).

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**Room and board expenses for residential treatment.** Obtaining federal matching funds for non-perinatal residential services was an important goal of the waiver and such services represent an essential element within the DMC-ODS treatment continuum. But Medi-Cal will reimburse counties for only the programmatic portion of residential treatment costs (e.g. staff time for therapy sessions), not for room and board.<sup>81</sup>

Counties that were previously meeting local needs for residential treatment costs using non-DMC funding sources can expect to be better off than they were before. Even partial DMC payments for residential treatment will free up dollars from other sources (see right). However, counties that need to add residential capacity and/or believe non-DMC funding may be inadequate to cover room and board see this as another source of financial risk. To minimize risk, they must accurately estimate the percentage of residential costs that go to room and board versus other expenses. This depends on the size and characteristics of the treatment facility; economies of scale can lower per-bed room and board costs in larger facilities. One administrator noted that during waiver negotiations, state and county leaders anticipated room and board costs would average only about 25% of total residential expenditures. But data indicates room and board at most of this county's facilities accounts for closer to two-thirds of residential treatment costs. Given uncertainty around utilization, the possibility that a county might end up responsible for higher-than-estimated room and board costs could be a "deal breaker" for continued waiver participation.

## Ensuring network adequacy

### Key Findings

- **Difficulty recruiting and retaining SUD providers may leave gaps in the care continuum.**

Opt-in counties trying to expand provider networks must contend with a nationally recognized shortage of SUD treatment professionals. Training and development of the existing workforce is critical but will only be a good investment if SUD staff retention improves. Practitioners expect provider organizations to continue a trend toward consolidation, but fear that the loss of small community providers will exacerbate existing challenges with delivering culturally inclusive care.

- **Shorter lengths of stay in residential treatment create an urgent need for recovery residences.**

The waiver limits residential lengths of stay to 90 days. Clients are then meant to “step down” into recovery residences if they do not have another source of stable housing. Historically, many clients in safety net residential treatment have been homeless and have utilized longer residential stays as a substitute for more permanent housing. California’s housing crisis will make it extremely difficult to meet the needs of this population.

- **Many counties are unable to offer SUD treatment targeted to youth.**

Medi-Cal-eligible youth are entitled to all medically appropriate care within the SUD continuum. However, most counties statewide have few SUD treatment programs targeted to the unique needs of young people. Notably, very few counties offer residential treatment for youth. Youth-specific services must be expanded to meet waiver requirements.

### Difficulty recruiting and retaining SUD providers may leave gaps in the care continuum.

**SUD provider shortages are a known issue.** Under the DMC-ODS, many counties must expand their provider networks to provide the full ASAM continuum of care. Simultaneously, existing SUD providers will need to add licensed staff to comply with waiver terms. As noted in the above discussion of expansion costs, all DMC certified providers must retain a medical director who is a licensed physician. The waiver also requires Licensed Practitioners of the Healing Arts (LPHAs) to participate directly in patient intake and assessment in order to make medical necessity determinations and approve treatment plans.<sup>82</sup>

Interviewees emphasized that hiring and retaining LPHAs to expand DMC networks and bring existing provider organizations into compliance will be uniformly difficult. Evidence supports this perception: the U.S. faces a shortage of behavioral health professionals that may be considered more acute among the SUD workforce.<sup>83</sup> In a 2013 report to Congress, SAMHSA noted that measuring the supply of addiction treatment workers was difficult due to a lack of data. But provider surveys cited numerous barriers to recruiting and retaining SUD treatment professionals. They included a lack of qualified applicants with appropriate certification, education, or experience, even fewer qualified professionals in rural areas, and “a lack of interest

in the positions due to salary and limited funding.”<sup>84</sup> For example, a social worker providing SUD treatment can expect an average annual salary of \$38,600 compared to \$47,230 elsewhere in health care<sup>85</sup> (to say nothing of the salary differences between safety net providers and private institutions).

Addressing SUD workforce challenges was identified as a statewide strategic priority by DHCS in its 2015 Statewide Needs Assessment and Planning (SNAP) Report for federal substance use grant funds. DHCS wrote that “with the implementation of recent parity and health reform legislation, behavioral health and SUD workforce development issues, which have been of concern for decades, have taken on a greater sense of urgency.” The state emphasizes the need to offer training and support to make the best possible use of the existing workforce, while also developing “a long-term strategy to attract and retain” new professionals.<sup>86</sup> A survey of behavioral health providers cited by DHCS in its 2015 SNAP report found that 20% felt it was highly probable they would change their place of employment within two years; 13% expected to leave the SUD treatment field.<sup>87</sup>

*“We train the behavioral health workforce for the state, and then they go to Kaiser.”*

*--County Administrator*

County administrators who responded to UCLA’s fall 2015 survey rated the addition of LPHAs as one of the most challenging aspects of the waiver to implement. Only 8 responding counties (17%) said they had the necessary LPHAs “fully available”. More than one-quarter estimated it could take a year or more to add the necessary staff.<sup>88</sup> Practitioners interviewed for this report described a struggle to recruit all categories of SUD treatment staff. This includes qualified medical directors, psychiatrists that work with SUD clients, physicians who can dispense MAT, licensed counselors like LMFTs and LCSWs, and certified drug and alcohol counselors. Interviewees attributed this difficulty to low compensation coupled with the high cost of living in the Bay Area (though this applies to other regions in California as well). Turnover rates are high, with many professionals leaving for higher paying positions or to gain additional training, certifications, or licensure. One administrator said it isn’t unusual to have ten or eleven treatment sites depending on the same licensed physician, and “we won’t be able to replace him when he leaves.”



## Snapshots of an SUD Workforce

- **27-28: Number of SUD treatment providers per 1000 non-elderly adults with SUD in California.** The nationwide average is 32 providers per 1000 clients; this puts California in the second-lowest quintile among the fifty states.<sup>89</sup>
- **2,000: Number of board-certified Addiction Psychiatrists in the entire United States.** Most of California's 4,260 psychiatrists do not work in addiction medicine or within the public health care delivery system. Many rural California counties have no psychiatrists at all.<sup>90</sup>
- **15%: Projected growth in demand for mental health and substance use social workers and substance use and behavioral health disorder counselors between 2008-2018.**<sup>91</sup>
- **1700: Number of LCSWs and MFTs that must be added** to meet California's behavioral health workforce needs.<sup>92</sup>
- **38%: Proportion of Californians of Hispanic/Latino origin.** Yet California's behavioral health workforce is "predominantly Caucasian, English-only speaking . . ." <sup>93</sup>

**Provider consolidation and culturally inclusive care.** One likely consequence of ongoing shortages within the SUD treatment workforce is provider consolidation. Small nonprofit providers have played an important role in making SUD treatment available over the years when it has not been a financially attractive field in a costly health care environment. These providers are the least able to absorb waiver-related costs like hiring medical directors and building electronic health record capabilities. Counties may face decisions about whether to subsidize these providers or allow them to go out of business if they are unable to meet the terms for waiver participation.

Alternately, providers may pursue mergers. For example, HealthRight 360 began with the merger of San Francisco's Walden House and Haight Ashbury Free clinics and has grown to incorporate 55 primary care, mental health, SUD, and re-entry programs in 11 California counties.<sup>94</sup> Provider consolidation is a health care trend outside the SUD field as well. Consolidation allows providers to enjoy economies of scale (particularly useful for keeping overhead costs low for residential facilities), and can help promote care coordination or integration. For example, HealthRight 360's SUD professionals can engage in case conferencing with their primary care & mental health counterparts that would be far less feasible if they weren't operating under the same organizational umbrella. Because the organization is also responsible for many of its clients' non-SUD health care needs and costs, it has a financial incentive to advance whole person care even if time spent on coordination is not reimbursed. Obtaining patient consent and navigating different EHRs is also simplified through physical proximity and consistent administrative practices.



Interviewees agreed that consolidation isn't necessarily a bad thing. Yet in the words of one key informant, in some cases the closure or merger of small providers can be "a real loss to our clients." Practitioners from San Mateo, Santa Cruz, and Alameda all pointed out that smaller providers often operate programs tailored to the needs of highly specific populations, such as LGBT individuals or Latino men. These programs fill important niches in diverse counties like Alameda, Los Angeles, San Francisco, and Santa Clara, all of which have more than four prevalent non-English languages in which services must be available to meet federal and state standards for culturally competent care.<sup>96</sup>

Even if culturally specific SUD treatment programs can be preserved under mergers or rescued by private funding sources, the provider shortage is likely to impact county goals for delivering culturally sensitive care. Providers that can deliver such care—for example, trained counselors that speak the prevalent non-English languages—are even harder to find than providers in general. One county cited a longstanding vacancy for a Chinese-speaking SUD-specialist physician. Writes DHCS, "The proportion of SUD service providers from diverse groups generally does not represent the proportion of those various groups in the United States."<sup>97</sup>

Another concern expressed by practitioners was the small number of providers who have substantial previous experience treating SUD clients or have been in recovery themselves. Several key informants maintained that certified drug and alcohol counselors who have focused on SUD are better-equipped to perform assessments and develop treatment plans than many of their LPHA colleagues who have little SUD experience. One interviewee pointed out that 60-hour licensure programs for LMFT/LPCCs typically require very little coursework in SUD. LPHAs must pursue this training themselves, or counties/providers must hire relatively inexperienced staff and invest in training them.

*"[California has] an addiction treatment workforce starved of resources, operating outside the medical profession, and lacking capacity to provide the full range of evidence-based practices . . ."*

--UCLA-ISAP  
2012 report to DHCS<sup>95</sup>

**Workforce training and development.** The state has acknowledged the need to invest in workforce training. DHCS' 2015 SNAP report emphasized the need to help equip the behavioral health workforce to deliver high-quality, evidence-based SUD care in more integrated settings and requested technical assistance on workforce development topics from CMS.<sup>98</sup> The state will continue to prioritize workforce goals identified in a June 2013 report from the former Department of Alcohol and Drug programs, including "Develop curricula and training for all healthcare workforce members who deliver SUD services. Make the training easy to access, affordable, and broad enough to address all elements of delivering SUD services in a wide variety of healthcare settings."<sup>99</sup> UCLA-ISAP has also outlined an array of specific recommendations around workforce training and development.<sup>100</sup>

Investment in training is no doubt critical—and takes on an added dimension under the waiver, given that all providers must learn to document and deliver care according to waiver terms. In its 2015 Evaluation, Training, and Technical Assistance (ETTA) report to DHCS, UCLA-ISAP writes that "an extensive training effort will be required to prepare the workforce for SUD service integration and for creating a functional, organized system of SUD care. Without a comprehensive training program conducted over the next 2-3 years . . . SUD services

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will not successfully function as an organized system of care.”<sup>101</sup> But such training will only be a sound investment if the state is able to retain and expand its SUD workforce over time. And non-federal resources—and creative solutions—for workforce challenges will be necessary to implement the waiver and produce a sustainable SUD continuum of care.

### Shorter lengths of stay in residential treatment create an urgent need for recovery residences.

**DMC-ODS limits on length of stay.** Under waiver terms, residential treatment stays of up to 90 days per client may be authorized no more than two times per calendar year with some exceptions.<sup>102</sup> For many providers this represents a departure from past practices. Longer residential stays have often been permitted according to client needs, particularly for those unable to find housing outside treatment facilities.

The waiver promotes a “stabilization model”: a client stays in residential treatment for a relatively brief interval, only until his condition is stable enough to allow him to “step down” to another level of care. This approach is already used within Santa Clara County’s organized delivery system: the average residential length-of-stay in Santa Clara County is 35-45 days.<sup>103</sup> In other counties, residential stays of 6 months or longer were common. Practitioners agreed that limits on residential lengths of stay are not problematic by definition. Stays of less than 90 days can be medically appropriate for most clients as long as they are able to transition into supportive environments. **Unfortunately, California’s housing crisis (particularly acute in the Bay Area but a factor elsewhere as well) could make it very difficult for some counties to comply with the 90-day limit while protecting the health of their clients.**

The scope of the challenge is difficult to quantify. Counties track client housing status alongside other utilization and demographic information in the statewide CalOMS treatment database, but no estimate of the numbers receiving treatment who are also homeless appears to be publicly available. Approaching the question in reverse, it is estimated that 50% of the state’s sizeable homeless population have SUDs.<sup>104</sup> Bay Area practitioners report that in some safety net residential facilities “one hundred percent” of clients are homeless. During a 2015 panel discussion of implementation challenges, San Francisco administrators described an artificial demand for residential services from clients who might not otherwise choose residential treatment, but seek it out because they need housing.<sup>105</sup>

**Need for recovery residences.** In order to step down from residential treatment, homeless individuals need access to transitional housing, often through what are known as “recovery residences.” Recovery residences are non-clinical group homes for individuals who are in substance use treatment. They are typically more affordable than market-rate housing and may incorporate supports like transportation that help clients remain engaged in treatment.

Yet recovery residences (as well as other options for transitional housing) are universally in short supply. All counties interviewed acknowledged challenges housing clients who leave residential treatment. Santa Clara has prioritized matching its transitional housing capacity to the number of residential treatment slots in the county as it has developed its organized system of care. Yet even Santa Clara county administrators acknowledged a struggle to place everyone who comes out of residential treatment. There is a log-jam effect: those occupying a limited stock of recovery residence beds may not be ready to move on before other clients finish residential, particularly if they cannot find more permanent housing. In combination with policies that

strive to accommodate client needs and preferences around specific programs/locations, this can mean that there are simultaneously wait lists *and* empty beds for residential treatment and the recovery residences.

Many clients who are wait-listed ultimately won't access services: staff are often unable to contact clients who are homeless. Santa Clara has engaged in targeted quality improvement work to improve timely client transitions and reduce a residential vacancy rate that had averaged 17-28%.<sup>112</sup> Meanwhile, San Francisco administrators estimate they need to add at least 80 transitional beds annually to keep up with demand. Santa Clara and San Francisco still have better existing capacity for recovery residences than other counties and greater financial resources to address their shortages.

**Barriers to expansion.** Because DMC does not pay for room and board in any capacity, recovery residence stays will not be reimbursed through the waiver. Existing residences have historically been funded by a variety of county-specific, non Medi-Cal funding sources. Opt-in counties hoping to expand their network of safety net recovery residences to accommodate clients leaving DMC-ODS residential programs must similarly rely on non-DMC funding sources. Interviewees reported that the state has received authorization to use federal Substance Abuse Prevention and Treatment block funding for this purpose (many of these dollars previously went to fund residential treatment but can be repurposed as DMC begins to cover the programmatic portion of the residential benefit). San Francisco has raised the possibility of using county funds to extend residential stays beyond the 90-day maximum if necessary. Nonprofit residential treatment providers that rely on private grants and donations in addition to DMC payments could theoretically take similar actions. But many counties/providers will have no feasible means for doing so.

## California faces a housing and homelessness crisis . . .

- With over **115,000 homeless** individuals counted on a single night in January 2015, California has more than one-fifth of the nation's homeless population. **64% of homeless people in the state are unsheltered; 31% are chronically homeless.**<sup>106</sup>
- California's homeless population **grew by 1.6% between 2014 and 2015**, the second-largest increase in the United States.<sup>107</sup> No region is exempt. Los Angeles County has the largest homeless population, but numbers have risen in San Diego and the Bay Area/Silicon Valley as well.
- In addition to housing those already homeless, the state must address housing affordability. Since 2000, **rents have increased by 21% while renter's incomes have decreased by 8%.**<sup>108</sup>

## . . . and housing, health, and substance use are deeply connected.

- **Poor health increases the risk** of homelessness, while **homelessness increases the risk** of poor health.<sup>109</sup>
- **One in five people experiencing homelessness** has a serious mental illness and/or a substance use disorder. Among the chronically homeless, **rates of both SMI and SUD are estimated at greater than 70%.**<sup>110</sup>
- Homeless individuals with SUDs are more likely to die from their conditions than are those who are housed. Studies have found that homeless people face a **risk of death from drug or alcohol-related causes that is at least seven times greater** than that for the housed population.<sup>111</sup>

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In addition to the necessary financial investments, counties face other barriers to expanding the number of available recovery residences. San Mateo and Marin’s implementation plans point to the siting and zoning challenges that can plague attempts to develop any type of new facility for individuals with SUD (i.e. “NIMBY” issues). Practitioners also emphasized the task of developing consistent standards for newly contracted recovery housing. Fortunately, counties including Santa Clara and Marin have existing standards for recovery residences that can serve as references for other counties.

Housing challenges leave many counties/providers facing a seemingly impossible choice. They must secure funding and overcome geographic and logistical barriers to rapidly expand recovery residences—or they will be forced to release DMC-ODS residential treatment clients into shelters or onto the streets. **The housing crisis creates a dangerous gap within the continuum of care by threatening the recovery and health outcomes of DMC-ODS clients while increasing costs to county delivery systems.** Housing in California has come to be perceived as a virtually intractable problem for many cities and counties. Nonetheless, it is highlighted here because its impact on the health of safety net populations cannot be ignored.

### Many counties are unable to offer SUD treatment targeted to youth.

**California youth and SUDs.** California youth ages 12-17 experience dependence or abuse of illicit drugs and alcohol at lower rates than the population as a whole (5.43% compared to 8.27%). However, at 17.41% rates of SUD for 18-25 year-olds are more than double the population average. Further, the numbers of youth needing but not receiving treatment are higher than those for other age groups. In California between 2013-14, only 2.47% of the general population fell into this category—but the proportion among 12-17 year olds was 3.85%, and among 18-25 year-olds 6.79%.<sup>113</sup>

Concerns about inadequate SUD treatment services for California’s youth predate the waiver. DHCS’ 2015 SNAP report states that “California faces particular challenges in addressing youth substance use . . . California’s SUD treatment system was established to address adult treatment issues and needs.” The report asserts the state’s goal to provide “a full continuum of care” for the youth population. But while 400 youth-targeted providers in the state admit over 21,000 young Californians to SUD treatment annually, access varies by county. DHCS estimates another 407,500 youth ages 12-17 are in need of treatment.<sup>114</sup> At a waiver advisory group meeting in 2014 “providers [agreed] that youth treatment in California is too limited” and stakeholders requested that DHCS coordinate a youth services workgroup.<sup>115</sup> The Department subsequently added a team focused on youth SUD services within its Prevention, Treatment, and Recovery Services Division (SUD-PTRSD) and is working with stakeholders to rewrite the state’s Youth Treatment Guidelines, last revised in 2002.<sup>116</sup>

**Medi-Cal SUD benefits for youth.** Despite widespread recognition of SUD treatment disparities facing California’s youth, the DMC-ODS waiver only briefly addresses youth and SUDs. A single paragraph states that “At a minimum, assessment and services for adolescents will follow the ASAM adolescent treatment criteria.”<sup>117</sup> (“Adolescent” in this context refers to individuals 11-21 years of age, the definition used by ASAM and attributed to the American Academy of Pediatrics. This paper uses “youth” interchangeably with adolescent to reflect language also used by both CMS and DHCS.) ASAM’s treatment framework distinguishes between adolescents and adults, offering parallel diagnostic criteria and levels of care to guide clinicians in considering the unique needs of adolescents. Services recommended for youth generally mirror those that

*“Because youth differ from adults physiologically and emotionally, it is crucial that treatment be adapted to meet their specific needs.”*

**--DHCS, 2015 SNAP Report**

should be available to adults, including early intervention and screening, outpatient/intensive outpatient, residential treatment, and medication assisted treatment (MAT).<sup>118</sup>

Practitioners generally interpret waiver terms to mean that counties opting into the waiver are committing to deliver the full spectrum of SUD services to youth as well as adults. And under federal and state law, even counties that do not opt in are obligated to provide SUD treatment that meets the needs of youth. Federal parity regulations and the ACA’s essential benefits (see Section IV) apply to beneficiaries of all ages. Medicaid-eligible youth nationwide are also entitled to a benefit known Early and Periodic Screening, Diagnosis,

and Treatment (EPSDT). EPSDT guarantees access to a broad range of Medicaid-covered services for the youth population, as long as the desired treatment is deemed medically necessary. It effectively skirts coverage exclusions by individual state Medicaid programs: “EPSDT covers physical and mental health and substance use disorder services, regardless of whether these services are provided under the state plan and regardless of any restrictions that states may impose on coverage for adult services . . .”<sup>119</sup>

**Gaps in youth SUD services.** Counties were not required to explicitly address services for youth in their implementation plans. Nonetheless, plans hint at weaker systemwide capacity for youth than for adults:

- L.A. County, with roughly 1/3 of the state’s Medi-Cal eligible population, estimates it is home to 70,439 DMC-eligible youth and 236,338 eligible adults. But out of 383 county-contracted provider sites operated by 93 agencies (including those that are not yet DMC certified), only 19 outpatient and five residential sites serve the youth population. To offer a crude comparison, this amounts to **one outpatient program for roughly 3700 DMC-eligible youth, versus one program per 1300 eligible adults**. Over the waiver term, L.A. anticipates additional demand for services that could increase the number of unique youth treated annually from 9,812 to 12,843. The county writes that “Given the very limited number of youth serving programs in [our] network, significant expansion of outpatient, intensive outpatient, and residential” services must occur.<sup>120</sup>
- Many counties’ tallies of anticipated DMC-ODS providers (including Los Angeles, San Francisco, and Marin) show **no intensive outpatient programs currently available** for youth. These services must be developed under the waiver.
- Among opt-in counties at the time of this report, **only Santa Clara and Los Angeles** operate residential programs for youth. Other counties (San Francisco, San Mateo) describe the need for regional collaboration to place youth in residential treatment, or say they are considering undertaking an RFP process for youth residential treatment (Riverside).

Key informants agreed there is ample need and demand for youth services but simply not enough youth-focused providers and programs. One practitioner noted that his Bay Area outpatient youth program was “busting at the seams [with demand] but there’s no money to expand.” Another interviewee estimated that there are perhaps 147 residential beds for youth available statewide. Youth residential facilities in Santa Clara



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have provided treatment for youth from as far south as Ventura county as well as those “all the way to the northern border.” Meanwhile, sending youth to far-flung geographic locations for treatment is at best highly disruptive to their educations and relationships—and at worst simply not feasible (e.g. for levels of care other than residential treatment).

Interviewees believe many California youth in counties that lack designated youth programs do receive counseling or other assistance for their SUDs: SUD treatment is essentially rolled into mental health services delivered under the EPSDT benefit. But such services do not necessarily align with ASAM guidelines and may not be delivered by professionals with deep expertise in treating youth SUD. Practitioners also pointed out that developing a specialized workforce for youth SUD treatment is likely to be even harder than adding to the adult workforce, as many behavioral health licensure programs require few hours of youth-focused training and even fewer hours focused on SUD.

Some interviewees felt that a lack of combined youth/SUD expertise in the state and particularly within DHCS had significantly slowed the process for developing new treatment standards. Yet they were simultaneously appreciative that the state is willing to commit resources to improving youth treatment as best it can. Further, California’s SUD provider organization and trade associations have historically been very adult-focused. Focusing some of these resources on youth (or forming new, youth-specific organizations) could help build capacity statewide.

In its 2015 SNAP report, DHCS concluded that “Various factors are preventing broader provision of youth services, and further research, possibly extending to direct contact on a county-by-county basis, will be needed to ascertain what those factors are.”<sup>121</sup> **The state’s acknowledged challenges with youth treatment must be considered in relation to the DMC-ODS waiver.** The waiver will prompt unprecedented levels of oversight and scrutiny from stakeholders ranging from community advocates to state-level policymakers to CMS. Youth are entitled to medically necessary SUD service and the dearth of those services is, in the words of one interviewee, “a lawsuit waiting to happen.”

## Aligning policy with clinical practice

### Key Findings

- **DMC documentation requirements do not match clinical best practices.**

Current DMC documentation requirements are not well-aligned with the ASAM continuum of care and do not reflect an understanding of SUD as a chronic condition. At best, providers face increased administrative burden. At worst, compliance begins to dictate patient care.

- **Standardized intake into an ODS must preserve treatment on demand.**

SUD providers are concerned that steering clients through centralized intake hubs to standardize screening and placement may delay access to treatment. Counties are conscious of the importance of facilitating treatment on demand and will adopt different strategies for client intake based on their existing system characteristics.

- **Multiple funding streams and managed care structures may undermine care integration.**

The waiver creates a third managed care structure within Medi-Cal. California's carve outs of SUD and SMI complicate efforts to improve care integration under the DMC-ODS and within Medi-Cal generally. Lack of I.T. capabilities and concerns about data privacy regulations governing the exchange of SUD health information are also barriers to waiver integration goals.

### DMC documentation requirements do not reflect clinical best practices.

**Increased administrative burden.** Practitioners in Bay Area counties believe DMC documentation requirements must change to align with the waiver's new approach to SUD care. For example, a requirement that providers complete admit/discharge forms every time a patient transitions between treatment modalities does not reflect an understanding of SUD as a chronic condition. The emphasis on admissions/discharges from different services types continues to frame SUD as an acute condition to be resolved through a single treatment interaction. This contrasts with the treatment model that underpins the ASAM continuum: individuals with SUD should be able to move seamlessly between levels and types of care as their needs shift over time. At minimum, this discrepancy between documentation and clinical practice adds to administrative burden. Counties/providers must maintain what one administrator described as "parallel" records. They must track their use of ASAM diagnostic criteria and each client's movement between ASAM levels of care while also adhering to DMC requirements to document each admission/discharge and create new treatment plans for each type of service.

*"Regulations will need to become more flexible to accommodate a person-oriented treatment approach, by shifting the focus from paperwork to the person."*

--Santa Clara County  
waiver implementation plan



Relatedly, counties have asked DHCS to clarify DMC-ODS documentation requirements for medical necessity determinations. At present, practitioners expect that under existing DMC regulations the county will have to re-establish medical necessity and create a new treatment plan every time a client moves between service types. This includes review of the treatment plan/medical necessity determination by a Medical Director or LPHA. These processes are resource-intensive as clients may be expected to transition between types and levels of care within short intervals of time, e.g. after 30-45 days on average following residential treatment within an organized delivery system, or after only a few days following detoxification/withdrawal management.<sup>122</sup> Instead, administrators advocate a system of documentation that reflects a more sustained approach to treatment, in which a treatment episode may incorporate several types/levels of care and the corresponding treatment plan could simply be revised on an ongoing basis.

**Impact on client care.** The overarching worry voiced by providers and administrators is that DMC administrative requirements may curtail providers' ability to respond flexibly to client needs. Santa Clara County made this case in its implementation plan: "From the perspective of a delivery system based on a client-focused, recovery-driven continuum of care, the current rules for reimbursement and reporting act as a constraint to the full development of a good and modern behavioral health delivery system." Examples of clashes between administrative processes and clinical practices that have implications for patient care include:

- **Time constraints on treatment planning.** Santa Clara's implementation plan cites a 30-day treatment planning window for DMC clients and notes this may harm provider efforts to engage with SUD clients on each client's own terms, gradually if need be.
- **Lag time in updating DMC regulations.** DMC requires medical necessity to be determined using criteria from the DSM III or IV—but the most current version of the DSM, DSM V, was released in 2013.<sup>123</sup> This sort of discrepancy can lead to DMC claims being disallowed on a technicality.
- **Ongoing lack of clarity around DMC certification requirements.** DHCS has worked through a backlog of provider certifications resulting from mass re-certification after the 2013-14 DMC fraud investigation. However, one key informant noted that every one of the county's SUD providers that has applied for certification in advance of waiver implementation has been required to revise its application after submission, which "may indicate the problem lies with the process, not the providers." Another practitioner pointed out that although DHCS has confirmed that facilities offering withdrawal management services must obtain DMC certification to participate in the DMC-ODS,<sup>124</sup> DHCS' provider enrollment division was unable to answer questions about application requirements and "doesn't seem to know what withdrawal management is."

*"Creating a treatment plan is a human services process, not a legal process."*

*--County Administrator*

DHCS has demonstrated a willingness to respond to county concerns around administrative procedures, provider certification, etc. But the Department's ability to partner effectively with counties to resolve such challenges in a timely manner is highly dependent on its staffing levels and the expertise and qualifications of its SUD and provider enrollment division staff. See Section VIII for additional discussion.

## Standardized intake into an ODS must preserve treatment on demand.

**Access concerns.** SUD providers and experts stress the importance of admitting a client into treatment “when the urgency strikes.” There is a body of literature indicating that individuals who face delays like wait lists are less likely to enter treatment.<sup>125</sup> “Most clients do not wait for treatment, so the drop-off from the waiting list is very high,” commented one respondent in UCLA’s fall 2015 county administrator survey.<sup>126</sup> This is the rationale behind the idea of SUD treatment on demand.

In practice, treatment on demand is closely related to the idea that there is “no wrong door” into a care delivery system. A client should be able to promptly access appropriate SUD treatment from wherever he enters the DMC system: via a referral from a primary care provider, through criminal justice proceedings, or by “self-referring” to an SUD provider. Counties affirm that this will be the case under DMC-ODS, but some providers expressed reservations. They fear that if counties begin to steer more clients through a central point of access to undergo standardized screening and placement into treatment, delays will occur. Santa Clara County, which operates an organized delivery system, already refers most clients to a central “gateway” for placement into treatment. Interviewees reported that this sometimes causes a bottleneck effect. Santa Clara is engaged in ongoing efforts to pilot programs that promote same-day intake and referrals, with the explicit goals of improving access and reducing attrition.<sup>127</sup>

**Relevant waiver requirements.** The DMC-ODS waiver does not require counties to direct all beneficiaries through a single access point or an identical intake process. But participating counties must consistently document that all clients have been assessed using ASAM’s diagnostic criteria, treatment plans have been constructed based on the ASAM levels of care, and medical necessity has been established. Residential treatment must be pre-authorized by the county. The waiver also calls for increased coordination and referrals between the DMC-ODS and physical and mental health providers. This includes MOUs with Medi-Cal managed care plans that specify how plans will screen and refer clients to the DMC-ODS.

*“We don’t want a narrow front door. The openness of our system is a strength and we don’t want to choke it.”*

*--County Administrator*

**County practices.** Failure to ensure system wide standardization of intake, assessment, and medical necessity determination processes could lead to a high volume of disallowed claims. To promote consistency, counties may choose to rely more heavily on a few specified points of access, including their 24-hour beneficiary call lines. Strategies for meeting DMC-ODS requirements while preserving a no-wrong-door philosophy will vary according to county characteristics. For example, San Francisco already operates a 24-hour beneficiary line and manages access to the county’s residential treatment beds. San Francisco’s county implementation plan affirms that the county “embraces a philosophy of care that supports any

door as the right door to access appropriate treatment services.” The county’s Howard Street Program, operated by the San Francisco Department of Public Health, will serve as “the main designated point of access” and includes both their 24-hour beneficiary line and the Treatment Access Program (TAP) for “walk-in, centralized intake, assessment, and referral/placement services”.<sup>128</sup> San Mateo County, with a relatively small DMC population and thus a smaller provider network, is testing an ASAM quick-screen tool that may eventually be used by all the county’s SUD providers (as well as the beneficiary call line). This would ensure that clients may continue to self-refer directly to any treatment location.<sup>129</sup> Alameda county, with a very large

and diverse provider network, is considering designating at least four “hubs” that can receive referrals and follow standardized protocols for screening, intake, and placement.<sup>130</sup>

Practitioners interviewed for this study were largely supportive of the waiver’s goals and provisions. At the same time, they emphasized that stakeholders and policymakers must carefully monitor access to care following such a significant cultural and operational shift. See Section VII for further discussion of waiver monitoring and oversight activities.

### Multiple funding streams and managed care structures may undermine care integration.

The waiver creates a third managed care structure within Medi-Cal. In opt-in counties a Medi-Cal beneficiary with co-occurring serious mental illness and substance use disorders will receive care from three different managed care plans: one for SUD under the terms of the DMC-ODS, one for serious mental illness (SMI) per California’s 1915(b) waiver for specialty mental health care, and one for primary / specialty care.

The implications of the SMI and SUD carve-outs within Medi-Cal are too numerous and complex to explore fully in this report (see end notes for additional references<sup>131</sup>). But many Bay Area practitioners discussed the ways that disparate funding streams and administrative processes for physical health, mental health, and SUD services hinder efforts to care for the whole person:

- **Separate billing and documentation requirements complicate enhanced integration between SUD and mental health systems of care.** Behavioral health providers with the appropriate licenses and qualifications may be capable of treating patients holistically for co-occurring mental health and SUD needs. But Medi-Cal’s carve outs effectively preclude such an approach. To ensure payment under disparate funding streams, a client must have separate SUD and MH diagnoses, separate records that meet pertinent privacy requirements, and separate medical necessity determinations. Practitioners believe these requirements so complicate care delivery that many beneficiaries with co-occurring disorders do not receive adequate care for both conditions. In the words of one administrator, the system demands that after a dual diagnosis a provider must “pack up the client and ship him over” to another system. But patients referred between multiple providers often encounter barriers to care: confusion over paperwork and coverage status, trouble with travel, inability to schedule at a convenient time or location, etc. And quality is compromised when providers are disincentivized from conferring with one another because such activities are not billable.
- **I.T. capabilities and health information privacy regulations pose significant barriers to better coordination between SUD and physical health providers.** County administrators responding to UCLA’s fall 2015 survey rated “sharing/tracking/monitoring client data along the continuum of care” as the most challenging aspect of the waiver to implement.<sup>132</sup> Medical directors from (non-MH, non-SUD) managed care plans, when asked how well county behavioral health departments share the data needed to coordinate primary care and SUD treatment, rated their SUD colleagues at 1.64 on a 5-point scale.<sup>133</sup>

*“Everyone wants to do whole person care, but then it becomes ‘my client’ and ‘your client’.”*

*--County Administrator*

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Sharing data to coordinate care is difficult due to lack of interoperable electronic health records (EHRs) and stringent privacy regulations protecting SUD-related health data.

Practitioners repeatedly stated that health information privacy provisions under 42 CFR Part 2 limit coordination between SUD and physical health care providers. Before records can be shared or treatment discussed, SUD clients must give written consent that names individual providers who will have access to their information.<sup>134</sup> The gravest concern expressed by informants was that a physical health provider considering an opioid prescription for an SUD client may not be able to determine whether the client has been treated for a SUD and if such care is contraindicated. Were that physical health provider to call the client's SUD treatment provider, the SUD provider wouldn't be able to acknowledge having treated the client without first obtaining the proper written consent. No one wishes to expose SUD patients to harmful breaches of privacy. Yet existing data privacy law runs counter to the sort of integrated, whole-person care being promoted within Medi-Cal.

Lack of I.T. infrastructure and data analytics capabilities (at both the state and county levels) may also stymie care integration. As discussed earlier in this report, UCLA ISAP's Evaluation, Training, and Technical Assistance reports to DHCS have stressed that interoperable electronic health records (EHRs) are critical to advance care integration.<sup>135</sup> Yet it has been estimated that nearly half of SUD treatment facilities do not have functional EHRs.<sup>136</sup> In addition to infrastructure improvements, both DHCS and county SUD departments need technical assistance and qualified staff to improve data collection and data analytics. Without supplemental funding, it will be difficult to overcome these deficiencies while simultaneously implementing the transformations required under the waiver.

Forthcoming policy developments may help with the privacy concerns, if not with I.T. needs. The U.S. Substance Abuse and Mental Health Services Association (SAMHSA) has issued a proposed rule that could relax 42 CFR Part 2 restrictions. As proposed, SUD patients could choose to sign a more inclusive consent form to share their health information with a health information exchange or designated group of treating providers.<sup>137</sup> DMC-ODS counties will also be able to look to DHCS for guidance on improving integration with physical health providers. DHCS will develop an integration strategy for physical and behavioral health/SUD as part of the Department's participation in CMS' Medicaid Innovation Accelerator Program. DHCS should release a "concept design" for this care model by October 1, 2016 and the approach should be implemented by April 1, 2017.<sup>138</sup> The Department has confirmed it is on schedule with this work; it will model its integration approach on one promoted by SAMHSA.<sup>139</sup> Whether these changes can take root rapidly enough to have an impact within the five year waiver term is an open question. Unfortunately, policy changes or supplemental resources to help counties improve their I.T. capabilities do not appear to be forthcoming.

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## VII. Considerations for Monitoring System Performance

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The waiver includes multiple mechanisms for assessing the performance of each county's DMC-ODS. Counties will be responsible for monitoring network providers annually and conducting continuous quality improvement within their own systems. As managed care organizations they will also be subject to an annual external quality review and triennial reviews conducted by DHCS. In addition, a team from UCLA's Integrated Substance Abuse Programs will conduct a formal, statewide program evaluation to determine whether the waiver as a whole achieved its goals related to both quality and cost of Drug Medi-Cal services.

Consequently, policymakers interested in determining whether the obstacles discussed in this report do, over time, limit the system's potential to deliver better care may turn to several sources of information. This section offers an overview of mechanisms for monitoring/assessing delivery system performance, and some considerations for those who will engage in ongoing oversight.

### Mechanisms for monitoring DMC-ODS performance

#### Summary of assessment activities

Mechanisms for monitoring DMC-ODS performance under the waiver include:

- Ongoing county monitoring and quality improvement activities.
- Annual external quality reviews by BHC-EQRO.
- Triennial reviews by DHCS.
- Statewide program evaluation by UCLA-ISAP.

Table 8 on the following page summarizes these activities.

**Table 8**

### **County Monitoring and Quality Improvement Activities (Continuous Improvement)**

- Ongoing responsibility of DMC-ODS administrators
- Focus is localized, data-driven improvement and oversight of network providers
- Includes regular review of data points related to timely access & network adequacy (e.g., time between first contact and first service, beneficiary experience data, & access to after-hours care)
- Incorporates review of utilization management processes: medical necessity, proper ASAM placement, & system wait lists
- All activity must be documented for external quality reviews & triennial reviews

### **External Quality Review (County-level Performance)**

- Annual process conducted by independent quality review organization (Behavioral Health Concepts, Inc., EQRO)
- Review of system performance measures and information systems capabilities; validation of county performance improvement projects (PiPs)
- EQR identifies deficiencies/areas where additional technical assistance is needed
- DHCS works with counties to address deficiencies; may require corrective action plan (CAP)
- DHCS may remove county from pilot participation if it fails to make adequate progress under its CAP

### **Triennial Review (County-level Compliance)**

- DHCS reviews county quality improvement plans and monitoring activities
- Assesses compliance with waiver requirements for service delivery processes, beneficiary protections, applicable contractual obligations, and record-keeping
- Non-compliance triggers Plan of Correction (POC) and enhanced monitoring

### **Program Evaluation (Statewide Performance)**

- Conducted by UCLA's Integrated Substance Abuse Programs
- Evaluates DMC-ODS performance in four domains: access, quality, cost, & integration/coordination of care
- Will use quantitative and qualitative data from sources including CalOMS and DATAR databases, Medi-Cal claims, county administrator surveys, interviews with participating counties, patient experience data when available, and "secret shopping" (calls to beneficiary access line & providers)
- Seeks to measure the impact of the waiver within opt-in counties and statewide; includes regular presentations of findings to stakeholders to facilitate continuous improvement



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## Status of EQR and program evaluation

Because California's DMC-ODS waiver is the first of its kind, the assessments conducted by BHC-EQRO and UCLA ISAP will be groundbreaking. The EQR process was initially developed to review the quality of Medicaid's managed care plans for physical health services and is governed by both federal and state regulations.<sup>140</sup> Throughout the U.S., EQR is used for a relatively small number of carved-out mental health plans like California's. It has never before been used to monitor a Medicaid SUD treatment delivery system. BHC-EQRO began to serve as the EQRO for the state's Specialty Mental Health plans in 2014. UCLA ISAP, for its part, has contracted with DHCS (or the former California Department of Alcohol and Drug Programs) to conduct assessments and technical assistance for safety net substance use disorder treatment in California since at least 2007.<sup>141</sup>

**Waiver-related planning, data collection, and assessment activities are underway.** UCLA ISAP and BHC-EQRO plan to collaborate throughout the five-year waiver period to streamline data collection and minimize the administrative burden on counties. At the time of this report, both organizations are refining their evaluation tools and working with DHCS and counties to establish expectations and procedures for county participation in EQR and evaluation activities.

UCLA has administered initial surveys to both county SUD department administrators and Medi-Cal managed care plan medical directors. Researchers are working to define performance metrics, collect and analyze baseline data, and develop processes for collecting data that has not previously been reported, e.g. determining how counties will document use of ASAM's diagnostic criteria.<sup>142</sup> An outline of UCLA's program evaluation can be found in Attachment DD of the Medi-Cal 2020 STCs, available through DHCS' website at [www.dhcs.gov](http://www.dhcs.gov). An initial report on waiver progress should be available in June 2016.

Core elements of the EQR process are mandated: review of performance measures, validation of performance improvement projects, and information systems capabilities assessment. But BHC-EQRO will develop specific measures and processes in collaboration with DHCS and county stakeholders. A survey of county SUD department administrators BHC-EQRO planned to administer during May 2016 will help gauge what counties are already doing, documenting, and tracking: performance measures already in use by counties, existing quality improvement activities and performance improvement projects, and a baseline assessment of I.T. capabilities. Annual quality reviews for counties that opt in during demonstration year one will begin in June 2016. However, as no DMC-ODS services are yet being delivered the focus of the first round of evaluations will be on providing technical assistance to counties to help them prepare for future EQR activities, and on establishing baseline measurements of performance and I.T. capability.<sup>143</sup>

**BHC-EQRO and UCLA ISAP will produce regular, public-facing reports on waiver progress.** BHC-EQRO will release annual reports for each individual county reviewed, as well as an aggregate report. EQR reports and information will be posted online; refer to Behavioral Health Concepts' website at [www.caleqro.com](http://www.caleqro.com). UCLA will make regular presentations of evaluation findings during meetings of the California Behavioral Health Director's Association (CBHDA) Substance Abuse Prevention and Treatment (SAPT) committee. A schedule of these meetings can be found on CBHDA's website at [www.cbhda.org](http://www.cbhda.org). UCLA ISAP's reports can typically be accessed at [www.uclaisap.org](http://www.uclaisap.org).<sup>144</sup>



## Considerations for monitoring and oversight

### Need for defined standards for timely access to care

Waiver participation presents an important opportunity for counties to expand access to drug treatment and improve the quality of SUD care. Careful monitoring of quality and access within participating counties is necessary to determine whether the waiver is an effective means for achieving these goals. Waiver STCs state that opt-in counties “must ensure that all required services covered under the DMC-ODS Pilot are available and accessible to enrollees in the DMC-ODS.”<sup>145</sup> **However, the waiver does not specify concrete, statewide metrics for timely access or quality.**

Instead, participating counties will establish county-specific access standards. These standards will be recorded in waiver implementation plans and state/county contracts<sup>146</sup> (see text box for examples). Counties are then responsible for contracting with a provider network that can offer all covered DMC services and consistently meet the county’s performance standards.<sup>147</sup> , <sup>148</sup> County quality assurance activities and timeliness-related data will be reviewed during the external quality review (EQR) process.

In a June 2015 panel discussion, county administrators stressed the importance of additional guidance from DHCS on metrics counties might use to assess quality.<sup>149</sup> Meanwhile, UCLA and EQR researchers interviewed for this report highlighted the difficulties in developing useful access measures, and the improvements in data collection that must be made for effective monitoring to occur. Many providers do not yet track all their referrals or contacts with potential clients. Without this data it is hard to determine whether patients who sought treatment were ultimately able to access it. Similarly, data on wait lists for services may be incomplete, leaving open questions about how many clients tried to access care but ultimately did not. Much of this information may be on paper and so difficult to analyze. Under the waiver, providers and counties must ensure that such data is captured electronically for optimal analysis by counties, the EQRO, and UCLA researchers. But even given better quantitative data on wait times and attrition, it is difficult to

### Standards for Beneficiary Access

**Waiver STCs** specify a limited number of hard-and-fast standards for access to care, including:

- Immediate access to care for any beneficiary whose condition is considered an emergency.
- A 24-hour turnaround time for a treatment authorization request for placement in residential treatment.
- An operable 24-hour beneficiary access line.

**County implementation plans** must describe projected utilization and service capacity for the DMC-ODS, as well as standards for timeliness and geographic and language accessibility. **Sample timeliness standards include:**

- **Los Angeles & San Mateo:** 15 day maximum from initial screening to first service. Target of 10 days by 2019 for San Mateo; 5 days by 2018 for L.A. San Mateo specifies 24 hours for urgent (non-emergency) conditions.
- **Santa Clara:** 14 days to first appointment for outpatient services. Care coordination for urgent conditions within 24 hours.
- **Marin & Santa Cruz:** No more than 10 days to first service. Urgent conditions (not emergencies) within 48 hours in Marin, 36 in Santa Cruz.
- **San Francisco:** Urgent conditions within 24 hours.

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follow-up with clients who do not attain treatment in order to learn about the barriers that prevented them from accessing care.

**If evaluators and practitioners succeed in addressing these measurement challenges, the absence of concrete and uniform performance standards could still undermine the effectiveness of oversight processes.** The EQR is the primary vehicle for helping counties identify performance deficiencies and devise strategies for improvement. (UCLA ISAP's waiver evaluation will measure variation in access to care indicators before and after the waiver, as well as between groups of opt-in and opt-out counties. But UCLA's focus will not be on delving into county-specific performance issues.) California's safety net SUD services have not undergone EQR in the past. However, counties are already subject to both an EQR process and DHCS-led triennial reviews under the terms of the Section 1915(b) waiver for specialty mental health services.

**Evidence from Specialty Mental Health reviews indicates that it may be hard to correct access issues through the EQR process without hard-and-fast performance standards for counties.** A 2015 report on oversight within the Specialty Mental Health system noted the following shortcomings of the EQR process:<sup>150</sup>

- **Evaluation indicators measured process, not performance.** EQR indicators focused on the *presence or absence of processes* for data collection, quality improvement, and corrective action, rather than on measuring system performance itself. This meant that if a site failed to meet its own timely access standards, but technically had a process in place that could be used to measure and correct the problem, the site could be described in the EQR as compliant with timely access indicators.
- **Low compliance rates.** The proportion of sites that fully met expectations on a given indicator was typically less than 50%. Specialty Mental Health EQR data from 2010-11 showed 50% of sites or less were fully compliant on any of five indicators related to timeliness of services. Yet due to the process-oriented EQR questions this statistic doesn't reveal anything about the actual timeliness of services. It does indicate that attempts to assess performance by analyzing timeliness data would have been problematic, as a high proportion of sites were not effectively tracking timeliness measures.
- **Lack of corrective action.** 80% or more of sites submitted corrective action plans during each year studied. Sites were directed to address three "priority" recommendations from the EQRO in their plans. In 2010-11, only 11% of sites fully addressed all three (though 64% addressed all three at least in part). DHCS did not use its authority to impose sanctions on participating sites during the first three years the agency was responsible for oversight.

CMS' approach to recent renewals of California's Specialty Mental Health (SMH) waiver reflected concerns about county mental health plan performance—and about the failure of existing oversight processes to meaningfully address such concerns. In 2013 CMS granted the state only a two-year waiver term, with instructions to address a number of specific issues in its 2015 renewal proposal. These included tracking timely access to services and the use of sanctions and corrective actions.<sup>151</sup> In 2015 the SMH waiver was renewed for five years, contingent upon the state accepting a set of terms and conditions attached by CMS. DHCS must now require county mental health plans to track and measure timeliness indicators including wait times to assessments and wait times to see providers. The state will collect this data and use it to establish baseline

measurements for access in all counties. DHCS will also create public-facing “dashboards” that “present an easily understandable summary” of each mental health plan’s quality, access, and timeliness data.<sup>152</sup>

The state has also committed to developing statewide performance standards for county mental health plans. Even before CMS attached the 2015 renewal conditions, DHCS had convened a metrics workgroup made up of SMH providers and measurement/evaluation experts to develop quantifiable performance targets for timely access to care (e.g. a 10-day maximum window between first screening and first service delivered), and standardized processes for recording and tracking these measures. DHCS administrators interviewed for this report indicated that they will undertake a similar process to design performance standards for DMC services, but plan to conclude the Specialty Mental Health standards work before moving on to DMC so as to apply lessons learned.<sup>156</sup> In an April 21, 2016 hearing conducted by the California Senate Budget and Fiscal Review Subcommittee No. 3, DHCS officials testified that they would release an information notice about proposed timely access standards for Specialty Mental Health services within two months time.<sup>157</sup> As of May 2016, no timeline for beginning (or completing) a similar process for SUD services had been announced.

## Monitoring DMC-ODS Access & Quality: What Will Be Measured and By Whom?

**County QI committees** will monitor the following access-related data points at least quarterly:<sup>153</sup>

- Number of days to first DMC-ODS service after screening / referral
- Existence of a 24-hour beneficiary access line with availability of prevalent non-English languages
- Access to DMC-ODS services that include translation in prevalent non-English languages
- Authorization requests approved and denied

**EQR & Triennial Reviews** will incorporate review of the above data points. Additional EQR performance measures will include:<sup>154</sup>

- Penetration rates
- Timeliness measures (TBD)
- Coordination Measures (TBD) with Medi-Cal managed care plans, county mental health plans, fee-for-service providers, Federally Qualified Health Centers and Rural Health Centers, and other services and supports
- Cultural competence measures (TBD)
- Appropriateness and effectiveness of services (TBD)

**UCLA ISAP’s evaluation** will measure access and quality under the waiver using measures that include the following (broken down by county, race, ethnicity and gender when possible):<sup>155</sup>

- First available appointment
- Average distance to provider
- Retention in treatment
- Appropriate placement in ASAM level of care
- Percent of referrals with successful treatment engagement (based on length of stay)
- Successful care transitions and discharges
- Readmissions to withdrawal, residential, IOP

Standardized performance measures for timely access to SMH care were developed only after several years of documented inconsistencies in measuring and enforcing access. In the case of the DMC-ODS, DHCS should seize the opportunity to begin this work—and incorporate lessons from Specialty Mental Health oversight—sooner rather than later. Practitioners report that during reviews of county waiver implementation plans, CMS has insisted counties be highly specific in defining access standards and describing the activities they will

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undertake to ensure timeliness. These commitments are good first steps but may prove meaningless if standards cannot be enforced through the EQR process. **Ultimately, measuring performance against clear targets for timely access is the most unambiguous way to detect whether any of the potential barriers discussed in this report interfere with DMC-ODS services.**

### Alignment with SMH EQRO process

In addition to recognizing the need for uniform DMC performance standards, DHCS is actively exploring ways to integrate the EQR process that counties will undergo for the DMC-ODS with that for Specialty Mental Health services. A majority of California counties have a county behavioral health department that includes the administrators for both SMH and Drug Medi-Cal. DHCS, BHC-EQRO, and county administrators agree that blending or merging the two EQR processes is the best approach for minimizing the administrative burden on county behavioral health teams. Beyond reducing administrative burden, aligning the two reviews presents an opportunity to incorporate improvements made to the SMH process into the DMC-ODS process at an early date.

However, a combined review process will not be possible immediately. Although SMH and DMC operate under the umbrella of county behavioral health departments in most counties, the two programs are typically administered separately. This means that the elements of the EQR (review of performance measures, validation of performance improvement projects, and I.T. system capabilities assessment) will draw on different documentation systems, different quality improvement infrastructures, different administrators and leadership teams, and even different I.T. systems. In practice, the work of the SMH and DMC EQRs can't be blended if the work of SMH and DMC is not blended.<sup>158</sup> Separate funding streams for MH and SUD services have over time contributed to very different cultures and practices, which can act as barriers to increased integration.

UCLA's 2015 county administrator survey offers a glimmer of hope. Overall, counties reported that their SUD and BH departments were "well-integrated," with the level of integration ranked at 3.59 on a five-point scale (in contrast to lower levels of integration between physical health and SUD providers, at 2.72). 54% of responding counties said their SUD and MH leadership "communicates regularly for collaboration purposes via scheduled face-to-face meetings and/or conference calls," with a majority of those reporting weekly collaboration.<sup>159</sup> According to BHC-EQRO, enhanced collaboration between SMH and DMC leadership teams is one of the most important changes that must occur for a joint EQR to become feasible. More integrated leadership should foster more integrated administrative procedures, which in turn will facilitate combined review. BHC-EQRO also indicated that streamlining the performance improvement project validation portion of the review might happen first, perhaps by requiring only three PiPs in total between SUD and MH (rather than two apiece).<sup>160</sup>

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## VIII. Strategies to Support Full Implementation

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DMC-ODS stakeholders are determined to seize the waiver opportunity to improve their SUD delivery systems. To succeed, they must overcome the structural barriers identified here. These challenges result from long-established Medi-Cal policy. They are systemic problems that have no simple fixes, yet this study highlights them with the hope that policymakers will begin to wrestle with them in earnest. Those in a position to support the DMC-ODS can seek feasible, incremental strategies to begin eroding entrenched regulatory and financial obstacles.

The recommendations below are not holistic solutions; they are potential next steps. In some cases they are low-hanging fruit: reasonable policy decisions that promise to help address one or more of the barriers discussed here. Others are intended as jumping-off points for more substantive work and thinking by decision-makers. None are mutually exclusive.

Suggestions revolve around three key strategies to support successful DMC-ODS implementation:

1. **Reduce financial uncertainty & increase capacity.**
2. **Enhance coordination across Medi-Cal programs.**
3. **Facilitate continuous feedback.**

### Reduce financial uncertainty & increase capacity

The foremost concern voiced by key informants was that there may not be enough funding under the waiver to support meaningful system transformation and make up for historical shortfalls. Yet given the realities of California's budget and political climate, pouring state general funds into Drug Medi-Cal is not a feasible recommendation. Short of a massive cash infusion, what can be done within the next five years to alleviate real and perceived financial risk? Possibilities might include the following:

1. **Raise the ceiling for county-specific interim payment rates.** As discussed above, counties and the state face mixed incentives in determining DMC reimbursement rates. There is widespread agreement that current reimbursement rates are too low to sustain the necessary number and variety of DMC providers. But counties fear proposed rates that better reflect care delivery costs in individual counties will be vetoed and reimbursement capped nearer to current rates to minimize the risk to the state. At the same time, both the state and counties have reason to be wary of rates that seem like a significant departure from past practices. Higher rates guarantee a heavier financial obligation for counties and ultimately for the state (technically the party responsible for guaranteeing the DMC non-federal share, regardless of how Realignment has distributed the dollars in question).

If county-specific interim rates are to support enhanced services, DHCS must resist letting the current rate-setting methodology negate counties' own calculations. The state has offered technical assistance to help counties better predict their costs and utilization and propose the most accurate rates possible. The next



step is to trust that proposed rates are in fact reasonable, or at the very least to approve rates that are higher than existing ones. Experimentation is the purpose of piloting a policy on a relatively small scale with careful regulation. If counties are comfortable with the risk they propose the state has reason to trust that judgment. Counties are not likely to inflate their rates; overly high DMC payments would only exacerbate financial risk for those uncertain whether their BH Subaccount funds will be adequate to meet DMC obligations. Under a worst-case scenario counties would have to recoup federal over-payments. Presumably if that were to occur, rates could be adjusted downward.

2. **Fast-track efforts to set a permanent base for the Behavioral Health Subaccount.** The Behavioral Health Subaccount which funds DMC services is the only 2011 Realignment program that lacks a permanent methodology to determine the annual base allocation. This creates unnecessary financial uncertainty for counties. In past years, many counties have not spent down their BH Subaccount funds.<sup>161</sup> The left-over funds could indicate there are adequate sums available to support full implementation of the DMC-ODS. Alternately, spending patterns may reflect difficulties in long-term planning and budgeting: county Boards of Supervisors may be reluctant to make new spending commitments due to the possibility that BH Subaccount allocations could be reduced if the state changes the allocation formula. As long as counties are unable to estimate their annual allocations with maximum possible accuracy (though some uncertainty will remain because the account depends on state sales tax revenues), perceived financial risk may factor into decisions like opting out of the DMC-ODS waiver or failing to contract with enough providers to meet DMC demand for services.

Similar argument have been made by the County Behavioral Health Directors Association (CBHDA), which represents county behavioral health systems and has long advocated that the state settle on a permanent methodology for allocating BH Subaccount dollars.<sup>162</sup> DHCS and representatives of the Brown Administration have been engaged in ongoing dialogue about the issue with CBHDA, the California State Association of Counties (CSAC), and other stakeholders. At an April budget hearing, DHCS officials reported that the Department will soon release an information notice with a proposed base methodology.<sup>163</sup> There will be some follow-up work to move from proposed methodology to finalized base allocation formula. This recommendation, then, falls into the low-hanging fruit category. The sooner outstanding questions around the BH Subaccount base can be resolved the better-positioned counties will be to take full advantage of the DMC-ODS opportunity.

3. **Fund DHCS personnel requests, particularly for SUD clinical positions.** Counties that opt into the DMC-ODS waiver depend on DHCS for an array of resource-intensive and time-sensitive tasks: processing provider certifications, facilitating waiver technical assistance, issuing implementation guidance, developing cost-claiming and billing protocols, managing SUD-related databases and data collection, participating in EQRs and Triennial Reviews, and much, much more. Although this report has focused on the demands that successful waiver implementation places on county SUD departments, county-level success is directly tied to DHCS' ability to meet its own waiver obligations.

County administrators consistently commented that personnel within DHCS' SUD departments were accessible, responsive, and dedicated to supporting county implementation efforts. According to many interviewees, DHCS typically "does the best it can with the resources it has." As such, it would be remiss not to recommend that the legislature carefully consider any and all budget requests from DHCS for

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additional personnel in departments and roles that support the DMC-ODS. Some interviewees felt that additional SUD clinical expertise within DHCS would be particularly helpful; lack of clinical knowledge was posited as a possible contributing factor the historical backlog in certifying DMC providers (now largely resolved).

DHCS did in fact request funds during the current budget cycle to convert ten limited-term positions to permanent positions (and add one new legal position). These positions support substance use disorders health care reform implementation activities such as modifying billing/claiming systems and departmental policies to accommodate the expansion of SUD services under SB X1-1.<sup>164</sup> Similar procedural changes will continue to be necessary as opt-in counties begin to deliver expanded DMC-ODS services. If the state wishes to see counties succeed under the waiver ensuring that DHCS' SUD departments are appropriately staffed is a relatively straightforward strategy.

- 4. Steer foundation funding to high-impact areas like provider training, I.T. capacity-building, and service gap assessment.** In its 2015 ETTA report UCLA ISAP wrote that, as counties begin to develop their organized delivery systems, “funding sources other than Medi-Cal must be braided to make the system function optimally.” UCLA evaluators recommend that county SUD programs identify and pursue “non-traditional” funding sources to supplement Medi-Cal and federal block grant monies.<sup>165</sup> The need for supplemental, non-public funding for safety net health care programs is something of an inconvenient universal truth. Fortunately, DHCS administrators interviewed for this study reported great interest from private funders in supporting Drug Medi-Cal reforms. California Health Care Foundation and Blue Shield are already funding DMC-ODS technical assistance programming.

A problem with continued reliance on private funding sources is that private funders must award grants according to their organizational missions and priorities—and these priorities don't always match up perfectly with the immediate needs of the safety net health care programs. For example, in the case of the DMC-ODS many practitioners described a need for additional person-hours. Providers, likewise, need staff above all—and both counties and providers (along with DHCS) need I.T. expertise. But foundations do not often fund non-programmatic operating or overhead costs like personnel and I.T. equipment. From a funder's perspective, it can be difficult to tie such awards directly to quantifiable program outcomes, and thus difficult to demonstrate that a grant has furthered the foundation's mission within the community.

Given these limitations, it is important that DHCS (or others in a position to do so) steer funders who wish to support the DMC-ODS toward high priority, high impact investments. Ongoing provider training (beyond the TA that will accompany the waiver rollout) is one choice that seems likely to be compatible with foundation priorities like expanding the health care workforce and would also be a genuinely useful service for counties. Opportunities to secure funding for improvements in information technology infrastructure and data analytics capability should be pursued as well. In lieu of paying for FTE positions, foundations might fund intensive I.T. consulting to help health systems build much-needed capacity and data analysis skills. This will ultimately improve the ease with which counties and providers can track and share client information for care coordination and engage in continuous quality improvement—activities that often appeal to funders. Finally, foundations might also use their financial resources to engage consultants who can help assess and quantify barriers to DMC-ODS success. Projects might include investigating gaps in the care continuum, like the lack of youth-specific SUD treatment programs, and



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helping to spark conversation and problem-solving around these issues. Seeking innovative approaches to mitigate the effects of the housing crisis on Medi-Cal beneficiaries could be another area for analysis or technical assistance (see discussion below around convening health and housing stakeholders).

5. **Explore options for state funding of county-level personnel and data infrastructure development.** If neither DMC payments nor foundation grants can cover waiver implementation costs like county staffing, higher provider salaries, or I.T. system overhauls, state funding options should be considered. State spending need not take the form of large or unrestricted general fund allocations. The legislature and Administration might consider smaller programs targeted specifically to time-limited implementation costs like personnel and data infrastructure.

For example, 2013's Mental Health Wellness Act appropriated Mental Health Services Act funds for Triage Personnel Grants. Counties were able to apply for funding to add crisis intervention staff.<sup>166</sup> Could a similar appropriation help counties recruit and hire, for instance, psychiatrists who are SUD specialists or who would commit to training and working in the SUD field for specified intervals? The MH Wellness Act also funded grants (administered through the California Health Facilities Financing Authority or CHFFA) for mental health mobile crisis teams and crisis residential treatment beds. These grants included equipment purchases like mobile crisis vans.<sup>167</sup> **It may not be possible to draw on MHSA funds to build county SUD programs, but these grant programs might offer blueprints for new initiatives targeted to SUD and DMC-ODS efforts.** Further, the Workforce Education and Training component of the MHSA has identified substance abuse training across mental health professions and continued integration of mental health and substance use services as a priorities over the next five years.<sup>168</sup> Any such work should be undertaken with input from waiver stakeholders and those with expertise in the state's SUD delivery system (e.g. UCLA ISAP or CAL-EQRO, DHCS' SUD teams) to ensure that training or integration efforts address the pressing workforce needs of the DMC-ODS as effectively as possible.

Despite economic recession and significant fiscal challenges, California in recent years has made meaningful financial commitments to improving mental health services. If parity in public health benefits is to play out in practice, the state will need to do the same for substance use services.

## Enhance coordination across Medi-Cal programs

The Affordable Care Act has ushered in a new focus on delivery system transformation within Medicaid. In addition to the DMC-ODS, enhanced quality assurance activities for county Specialty Mental Health plans under the renewed 1915(b) waiver are part of these efforts. The state is also implementing a number of specific initiatives that focus on reducing system expenditures by improving health outcomes for beneficiaries with complex health care needs. These programs are typically administered "in silos," to use the language typical among practitioners and policymakers. The state should make a concerted effort to identify the ways in which such transformation initiatives overlap. How can programs targeting the same populations be better aligned or integrated to ensure that Medi-Cal resources are used efficiently and effectively? Examples of enhanced coordination among Medi-Cal programs that could benefit DMC-ODS clients include:

1. **Convene health care and housing stakeholders for collective problem-solving around housing for homeless Medi-Cal beneficiaries.** A number of current Medi-Cal initiatives focus on improving care for beneficiaries with complex needs: low-income individuals who are likely to suffer from co-occurring physical, mental health, and/or substance use disorders, and as such are disproportionately likely to be homeless or marginally housed. These programs include:

- Care coordination and case management activities that will take place under the DMC-ODS waiver.
- Whole Person Care pilots authorized under Medi-Cal 2020.<sup>169</sup>
- Health Homes programs authorized under Section 2703 of the Affordable Care Act.<sup>170</sup>
- Full Service Partnerships funded by California's Mental Health Services Act.<sup>171</sup>

Not every program above will be implemented in every DMC-ODS county and the characteristics of the target populations for each do differ to some extent.<sup>172</sup> Some DMC beneficiaries will qualify for these other initiatives and some will not. But on the whole, the populations are likely to overlap and to include a significant number of homeless individuals whose health outcomes will be jeopardized by continued homelessness. The Medi-Cal stakeholders tasked with implementing these programs cannot solve the housing crisis, but they can collaborate with each other and with stakeholders from the housing services world to link Medi-Cal beneficiaries as promptly as possible to existing housing resources. If this is already happening optimally in a given county, health care and housing leaders might find it useful to learn more about the work being done on both sides of the aisle and to think collectively about how to navigate the housing crisis within their localities.

DHCS or another state agency could take the lead in convening county leaders of Medi-Cal transformation programs with housing leaders (perhaps representatives from each county's local Continuum of Care planning team<sup>173</sup>). This could be done locally or regionally, in phases and as often as resources allow. The intersection of health care and housing could be a technical assistance topic for which foundation funding and resources might be leveraged. If SB 1380 is passed during the current legislative session, coordinating such efforts might even fall under of the Homeless Coordinating and Financing Council that would be created under that bill.<sup>174</sup> Counties can also take it upon themselves to foster further collaboration between health care and housing entities—or, for that matter, to bring together the leadership teams for Medi-Cal programs seeking to improve care coordination and outcomes for high-needs beneficiaries within their individual counties. But state-level support could create time and space for important conversations. It might also help to draw an explicit connection for policymakers: until California makes progress on addressing its housing crisis, Medi-Cal programs that intend to improve the health of high-need, often homeless, individuals are likely to fall short of their goals.

2. **Explore options to pilot combined funding for Specialty Mental Health & Drug Medi-Cal.** SUD stakeholders generally acknowledge that the intended purpose of Medi-Cal's mental health and substance use disorder carve-outs is to ensure beneficiaries with these disorders receive the most appropriate specialty care. There is also widespread agreement that separate funding streams for MH and SUD hamper necessary care coordination. By way of further example, participants in a stakeholder feedback process conducted as part of the Mental Health Services Act's Workforce Education and Training 5-Year Needs Assessment identified five barriers to better care integration. Three are inextricably linked to financial and

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administrative carve-outs: “lack of link between primary and mental health care providers,” “reimbursement,” and “professional silos.” Stakeholders recommended that the state should “ensure reimbursement aligns with integration.”<sup>175</sup>

Finding a way for counties to pilot combined funding for mental health and substance abuse services could help determine whether an eventual reversal of the carve-out policy is a feasible way to improve patient care. It would likely require some sort of waiver authority, and may have to take the form of a pilot program that targets a defined population, namely those with co-occurring SMI and SUD. The topic could be explored further via foundation-funded research or stakeholder advisory groups. In the absence of combined funding, county administrators can work to increase administrative collaboration between SMH plans and the DMC-ODS. Ultimately, though, the state must reckon with the question of whether it is counterproductive to have care for some Medi-Cal beneficiaries managed by three different entities.

**3. Promptly apply “lessons learned” from Specialty Mental Health oversight to DMC oversight.** The DMC-ODS is a pilot program; it would be unfair and unrealistic to expect all counties to immediately perform well on all quality and access indicators. But performance should be rigorously measured from the outset. Consistently poor performance over the five-year waiver period should not be allowed to persist due to a lack of clear standards or an unwillingness to impose sanctions if and when they are merited. The state faces a meaningful opportunity to draw on past experiences with Specialty Mental Health plan oversight to inform and improve DMC-ODS oversight, beginning in year one. DHCS does intend to integrate the External Quality Review processes for SMH and the DMC-ODS in whatever ways are feasible. In addition, DHCS, along with BHC-EQRO, can strive to ensure the following:

- EQR performance measures should include access to care metrics that go beyond verifying data collection or the presence of processes to monitor access.
- If counties are not immediately able to measure timely access or quality due to limitations in their data systems or analytic capacity, DHCS should engage them in constructing Corrective Action Plans (CAPs) per waiver terms. Each CAP should specify a timeline for the county to meet expectations for monitoring the data in question.
- If DHCS determines that removal from waiver participation is not an effective sanction—meaning a substantial number of counties are non-compliant in waiver years two and three—the Department should investigate and pursue policy options for additional sanctions or incentives.
- The development of concrete performance standards for Drug Medi-Cal, using a metrics workgroup akin to that used for SMH, should be undertaken as early as possible during the initial waiver term.

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## Facilitate continuous feedback

Thus far, DHCS and DMC-ODS leaders have taken care to make waiver planning a participatory process that incorporates input from a variety of stakeholders. The waiver proposal was the result of lengthy engagement between DHCS and a statewide Waiver Advisory Group with representatives from counties, provider organizations, Medi-Cal managed care plans, community advocates, and legislative staff.<sup>176</sup> In addition to formalized technical assistance and training, DHCS' SUD teams are in ongoing contact with county leaders during biweekly conference calls, and have been by all accounts accessible and responsive to dialogue with county administrators. At the county level, implementation plans must describe a stakeholder process for local DMC-ODS planning. These activities have created a strong foundation for soliciting meaningful feedback from the SUD services community going forward. Over the next five years it will be critical for counties, DHCS, and state-level policymakers to continue to seek out diverse perspectives to inform DMC-ODS decision-making. The following recommendations are considerations for this process.

1. **Continue to use foundation resources to engage diverse community stakeholders.** The California Health Care Foundation helped to fund the stakeholder engagement and planning processes for Medi-Cal 2020. Similarly, foundation funding can facilitate proactive and meaningful feedback from stakeholders throughout the five-year waiver term. Projects like panel discussions, focus groups, or a three-year report on “lessons learned” that draws heavily on stakeholder interviews could provide valuable forums for community input, but may not be possible with DHCS or county resources alone. Foundations and their community-based partners may be better equipped than state and county administrators to seek out underrepresented voices and broaden the circle of stakeholders who can engage in improving safety net SUD services.
2. **Incorporate county, provider, and beneficiary testimony into legislative hearings on DMC-ODS funding, access, and quality.** If at some point the legislature does review proposed supplemental funding measures for SUD services—and perhaps even in the course of Drug Medi-Cal program reviews during budget hearings—testimony from the broader SUD services community should be solicited. State legislators and staff members charged with Medi-Cal oversight can benefit from hearing the insights of those who are implementing DMC policy “on the ground” (in addition to the DHCS perspective). This includes county administrators, providers, and when possible, DMC clients who have navigated the delivery system. It is likely the role of community advocates, including provider organizations and trade associations, to organize such stakeholder participation.

This report, commissioned by the Senate Office of Research, is an early example of state-level decision-makers seeking to learn from the substantial experience and expertise of those within the SUD delivery system. Ideally, such efforts will continue throughout the waiver journey.

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## Appendix A: Key Informants

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### **Alameda County Behavioral Health Care Services**

- Tom Trabin

### **BAART Programs**

- Jason Kletter

### **Behavioral Health Concepts, Inc. (BHC-EQRO)**

- Saumitra SenGupta

### **CA Association of Public Hospitals and Health Systems**

- Allison Homewood

### **CA Department of Health Care Services (DHCS)**

- Karen Baylor
- Kendra Penner
- Marlies Perez
- Melissa Rolland
- Krystal Sanchez

### **California Health Care Foundation (CHCF)**

- Catherine Teare

### **California Senate Budget and Fiscal Review Committee**

- Michelle Baass

### **California Senate Health Committee**

- Scott Bain
- Reyes Diaz

### **California Senate Office of Research**

- Kim Flores

### **California Senate, Office of the President pro Tempore**

- Marjorie Swartz

### **County Behavioral Health Directors Association (CBHDA)**

- Tom Renfree

### **Harbage Consulting**

- Molly Brassil

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**HealthRight 360**

- Vitka Eisen
- Wayne Garcia
- Mardell Gavriel
- Ako Jacinto
- Lauren Kahn
- Fermin Loza
- Sarah Schoenberger
- Ana Valdes

**Horizon Services, Inc.**

- Keith Lewis

**San Francisco Substance Use Services (Department of Public Health)**

- Judith Martin

**San Mateo County Behavioral Health and Recovery Services**

- Clara Boyden

**Santa Clara County Department of Alcohol and Drug Services**

- Kakoli Bannerjee
- Cheryl Berman
- Bruce Copley
- Josefina Covarrubias
- Michael Hutchinson
- Sue Nelson
- Tuanduc Nguyen
- Noel Panlilio
- Mira Parwiz

**Santa Cruz County Alcohol and Drug Programs**

- Bill Manov

**UCLA Integrated Substance Abuse Programs**

- Darren Urada

## Appendix B: ASAM Diagnostic Criteria & Continuum of Care

\*Adapted from images and information by the American Society of Addiction Medicine, published online as “What is the ASAM Criteria?” and available at [www.asam.org](http://www.asam.org).

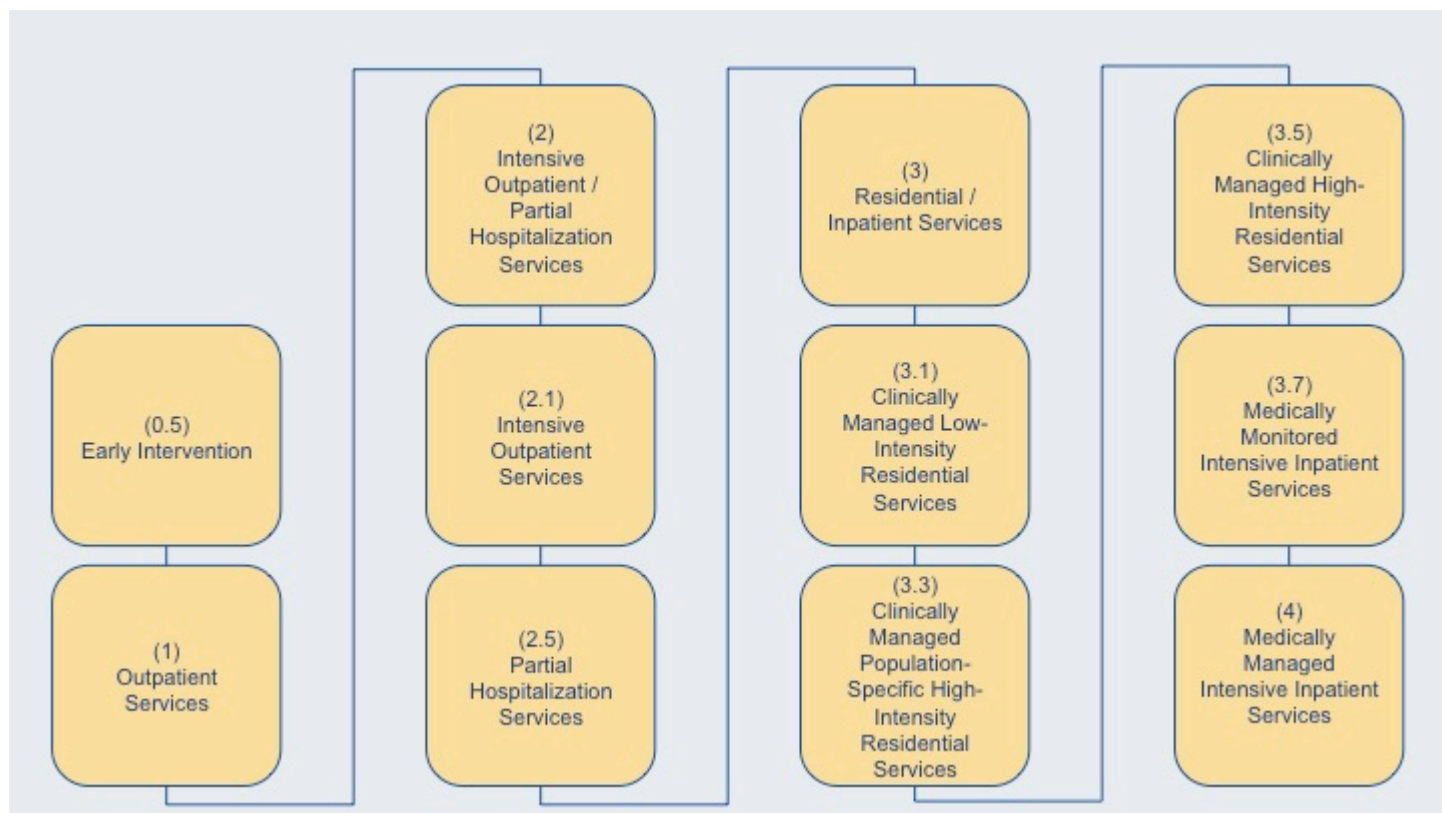
### ASAM’s Six Dimensions for Multidimensional SUD Assessment

<b>1) Acute Intoxication and/or Withdrawal Potential</b>	<b>Past and current experiences of substance use and withdrawal</b>
<b>2) Biomedical Conditions &amp; Complications</b>	<b>Health history and current physical condition</b>
<b>3) Emotional, Behavioral, or Cognitive Conditions and Complications</b>	<b>Thoughts, emotions, and mental health issues</b>
<b>4) Readiness to Change</b>	<b>Readiness and interest in changing substance use practices</b>
<b>5) Relapse, Continued Use, or Continued Problem Potential</b>	<b>Relationship with relapse or continued use or problems</b>
<b>6) Recovery/Living Environment</b>	<b>Recovery or living situation and surrounding people, places and things</b>



## The ASAM Continuum of Care

(Withdrawal management and youth services not pictured)



## Appendix C: Summary Definitions of SUD Treatment Services

The following definitions are quoted and/or adapted from Section 129-140 of the Medi-Cal 2020 STCs.

DMC-ODS Services	Definitions	Corresponding ASAM Levels of Care
Early Intervention*	Screening, brief intervention, and referral to treatment (SBIRT)	0.5
Outpatient Services	Counseling and other therapies for SUD recovery or motivational enhancement.  Less than 9 hours of services per week for adults and less than 6 hours per week for adolescents.	1.0
Intensive Outpatient Services	Counseling and other therapies to treat multidimensional instability (see ASAM six-dimensional diagnostic criteria under Appendix B).  9 or more hours of services per week for adults and 6 or more hours for adolescents.	2.1
Narcotic (Opioid) Treatment Program**	Daily or several times weekly opioid agonist medication (e.g. methadone, buprenorphine) combined with counseling to maintain multidimensional stability for those with severe opioid use disorder.  Programs federally certified and accredited through SAMHSA as well as licensed by the state of California.	N/A: includes outpatient counseling
Residential Services	24-hour structured care in a residential facility with trained personnel.  ASAM levels at right refer to different treatment approaches according to an individual's degree of impairment and ability to tolerate group treatment within a therapeutic community.	3.1, 3.3, 3.5
Withdrawal Management	Support, supervision and monitoring to manage withdrawal from substance use.  ASAM level 1-WM and 2-WM are ambulatory for mild to moderate withdrawal. 3.2-WM is 24-hour residential support for moderate withdrawal.	1-WM, 2-WM, 3.2-WM
Recovery Services	Therapies for ongoing support of recovery, to assist clients in managing their own health after completion of more intensive treatment. May include counseling, coaching, peer services, education and job training, support groups for clients and families, and links to ancillary social services like housing and transportation.	N/A

Case Management	Services delivered by an LPHA or certified counselor to assist a client in accessing necessary medical, educational, social, pre-vocational, vocational, rehabilitative, or community services. Includes coordination with physical/mental health services and transitions between SUD levels of care.	Component of all levels
Physician Consultation	DMC physicians may bill for time spent consulting with addiction medicine specialists, addiction psychiatrists, or clinical pharmacists to support DMC client care.	N/A
Partial Hospitalization***	20 or more hours of clinically intensive SUD treatment programming per week for clients with multidimensional instability not requiring 24-hour care. Typically with direct access to psychiatric, medical, and laboratory services.	2.5
Additional Medication*** Assisted Treatment	Reimbursement for onsite dispensation of specified medications through NTP programs: buprenorphine, naloxone, and disulfiram, in addition to methadone which is currently covered. All DMC physicians may also be reimbursed for time spent ordering, prescribing, administering, and monitoring MAT for DMC clients.	Component
Medically Monitored/Managed Intensive Inpatient Services****	Services for severe withdrawal needing a 24-hour nursing care and physician visits; within a hospital environment capable of managing medical instability.	3.7, 4.0

\*Provided outside of the DMC-ODS by Medi-Cal primary care managed care or fee-for-service providers

\*\*Covered as a DMC-ODS service but exempt from county-specific interim rates and related cost-reporting requirements.

\*\*\*Optional for DMC-ODS opt-in counties.

\*\*\*\*Part of the ASAM continuum of care and must be available to beneficiaries in opt-in counties. However, because these are hospital-based services they will not be reimbursed or administered directly by counties as part of the DMC-ODS.

## Appendix D: Frequently Used Acronyms

<b>AB</b>	<p><b><u>(California) Assembly Bill</u></b></p> <p>Legislation introduced in the California State Assembly, one of the state's two legislative bodies.</p>
<b>ASAM</b>	<p><b><u>American Society of Addiction Medicine</u></b></p> <p>ASAM is an organization of addiction medicine professionals with a mission that includes promoting access to substance use disorder treatment, evidence-based clinical practices, and public education about substance use. The DMC-ODS continuum of care is based on a diagnostic and treatment framework developed by ASAM and considered the industry standard.</p>
<b>BHC-EQRO</b>	<p><b><u>Behavioral Health Concepts, Inc. – External Quality Review Organization</u></b></p> <p>BHC-EQRO has been contracted to conduct External Quality Reviews (EQRs) of county DMC-ODS services as mandated for Medicaid managed care organizations under federal law.</p>
<b>CMS</b>	<p><b><u>(Federal) Centers for Medicare and Medicaid Services</u></b></p> <p>CMS is the federal agency that administers state Medicaid programs and must approve Medicaid waiver requests from states and oversee waiver programs and activities.</p>
<b>DHCS</b>	<p><b><u>(California) Department of Health Care Services</u></b></p> <p>DHCS administers California's publicly funded health coverage programs, including Medi-Cal and its subsidiary Drug Medi-Cal.</p>
<b>DMC-ODS</b>	<p><b><u>Drug Medi-Cal Organized Delivery System</u></b></p> <p>Drug Medi-Cal refers to services/benefits for Medi-Cal beneficiaries with substance use disorders. DMC-ODS is the name for the enhanced DMC program authorized for opt-in counties under the state's Section 1115 Medicaid waiver, or "Medi-Cal 2020."</p>
<b>EQR/EQRO</b>	<p><b><u>External Quality Review/External Quality Review Organization</u></b></p> <p>Under federal regulations (42 CFR Part 438, subpart E), states must conduct external quality reviews of managed care organizations that contract to deliver publicly funded health services under Medicaid. EQROs are independent organizations with expertise in health care quality assurance and Medicaid policy that contract with the state to conduct reviews and provide technical assistance to managed care plans.</p>

<b>ETTA</b>	<p><b><u>Evaluation, Training, and Technical Assistance for Substance Use Disorder Services Integration</u></b></p> <p>ETTA, in this report, generally refers to a technical assistance contract between UCLA ISAP and DHCS and related activities, reports, and documentation.</p>
<b>IMD</b>	<p><b><u>Institution for Mental Disease</u></b></p> <p>IMDs are residential treatment facilities with more than sixteen beds for individuals with mental health or substance use disorders. Historically, these facilities were not eligible for participation in Drug Medi-Cal; the DMC-ODS waiver removes this “IMD exclusion” within participating counties.</p>
<b>MAT</b>	<p><b><u>Medication Assisted Treatment</u></b></p> <p>MAT is an approach to treating opioid dependence that utilizes medications like methadone or buprenorphine to relieve physical withdrawal symptoms and curb psychological cravings in combination with behavioral therapies/ counseling.</p>
<b>MCO</b>	<p><b><u>(Medi-Cal) Managed Care Organization</u></b></p> <p>MCOs administer health benefits for Medi-Cal enrollees through organized networks of contracted care providers. In California, a majority of Medicaid beneficiaries are enrolled in managed care plans that oversee their primary and specialty care benefits. Care for serious mental illness is “carved out” and managed separately by county-administered managed care plans. Under the DMC-ODS waiver, counties will act as managed care entities to oversee substance use disorder treatment as well.</p>
<b>NSDUH</b>	<p><b><u>National Survey of Drug Use and Health</u></b></p> <p>The NSDUH is an extensive, annual nationwide survey of drug use behaviors sponsored by SAMHSA.</p>
<b>NTP/OTP</b>	<p><b><u>Narcotic Treatment Program/Opioid Treatment Program</u></b></p> <p>NTPs/OTPs are treatment programs for individuals with opioid use disorders that are certified and accredited by SAMHSA according to federal law (42 CFR Section 8). NTPs offer medication-assisted treatment along with counseling.</p>
<b>SAMHSA</b>	<p><b><u>Substance Abuse and Mental Health Services Association</u></b></p> <p>SAMHSA, an agency within the United States Department of Health and Human Services, is responsible for public programs and activities related to behavioral health (substance abuse and mental health).</p>
<b>SAPT BG</b>	<p><b><u>Substance Abuse Prevention and Treatment Block Grant</u></b></p> <p>SAPT block grants are noncompetitive, annual awards from the federal government to states to fund public programs for the prevention and treatment of substance use disorders (administered by SAMHSA).</p>

<b>SB</b>	<p><b><u>(California) Senate Bill</u></b></p> <p>Legislation introduced in the California State Senate, one of the state’s two legislative bodies.</p>
<b>SMH</b>	<p><b><u>Specialty Mental Health</u></b></p> <p>SMH refers to California’s publicly funded services for Medi-Cal beneficiaries with serious mental illness. These services are delivered by county-administered mental health managed care plans and authorized by a 1915(b) Medicaid waiver, the “Specialty Mental Health waiver.”</p>
<b>SMI</b>	<p><b><u>Serious Mental Illness</u></b></p> <p>In California, health care benefits for Medi-Cal enrollees diagnosed with serious mental illness are “carved out” from the managed care plans that manage standard physical and mild-to-moderate mental health care services. Care for SMI is delivered separately through county-run Specialty Mental Health plans (see SMH).</p>
<b>SNAP</b>	<p><b><u>Statewide Needs Assessment and Planning (Report)</u></b></p> <p>SNAP refers to a bi-annual report prepared by DHCS in compliance with requirements for receiving federal Substance Abuse Prevention and Treatment block grant funds.</p>
<b>STCs</b>	<p><b><u>Special Terms and Conditions</u></b></p> <p>DMC-ODS waiver provisions are outlined within the extensive Special Terms and Conditions of the larger Medi-Cal 2020 waiver.</p>
<b>SUD</b>	<p><b><u>Substance Use Disorder</u></b></p> <p>Substance use disorder has been defined by SAMHSA as “the recurrent use of alcohol and/or drugs, [causing] clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.”</p>
<b>UCLA ISAP</b>	<p><b><u>University of California Los Angeles, Integrated Substance Abuse Programs</u></b></p> <p>UCLA’s ISAP team has been contracted to conduct a statewide program evaluation of the DMC-ODS waiver (following a long history of contracts with DHCS for evaluation and technical assistance to support the state’s substance use treatment programs).</p>

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## Endnotes

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1. California Behavioral Health Director's Association, *Expanding California's Capacity To Treat Individuals With Substance Use Disorders*, CBHDA Governing Board Policy Brief, 2015, [http://www.cbhda.org/wp-content/uploads/2014/12/2\\_SUD-Policy-Brief1.pdf](http://www.cbhda.org/wp-content/uploads/2014/12/2_SUD-Policy-Brief1.pdf).

Rates of treatment, or penetration rates (the proportion of individuals with diagnosable SUD who receive treatment, typically calculated as the number receiving treatment over the number believed to have SUD) are difficult to estimate with a high degree of accuracy. It can be hard to assess the prevalence of SUD; different measurement techniques and/or different definitions of SUD will lead to very different numbers. It is also hard to define "treatment" and attain reliable data about numbers treated.

Data from the National Survey on Drug Use and Health indicates that rates of treatment among those with SUD nationwide are about 11.6%. See: Substance Abuse and Mental Health Services Administration and RTI International, *Receipt Of Services For Behavioral Health Problems: Results From The 2014 National Survey On Drug Use And Health*, NSDUH Data Review (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015), <http://www.samhsa.gov/data/>.

The 10% treatment rate cited by CBHDA above appears to refer to the general population in California, not necessarily to the Medi-Cal population. Numbers receiving treatment are generally estimated to be lower among low-income ("safety net") populations than for the population as a whole. A 2012 statewide needs assessment found that in 2009 only about 4% of individuals with SUD in the state were accessing treatment through Medi-Cal; about 6% were accessing treatment through county drug and alcohol programs outside of Medi-Cal. These are overestimates because they likely include people who accessed care under both systems. Penetration rates for different counties ranged from 1-14%, and for different ethnic groups from 2-16%. See: Technical Assistance Collaborative and Human Services Research Institute, *California Mental Health And Substance Use System Needs Assessment Final Report*, Submitted To California Department Of Health Care Services, California Bridge To Reform Waiver, 2012, p. 222. Available at: <http://www.dhcs.ca.gov/provgovpart/Pages/BehavioralHealthServicesAssessmentPlan.aspx>. These rates have likely shifted or even increased slightly in the years since 2009, as Drug Medi-Cal benefits have been expanded, but they help to paint a picture of overall unmet need.

Finally, it should be noted that a large proportion of those who do not receive treatment also do not seek treatment. See Section II, "Substance Use and the Medicaid Population" for further discussion.

2. California Department of Health Care Services, *California Medi-Cal 2020 Demonstration* (Waiver Special Terms and Conditions, No. 11-W-00193/9, Centers for Medicare and Medicaid Services, 2015), retrieved from <http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx>.

3. Karen Baylor, Marlies Perez, Don Kingdon, and Molly Brassil, "Drug Medi-Cal Organized Delivery System Pilot Program", (DHCS Stakeholder Webinar, Sacramento, CA, 2015). Available at: <http://www.dhcs.ca.gov/provgovpart/Pages/Fact-Sheets-and-FAQs.aspx?>

4. California Department of Health Care Services, *California Medi-Cal 2020 Demonstration* (Waiver Special Terms and Conditions, No. 11-W-00193/9, Centers for Medicare and Medicaid Services, 2015), retrieved from <http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx>.

5. "Waivers", *Medicaid.Gov*, accessed May 11, 2016, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.

6. For an overview of Medicaid waivers, see Cynthia Shirk, *Shaping Medicaid And SCHIP Through Waivers: The Fundamentals*, National Health Policy Forum (Washington, D.C.: George Washington University, 2008), [https://www.nhpf.org/library/background-papers/BP64\\_MedicaidSCHIP.Waivers\\_07-22-08.pdf](https://www.nhpf.org/library/background-papers/BP64_MedicaidSCHIP.Waivers_07-22-08.pdf).

7. "Substance Use Disorders", *Samhsa.Gov*, 2016, <http://www.samhsa.gov/disorders/substance-use>.

8. Center for Behavioral Health Statistics and Quality, *Behavioral Health Trends In The United States: Results From The National Survey On Drug Use And Health*, HHS Publication No. SMA 15-4927, NSDUH Series H-50, (Rockville, MD: Substance Abuse and Mental Health Administration, 2014), <http://www.samhsa.gov/data/>.



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  10. "Overdose Death Rates", National Institute On Drug Abuse, Drugabuse.Gov, 2015, <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>.
  11. "Fatal Injury Data", Cdc.Gov, 2016, <http://www.cdc.gov/injury/wisqars/fatal.html>.
  12. White House Office of the Press Secretary, *Fact Sheet: Obama Administration Announces Additional Actions To Address The Prescription Drug Abuse And Opioid Epidemic* (Washington, D.C.: White House Office of the Press Secretary, 2016), <https://www.whitehouse.gov/the-press-office/2016/03/29/fact-sheet-obama-administration-announces-additional-actions-address>.
  13. Substance Abuse and Mental Health Services Administration, *Behavioral Health Treatment Needs Assessment Toolkit For States*, HHS Publication No. SMA13-4757 (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015), <http://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf>.
  14. Substance Abuse and Mental Health Services Administration and RTI International, *Receipt Of Services For Behavioral Health Problems: Results From The 2014 National Survey On Drug Use And Health*, NSDUH Data Review (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015), <http://www.samhsa.gov/data/>.
  15. Ibid.
  16. UCLA Integrated Substance Abuse Programs, *Evaluation, Training, And Technical Assistance For Substance Use Disorder Services Integration (ETTA) 2015 Report*, Prepared For The Department Of Health Care Services, California Health And Human Services Agency (UCLA Integrated Substance Abuse Programs, 2015), p. 9-11, <http://www.uclaisap.org/html/past-updates-reports.html>.
  17. Susan H. Busch et al., "Characteristics Of Adults With Substance Use Disorders Expected To Be Eligible For Medicaid Under The ACA", *PS* 64, no. 6 (2013): 520-526, doi:10.1176/appi.ps.201200011.
  18. UCLA Integrated Substance Abuse Programs, *ETTA 2015 Report*, p. 12. (See note 13.)
  19. California Department of Health Care Services, *2015 California Substance Use Disorder Block Grant And Statewide Needs Assessment And Planning Report* (Sacramento, CA: California Department of Health Care Services, Substance Use Disorder Prevention, Treatment and Recovery Services Division, 2015), 48, retrieved from <http://www.dhcs.ca.gov/provgovpart/Pages/SAPTBLOCKGRANT.aspx>.
  20. Substance Abuse and Mental Health Services Administration, *Highlights Of The 2011 Drug Abuse Warning Network (DAWN) Findings On Drug-Related Emergency Department Visits*, The DAWN Report (Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2013), <http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm>.
  21. The National Center on Addiction and Substance Use at Columbia University, *Shoveling Up II: The Impact Of Substance Abuse On Federal, State And Local Budgets* (New York, NY: The National Center on Addiction and Substance Use at Columbia University, 2009), <http://www.centeronaddiction.org/addiction-research/reports/shoveling-ii-impact-substance-abuse-federal-state-and-local-budgets>.
  22. California Department of Health Care Services, *Federal Government Approves New Model Of Treatment For Drug Medi-Cal Program*, Press Release, August 14, 2015, <http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/15-02%20DMC%20ODS%20Waiver%208-14-15.pdf>.
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  24. California Department of Health Care Services, *California Bridge To Reform Demonstration (No. 11-W-00193/9) Amendment For Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver* (Sacramento, CA: State of California Health and Human Services

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Agency, Department of Health Care Services, 2014), [http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS\\_Waiver\\_Amendment\\_Request.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver_Amendment_Request.pdf).

25. For a more extensive discussion of the effect of the IMD exclusion on DMC services, as well as the policy landscape surrounding SB X1-1 and California's subsequent Section 1115 Waiver proposal, see: John Connolly and Chauntrece Washington, *Transforming Drug Medi-Cal: Key Considerations For A Waiver Amendment* (Insure the Uninsured Project (ITUP), 2014), <http://itup.org/delivery-systems/2014/06/02/transforming-drug-medi-cal-key-considerations-for-a-waiver-amendment/>.

For a summary of relevant federal law governing parity of benefits for behavioral health services, including SUD services, see: "Behavioral Health Services", *Medicaid.Gov*, 2016, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html>.

For an explanation of the significance of the Affordable Care Act's Essential Health Benefits, see: "Information On Essential Health Benefits (EHB) Benchmark Plans", *Cms.Gov*, 2016, <https://www.cms.gov/ccio/resources/data-resources/ehb.html>.

26 The IMD exclusion falls under section 1905(a)(B) of the Social Security Act. For a summary of the provision, related law, and opportunities for reform, see: Legal Action Center, *The Medicaid IMD Exclusion: An Overview And Opportunities For Reform*, Fact Sheet (New York, NY: Legal Action Center, 2014), [http://lac.org/wp-content/uploads/2014/07/IMD\\_exclusion\\_fact\\_sheet.pdf](http://lac.org/wp-content/uploads/2014/07/IMD_exclusion_fact_sheet.pdf).

27. Karen Baylor, Marlies Perez, Don Kingdon, and Molly Brassil, "Drug Medi-Cal Organized Delivery System Pilot Program", (DHCS Stakeholder Webinar, Sacramento, CA, 2015). Available at: <http://www.dhcs.ca.gov/provgovpart/Pages/Fact-Sheets-and-FAQs.aspx?>.

28. California Department of Health Care Services, *California Bridge To Reform Demonstration (No. 11-W-00193/9) Amendment For Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver* (Sacramento, CA: State of California Health and Human Services Agency, Department of Health Care Services, 2014), [http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS\\_Waiver\\_Amendment\\_Request.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver_Amendment_Request.pdf).

29. California Senate Bill No.1, Medi-Cal: Eligibility (2013-14), CA Welf. & Inst. Code § § 11026, 14005-14132, 14189 (2013). Available at: [http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201320141SB1](http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201320141SB1).

The state was explicitly required to seek federal authority to address the residential IMD exclusion to improve access to treatment in residential SUD facilities as well as hospital detoxification units in SB 1161, a trailer bill to 2013's SB 1. See California Senate Bill No. 1161, Drug Medi-Cal (2013-14), CA Welf. & Inst. Code § § 14124.29 (2014). Available at: [http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill\\_id=201320140SB1161](http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201320140SB1161).

30. California State Auditor, *California Department Of Health Care Services: Its Failure To Properly Administer The Drug Medi-Cal Treatment Program Created Opportunities For Fraud* (Sacramento, CA: California State Auditor, 2014), <https://www.auditor.ca.gov/pdfs/reports/2013-119.pdf>

31. *Rehab Racket*, video (Emeryville, CA: Center for Investigative Reporting and CNN, 2013), <http://cironline.org/rehabracket>.

32. California Department of Health Care Services, *Annual Report To The Legislature: Transfer Of Administrative And Programmatic Functions Of The Department Of Alcohol And Drug Programs To The Department Of Health Care Services* (Sacramento, CA: California Department of Health Care Services, 2015), [http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/AB75\\_CY%202014\\_10-2015.pdf](http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/AB75_CY%202014_10-2015.pdf).

33. 22 CCR § 51341.1, 51490.1, and 51516.1. Available via: [http://www.dhcs.ca.gov/services/adp/Pages/CA\\_Code\\_Regulations.shtml.aspx](http://www.dhcs.ca.gov/services/adp/Pages/CA_Code_Regulations.shtml.aspx).

See also: "DHCS-14-006E-DMC Program Integrity", *Dhcs.Ca.Gov*, 2016, <http://www.dhcs.ca.gov/formsandpubs/laws/Pages/DHCS-14-006E-DMCProgramIntegrity.aspx>.

34. United States Government Accountability Office, *Medicaid: A Small Share Of Enrollees Consistently Accounted For A Large Share Of Expenditures* (Report to Congressional Requesters, Washington, D.C.: United States Government Accountability Office, 2015), <http://www.gao.gov/assets/680/670112.pdf>.

35. For example, California's previous 5-year 1115 waiver included a commitment to extend coverage to the ACA's low-income expansion group in advance of Affordable Care Act implementation through the Low Income Health Program, or LIHP. Following

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full ACA implementation in 2014, LIHP enrollees were transferred into Medi-Cal and California cut its uninsured rate almost in half. See: Peter Harbage and Meredith Ledford-King, *A Bridge To Reform: California's Medicaid Section 1115 Waiver* (California HealthCare Foundation, 2012), available at [www.chcf.org](http://www.chcf.org).

36. Numbers are January 2016 estimates from the following sources. For population, see: California Department of Finance, *New State Population Report: California Grew By 348,000 Residents In 2015*, 2016, <http://www.dof.ca.gov/research/demographic/reports/estimates/e-1/view.php>. For Medi-Cal caseloads, see: California Department of Health Care Services, *May 2016 Medi-Cal Estimate* (Sacramento, CA: California Department of Health Care Services, 2016), [http://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2016\\_May\\_Estimate/M1604\\_v6.0\\_Caseload\\_Tab.pdf](http://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2016_May_Estimate/M1604_v6.0_Caseload_Tab.pdf).

37. Karen Baylor, Marlies Perez, Don Kingdon, and Molly Brassil, "Drug Medi-Cal Organized Delivery System Pilot Program", (DHCS Stakeholder Webinar, Sacramento, CA, 2015). Available at: <http://www.dhcs.ca.gov/provgovpart/Pages/Fact-Sheets-and-FAQs.aspx?>.

38. Outside of waiver authority, states maintain Medicaid State Plans (adjusted as needed through State Plan Amendments, SPAs) that detail the benefits available to the state's Medicaid participants. See: "California State Plan", *Dhcs.Ca.Gov*, 2016, <http://www.dhcs.ca.gov/formsandpubs/laws/pages/californiastateplan.aspx>.

39. More than three-quarters of Medi-Cal beneficiaries are enrolled in local managed care plans that oversee health benefits for primary and specialty care, with the exceptions of substance use disorder and specialty mental health services. For additional information on Medi-Cal managed care, see Margaret Tater, Julia Paradise and Rachel Garfield, *Medi-Cal Managed Care: An Overview And Key Issues*, The Kaiser Commission On Medicaid And The Uninsured (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2016), <http://files.kff.org/attachment/issue-brief-medi-cal-managed-care-an-overview-and-key-issues>.

40. *Part B: Health Agenda including Health Facilities Financing Authority and Mental Health Services Oversight and Accountability Commission*: Hearing before California Senate Budget Subcommittee No. 3, (April 21, 2016), (Statement of Marlies Perez, Division Chief, Substance Use Disorder Compliance, CA Department of Health Care Services). Video available via [www.calchannel.com](http://www.calchannel.com).

41. See: *Part B: Health Agenda including Health Facilities Financing Authority and Mental Health Services Oversight and Accountability Commission*: Agenda for Hearing before California Senate Budget Subcommittee No. 3, (April 21, 2016). Available at: <http://sbud.senate.ca.gov/subcommittee3>.

See also: "State Implementation Plan", *Dhcs.Ca.Gov*, 2016, <http://www.dhcs.ca.gov/provgovpart/Pages/State-Implementation-Plan.aspx>.

42. *Part B: Health Agenda including Health Facilities Financing Authority and Mental Health Services Oversight and Accountability Commission*: Agenda for Hearing before California Senate Budget Subcommittee No. 3, (April 21, 2016). Available at: <http://sbud.senate.ca.gov/subcommittee3>.

43. Centers for Medicare and Medicaid Services, *New Service Delivery Opportunities For Individuals With A Substance Use Disorder* (Baltimore, MD: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2015), <https://www.medicare.gov/federal-policy-guidance/downloads/SMD15003.pdf>

44. UCLA Integrated Substance Abuse Programs, *California County Administrator Survey 2015 Results* (Los Angeles, CA: UCLA Integrated Substance Abuse Programs, 2016).

45. Through its contract with DHCS, the California Institute for Behavioral Health Solutions will offer training, consultation, and technical assistance services to DMC-ODS counties free of charge (including up to 40 hours of individualized on-site consultation per program). In addition to the ASAM criteria and framework, possible topics for training/assistance include SUD clinical practice (e.g. relapse prevention, issues related to medication assisted treatment), DMC administration (licensing and certification for providers, assistance with EHR use and data collection), and strategic planning (policy and procedure development, resolution of management and financial challenges). For additional information, see "SUD Technical Assistance/Consulting", *Cibhs.Org*, <http://www.cibhs.org/sud-technical-assistanceconsulting>.

46. California Department of Health Care Services, *California Medi-Cal 2020 Demonstration* (Waiver Special Terms and Conditions, No. 11-W-00193/9, Centers for Medicare and Medicaid Services, 2015), § X.129, p. 91-95, retrieved from <http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx>.

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47. California Department of Health Care Services, *Update To The Legislature: Transfer Of The Drug Medi-Cal Treatment Program To The Department Of Health Care Services* (Sacramento, CA: California Department of Health Care Services, 2014), [http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Drug\\_MediCal\\_Update-Apr2013-Jun2014.pdf](http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Drug_MediCal_Update-Apr2013-Jun2014.pdf).
48. Marlies Perez, "Drug Medi-Cal ODS Demonstration Waiver: SAC Update", (Presentation, 1115 Waiver Stakeholder Advisory Meeting, 2016). Available at: [http://www.dhcs.ca.gov/services/Documents/SAC\\_ODSWaiver\\_051616.pdf](http://www.dhcs.ca.gov/services/Documents/SAC_ODSWaiver_051616.pdf).
49. UCLA Integrated Substance Abuse Programs, *California County Administrator Survey 2015 Results* (Los Angeles, CA: UCLA Integrated Substance Abuse Programs, 2016).
50. California Department of Health Care Services, *California Medi-Cal 2020 Demonstration* (Waiver Special Terms and Conditions, No. 11-W-00193/9, Centers for Medicare and Medicaid Services, 2015), § X.127, p. 89, retrieved from <http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx>.
51. CalOMS Treatment is California's statewide SUD treatment data collection and reporting tool; SUD treatment providers share treatment data with DHCS monthly. See UCLA Integrated Substance Abuse Programs, *Evaluation, Training, And Technical Assistance For Substance Use Disorder Services Integration (ETTA) 2015 Report*, Prepared For The Department Of Health Care Services, California Health And Human Services Agency (UCLA Integrated Substance Abuse Programs, 2015), p. 16, <http://www.uclaisap.org/html/past-updates-reports.html>.
52. Ibid.
53. UCLA Integrated Substance Abuse Programs, *California County Administrator Survey 2015 Results* (Los Angeles, CA: UCLA Integrated Substance Abuse Programs, 2016).
54. Ibid.
55. For a description of how the federal share of Medicaid payments (or FMAP, Federal Medicaid Assistance Percentage) are calculated, see: Laura Snyder and Robin Rudowitz, *Medicaid Financing: How Does It Work And What Are The Implications?*, Issue Brief (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2015), <http://kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/>.
56. For a more detailed explanation of 2011 Realignment, see: California Legislative Analyst's Office, *2011 Realignment: Addressing Issues To Promote Its Long-Term Success* (Sacramento, CA: California Legislative Analyst's Office, 2011), [http://www.lao.ca.gov/reports/2011/stadm/realignment/realignment\\_081911.pdf](http://www.lao.ca.gov/reports/2011/stadm/realignment/realignment_081911.pdf).
57. Counties are generally responsible for providing the non-federal share of Drug Medi-Cal payments using the Behavioral Health Subaccounts established under 2011's Public Safety Realignment policies and funded by state sales tax revenue. However, the state may not impose new entitlement spending on counties without also contributing new funding. For example, the state is responsible for covering the non-federal share of cost for the enhanced Drug Medi-Cal benefits instated under 2013's Senate Bill 1. See California Senate Bill No.1, Medi-Cal: Eligibility (2013-14), CA Welf. & Inst. Code § § 11026, 14005-14132, 14189 (2013). Available at: [http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill\\_id=201320141SB1](http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201320141SB1).
58. Robin Rudowitz, *Understanding How States Access The ACA Enhanced Medicaid Match Rates*, Issue Brief (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2014), <http://kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/>.
59. *Part B: Health Agenda including Health Facilities Financing Authority and Mental Health Services Oversight and Accountability Commission*: Hearing before California Senate Budget Subcommittee No. 3, (April 21, 2016), (Statement of Karen Baylor, Deputy Director, Mental Health and Substance Use Disorder Services, CA Department of Health Care Services). Video available via [www.calchannel.com](http://www.calchannel.com).
60. Drug Medi-Cal rates are calculated in accordance with the CA Welfare and Institutions Code Sections 14021.51, 14021.6 and 14021.9. For a summary of the rate-setting methodology, see: California Department of Health Care Services, "County Behavioral Health Directors Association - All Members Meeting Drug Medi-Cal Presentation", (Presentation, Sacramento, CA, 2015), [http://www.cbhda.org/member-info/all-members/all-members-handouts/attachment/dhcs\\_cbhda-presentation-dmc-08112015/](http://www.cbhda.org/member-info/all-members/all-members-handouts/attachment/dhcs_cbhda-presentation-dmc-08112015/).



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61. For a summary of concerns and links to recent research about Medi-Cal provider payment rates, see: Scott Graves, "Key Facts About Medi-Cal Provider Payments And The Governor's Special Session", Blog, California Budget Bites, California Budget And Policy Center, 2015, <http://calbudgetcenter.org/blog/key-facts-about-medi-cal-provider-payments-and-the-governors-special-session/>.

As a further example, an administrative complaint alleging inadequate access to care resulting in a civil rights violation due to disparate impact on California's Latino population was filed in December, 2015, by the Mexican American Legal Defense and Education Fund, National Health Law Program and the Civil Rights Education and Enforcement Center. See: National Health Law Program, "HHS Administrative Complaint: Inadequate Access To Health Care Violates Latino Civil Rights In California's Medi-Cal Program," Healthlaw.Org, 2016, <http://www.healthlaw.org/publications/HHS-CA-Complaint#.V1Oo3JMrLfB>.

62. While the federal government will pay the majority of costs for the ACA expansion population, states can expect to pay at least 10% of these costs after 2020. California must also account for the "woodwork" effect of increased Medi-Cal enrollments among the previously eligible population that has followed ACA marketing and the introduction of the Covered California marketplace. For an explanation of federal and state cost-sharing under the ACA's Medicaid expansion, see: Robin Rudowitz, *Understanding How States Access The ACA Enhanced Medicaid Match Rates*, Issue Brief (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2014), <http://kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicare-match-rates/>.

63. State of California Executive Department, *A Proclamation By The Governor Of The State Of California: Health Care Special Session* (Sacramento, CA: Executive Department, State of California, 2015), [https://www.gov.ca.gov/docs/6.16.15\\_Health\\_Care\\_Special\\_Session.pdf](https://www.gov.ca.gov/docs/6.16.15_Health_Care_Special_Session.pdf).

64. *Informational Hearing: Shoring up California's Public Health Care and Developmental Services Financing*: Hearing before the Public Health and Developmental Services Committee Second Extraordinary Session, (July 2, 2015), (Statement of Jennifer Kent, Director, California Department of Health Care Services), as cited by: Scott Graves, "Key Facts About Medi-Cal Provider Payments And The Governor's Special Session", Blog, California Budget Bites, California Budget And Policy Center, 2015, <http://calbudgetcenter.org/blog/key-facts-about-medi-cal-provider-payments-and-the-governors-special-session/>.

65. California Department of Health Care Services, *California Medi-Cal 2020 Demonstration* (Waiver Special Terms and Conditions, No. 11-W-00193/9, Centers for Medicare and Medicaid Services, 2015), § X.158, p. 117-18, retrieved from <http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx>. Counties will propose county-specific rates for all DMC-ODS covered services except Narcotic Treatment Programs/Opioid Treatment Programs (NTP/OTP). NTP/OTP reimbursement will continue to follow a previously established process per California Welfare and Institutions Code Section 14021.51. Reimbursements for services provided by counties that do not opt in to DMC-ODS will still be determined under existing statewide (not county-specific) guidelines. For citations on the current statewide reimbursement rates and claiming procedures, see Note 60.

66. For additional information on DMC-ODS fiscal provisions and the information that must be included in county fiscal plans, see California Department of Health Care Services, *MHSUDS Information Notice 15-034* (Sacramento, CA: CA Department of Health Care Services, 2015), and California Department of Health Care Services, *MHSUDS Information Notice 16-006* (Sacramento, CA: CA Department of Health Care Services, 2016), both available at [http://www.dhcs.ca.gov/provgovpart/Pages/Waiver\\_Information\\_Notices.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/Waiver_Information_Notices.aspx).

67. For example: some counties may already offer recovery services, funded by non-DMC sources, but others do not. Counties that do not currently have any available residential treatment or detox programs—but perhaps wish to opt into the waiver in part to help expand those services—have little to no historical data on which to rely. One county noted that in past years, virtually all the county's DMC-certified providers have operated NTPs. NTPs are exempt from rates negotiated by the waiver; payment rates for these services will continue to be determined via a statewide process. There is likely even less data on costs associated with a brand new benefit like physician consultation. When possible, counties must look to providers who have not previously participated in DMC for cost estimates and to potentially analogous payment rates (like those for Specialty Mental Health services) for reference.

68. One provider interviewed for this study pointed out that a county in which his organization operates submitted cost estimates based solely on data from his organization. This presumably happened because other providers were unable to provide cost reports in a timely manner. This sort of reliance on very limited data increases the risk of proposing rates that are based on bad math—or, of counties deciding they are unable to propose tailored rates and choosing to operate under statewide rates, which may continue to be too low to attract the new providers needed to round out the DMC-ODS.

69. SUD treatment penetration rates—the proportion of individuals who actually receive treatment within the population estimated to need treatment—have historically been low statewide; see Note 1. Further, total admissions to treatment did not increase in a sustained

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way following the ACA expansion in 2014. See: UCLA Integrated Substance Abuse Programs, *Evaluation, Training, And Technical Assistance For Substance Use Disorder Services Integration (ETTA) 2015 Report*, Prepared For The Department Of Health Care Services, California Health And Human Services Agency (UCLA Integrated Substance Abuse Programs, 2015), p. 11, <http://www.uclaisap.org/html/past-updates-reports.html>. As one example, Santa Cruz's county SUD programs have typically served about 1500 clients annually; a 2013 statewide needs assessment estimated that 21,000 Santa Cruz county residents likely meet the clinical criteria for SUD diagnosis. Low penetration is not unique to California, and is due in large part to the low numbers of people with SUD who actually seek treatment. However NSDUH surveys have also identified other barriers to treatment, namely affordability. Combined 2011-2014 results from SAMHSA's National Survey on Drug Use and Health (NSDUH) showed that among respondents who sought but did not obtain treatment for their SUDs, the top reason, affecting 35.3% of this group, was "No health coverage and could not afford cost." 11% also responded that they "had health coverage but did not cover treatment or did not cover cost." See: Substance Abuse and Mental Health Services Administration and RTI International, *Receipt Of Services For Behavioral Health Problems: Results From The 2014 National Survey On Drug Use And Health*, NSDUH Data Review (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015), <http://www.samhsa.gov/data/>.

Concerns about paying for treatment should continue to decrease as more services are covered, and those with new Medi-Cal coverage learn about their benefits and begin to use them. Inadequate provider networks, which have led to wait lists for services in many counties, may also have played a role in the relatively low numbers receiving SUD. Consequently, in counties where penetration has been low and services have been less available, there is concern about a "woodwork" effect. Returning to Santa Cruz: using NSDUH data and Medi-Cal enrollment percentages, the county estimates it could possibly encounter as many as 2600 Medi-Cal beneficiaries seeking treatment under the DMC-ODS annually, a substantial increase. See: Santa Cruz County Mental Health and Substance Abuse Services, *County Of Santa Cruz Implementation Plan For Drug Medi-Cal Organized Delivery System (DMC-ODS)* (Santa Cruz, CA: County of Santa Cruz Health Services Agency, 2015). Available at: <http://www.dhcs.ca.gov/provgovpart/Pages/County-Implementation-Plans-.aspx>.

70. UCLA Integrated Substance Abuse Programs, *Evaluation, Training, And Technical Assistance For Substance Use Disorder Services Integration (ETTA) 2015 Report*, Prepared For The Department Of Health Care Services, California Health And Human Services Agency (UCLA Integrated Substance Abuse Programs, 2015), p. 95, <http://www.uclaisap.org/html/past-updates-reports.html>.

71. UCLA Integrated Substance Abuse Programs, *Evaluation, Training, And Technical Assistance For Substance Use Disorder Services Integration (ETTA) 2014 Report*, Prepared For The Department Of Health Care Services, California Health And Human Services Agency (UCLA Integrated Substance Abuse Programs, 2014), <http://www.uclaisap.org/html/past-updates-reports.html>.

72 For a primer on the financing of public mental health care in California, see Sarah Arnquist and Peter Harbage, *A Complex Case: Public Mental Health Delivery And Financing In California* (California HealthCare Foundation, 2013), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20ComplexCaseMentalHealth.pdf>.

73. "Mental Health Services Act (MHSA)", *Dhcs.Ca.Gov*, 2016, [http://www.dhcs.ca.gov/services/mh/Pages/MH\\_Prop63.aspx](http://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx).

74. California Senate Bill No.82, Investment in Mental Health Wellness Act of 2013, (2013-14), CA Welf. & Inst. Code § 5892, 5848.5, (2013). Available at: [http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140SB82](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB82)

75. Counties may claim Drug Medi-Cal administrative activities separately from direct service costs; administrative costs are calculated as a fixed percentage of direct costs claimed (typically 15%). See: DHCS Substance Use Disorder Prevention, Treatment, and Recovery Services Division, Fiscal Management and Accountability Branch, *Drug Medi-Cal Billing Manual* (Sacramento, CA: California Department of Health Care Services, 2015), [http://www.dhcs.ca.gov/formsandpubs/Documents/Info%20Notice%202015/DMC\\_Billing\\_Manual%20FINAL.pdf](http://www.dhcs.ca.gov/formsandpubs/Documents/Info%20Notice%202015/DMC_Billing_Manual%20FINAL.pdf). The procedure for claiming administrative costs under the DMC-ODS will be finalized within the Certified Public Expenditure protocol that DHCS has developed which was, at the time of this report, awaiting CMS approval. Most interviewees expected that 15% of direct costs would continue to be the maximum administrative claim.

76. California Department of Health Care Services, *California Medi-Cal 2020 Demonstration* (Waiver Special Terms and Conditions, No. 11-W-00193/9, Centers for Medicare and Medicaid Services, 2015), § X.128.e.ii, X.131.i.g, pp. 90, 97-98, retrieved from <http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx>.

77. UCLA Integrated Substance Abuse Programs, *Evaluation, Training, And Technical Assistance For Substance Use Disorder Services Integration (ETTA) 2015 Report*, Prepared For The Department Of Health Care Services, California Health And Human

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Services Agency (UCLA Integrated Substance Abuse Programs, 2015), p. 113, <http://www.uclaisap.org/html/past-updates-reports.html>.

78. Technical Assistance Collaborative and Human Services Research Institute, *California Mental Health And Substance Use System Needs Assessment And Service Plan Volume 2: Service Plan*, Submitted To California Department Of Health Care Services, California Bridge To Reform Waiver, 2013, <http://www.dhcs.ca.gov/provgovpart/Documents/CABridgetoReformWaiverServicesPlanFINAL9013.pdf>.

79. Ibid., p. 107.

80. California Department of Health Care Services, *2015 California Substance Use Disorder Block Grant And Statewide Needs Assessment And Planning Report* (Sacramento, CA: California Department of Health Care Services, Substance Use Disorder Prevention, Treatment and Recovery Services Division, 2015), available at <http://www.dhcs.ca.gov/provgovpart/Pages/SAPTBLOCKGRANT.aspx>.

81. The room and board exclusion is a provision of California's state Medicaid plan and pre-dates the DMC-ODS waiver. It was less significant in the past when only very small numbers of pregnant or parenting women were able to access the DMC SUD residential treatment benefit. See: "California State Plan", *Dhcs.Ca.Gov*, 2016, <http://www.dhcs.ca.gov/formsandpubs/laws/pages/californiastateplan.aspx>.

82. California Department of Health Care Services, *California Medi-Cal 2020 Demonstration* (Waiver Special Terms and Conditions, No. 11-W-00193/9, Centers for Medicare and Medicaid Services, 2015), § X.131.i.g, pp. 97-98, retrieved from <http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx>.

83. For an overview of mental health and substance use workforce challenges in the U.S. see: U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), *Report To Congress On The Nation's Substance Abuse And Mental Health Workforce Issues* (Washington, D.C.: U.S. Department of Health and Human Services, 2013), p. 11, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>.

For a discussion of these issues in California, see: California Department of Alcohol and Drug Programs, *Workforce Development Needs In The Field Of Substance Use Disorders* (Sacramento, CA: CA Department of Alcohol and Drug Programs, 2013), <http://cchealth.org/aod/pdf/Workforce-Development-Needs-in-the-Field-of-Substance-Use-Disorders.pdf>.

84. U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), *Report To Congress On The Nation's Substance Abuse And Mental Health Workforce Issues* (Washington, D.C.: U.S. Department of Health and Human Services, 2013), p. 11, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>.

85. U.S. Bureau of Labor Statistics, as cited by: Christine Vestal, "How Severe Is The Shortage Of Substance Abuse Specialists?", Blog, *Stateline, The Pew Charitable Trusts*, 2015, <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/01/how-severe-is-the-shortage-of-substance-abuse-specialists>.

86. California Department of Health Care Services, *2015 California Substance Use Disorder Block Grant And Statewide Needs Assessment And Planning Report* (Sacramento, CA: California Department of Health Care Services, Substance Use Disorder Prevention, Treatment and Recovery Services Division, 2015), pp. 63-67, available at <http://www.dhcs.ca.gov/provgovpart/Pages/SAPTBLOCKGRANT.aspx>.

87. California Department of Health Care Services, *2015 California Substance Use Disorder Block Grant And Statewide Needs Assessment And Planning Report* (Sacramento, CA: California Department of Health Care Services, Substance Use Disorder Prevention, Treatment and Recovery Services Division, 2015), p. 65, available at <http://www.dhcs.ca.gov/provgovpart/Pages/SAPTBLOCKGRANT.aspx>.

88. UCLA Integrated Substance Abuse Programs, *California County Administrator Survey 2015 Results* (Los Angeles, CA: UCLA Integrated Substance Abuse Programs, 2016).

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147. Ibid. This section of the DMC STCs repeatedly states that counties must ensure access to all required services under the DMC-ODS pilot. Access "must remain at the current level or expand" with DMC-ODS implementation, and access must not be indirectly limited as a result of the selective contracting process with network providers.

148. The DMC STCs include a list of access-related factors counties must consider when establishing and monitoring provider networks, including the number and type of providers in the network and the geographic locations of providers throughout the county. Counties will track system performance through a structured quality improvement process. Accessibility indicators to be monitored include: length of time between a client's first contact with the delivery system and first face-to-face appointment; number of days to first service at appropriate level of care after referral; access to services in the prevalent non-English language(s), using translation if



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needed authorization requests approved and denied; coordination with physical and mental health services; and “responsiveness” of the beneficiary access line. See: California Department of Health Care Services, *California Medi-Cal 2020 Demonstration* (Waiver Special Terms and Conditions, No. 11-W-00193/9, Centers for Medicare and Medicaid Services, 2015), § X.157, pp. 116-117, retrieved from <http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx>.

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169. Whole Person Care pilots are county-wide, optional initiatives under the Medi-Cal 2020 waiver to coordinate physical health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are “high users of multiple [health and service] systems.” For additional information, see: "Whole Person Care Pilots", *Dhcs.Ca.Gov*, 2016, <http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx>.
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171. Full Service Partnerships are county-led programs created under California’s 2004 Mental Health Services Act (MHSA, or Proposition 63) that offer intensive services, including physical/behavioral health care as well as housing, employment, and education assistance, to individuals with serious mental illness. For more information on Proposition 63 and Full Service Partnerships, see: [http://www.dhcs.ca.gov/services/mh/Pages/MH\\_Prop63.aspx](http://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx).
172. Full Service Partnerships target those with serious mental illness; eligibility for Health Homes follows a specific list of criteria that includes serious mental illness or multiple chronic health conditions; and counties themselves have some discretion over how they will define the population of “high utilizers” for enrollment in Whole Person Care pilots.
173. Continuums of Care, or CoCs, are local or regional organizations that receive grant funding from the U.S. Department of Housing and Urban Development (HUD) to coordinate housing and related services for homeless individuals. California has 40 CoCs serving its 58 counties. For more information, see: "CoC: Continuum Of Care Program - HUD Exchange", *Hudexchange.Info*, 2016, <https://www.hudexchange.info/programs/coc/>.
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