SENATE
CALIFORNIA LEGISLATURE

STATE CAPITOL
SACRAMENTO, CALIFORNIA
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Joint Hearing of the Senate Budget and Fiscal Review Committee &
Senate Health Committee
Oversight Hearing – The Administration's Drug Medi-Cal
Organized Delivery System Proposed Waiver
State Capitol, Room 4203
1:00 p.m. – 3:00 p.m.
October 21, 2014
Background Paper

OVERVIEW

The Department of Health Care Services (DHCS) plans to request a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to operate the Drug Medi-Cal (DMC) program as a county-optional, organized delivery system. (DMC is the substance use disorder treatment benefit in the Medi-Cal program.) DHCS states the waiver will give state and county officials more authority to select quality providers to meet drug treatment needs. DHCS indicates the waiver will support coordination and integration across systems, increase monitoring of provider delivery of services, and strengthen county oversight of network adequacy, service access, and standardized practices in provider selection.

The purpose of this hearing is to examine the DHCS' proposed DMC Organized Delivery System waiver, to examine DHCS' authority to pursue a waiver, to assess what statutory changes are needed to implement a DMC waiver, to consider whether DHCS proposed DMC waiver should be implemented (i.e., adopted by the Legislature), and to provide a forum for affected stakeholders and the public to express their views on DHCS's proposed DMC Organized Delivery System waiver.

BACKGROUND

Substance Use Disorder Prevalence in California. As part of federal approval of California's 2010 "Bridge to Reform" Medicaid waiver, the Centers for Medicare and Medicaid Services (CMS) required California to submit a mental health and substance use disorder needs assessment. Findings of the statewide estimated prevalence from the report are as follows:

- Youth (0-17) with substance use disorder treatment needs - 8.15%
- Adults (18+) with substance use disorder treatment needs - 8.83%
- Youth with serious emotional disturbance - 7.56%
- Adults with serious mental illness - 4.28%
- Adults with broad definition of mental health need - 15.85%

Using these prevalence rates, it could be roughly estimated that about one million individuals in Medi-Cal have substance use disorder treatment needs.

Drug Medi-Cal (DMC). Since 1980, the Drug Medi-Cal (DMC) program has provided limited medically necessary drug and alcohol-related treatment services to specific categories of eligible Medi-Cal beneficiaries. DMC operates as a "carve out" from Medi-Cal managed care plans. Consequently, Medi-Cal managed care plans which deliver primary and specialty health care services are not responsible for providing and arranging DMC services for their members. Approximately 70 percent of Medi-Cal eligible adults and children receive their health care services through Medi-Cal managed care plans. (Medi-Cal managed care plans are responsible for some substance use disorder treatment services as described below.) DMC services are delivered by a specialized system of providers certified by the state and counties, rather than through Medi-Cal managed care health plans. DMC services are reimbursed on a fee-for-service basis at maximum rates set by the state. These providers and services are not coordinated or managed by a central entity.

In 2011, funding for the DMC program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS as part of the Public Safety Realignment initiated by AB 109 (Committee on Budget), Chapter 15, Statutes of 2011. Prior to the realignment of the DMC program, DMC was funded with General Fund and federal funds. Enactment of the 2011 Public Safety Realignment marked a significant shift in the state's role in administering programs and functions related to substance use disorder (SUD). Realignment also redirected funding for DMC and discretionary substance use disorder programs to the counties. Consequently, counties are responsible for providing the non-federal match used to draw down federal Medicaid funds for DMC services as they existed in 2011 and for individuals eligible for DMC under 2011 Medi-Cal eligibility rules (pre-health care reform).

Additionally, the enactment of 2012-13 and 2013-14 state budgets transferred the responsibility for the SUD programs including DMC, from the former DADP to DHCS.

Current regulations create requirements for oversight of DMC providers at both the state and county levels. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and

utilization review. Counties can contract for DMC services directly, or contract with DHCS, which then directly contracts with DMC providers to deliver DMC services. Counties that elect to contract with DHCS to provide DMC services are required to maintain a system of fiscal disbursement and controls, monitor to ensure that billing is within established rates, and process claims for reimbursement. As of November 2013, DHCS contracts with 44 counties for DMC services. Another county has direct provider contracts thus resulting in DMC services being offered in 45 total counties. DHCS also has 15 direct provider contracts for DMC services in five counties (Imperial, Orange, San Diego, Solano, and Yuba-Sutter).

Health Care Reform Expansion of SUD Benefits. The federal Affordable Care Act (ACA) requires states electing to enact the Act's Medicaid expansion to provide all components of the "essential health benefits" (EHB) as defined within the state's chosen alternative benefit package to the Medicaid expansion population. The ACA included mental health and substance use disorder services as part of the EHB standard, and because California adopted the alternative benefit package it was required to cover such services for the expansion population.

SB 1 X1 (Hernandez and Steinberg), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session, required Medi-Cal to provide the same mental health and substance use disorder services for its enrollees that they could receive if they bought a particular Kaiser small group health plan product designated in state law as the EHB benchmark plan for individual and small group health plan products. SB 1X 1 required this benefit expansion for both the expansion population and the pre-ACA Medi-Cal population. Consequently, those individuals previously and newly-eligible for Medi-Cal will have access to the same set of services.

For SUD-related services, SB 1 X1:

- Expanded residential substance use services to all populations (previously these benefits were only available to pregnant and postpartum women);

- Expanded intensive outpatient services to all populations (previously these benefits were only available to pregnant women and postpartum women and children and youth under 21); and

- Provided medically necessary voluntary inpatient detoxification (previously this benefit was covered only when medically necessary for physical health reasons).

DHCS received approval from CMS to expand intensive outpatient services to all populations and to provide medically necessary voluntary inpatient detoxification in general acute hospital settings. However, CMS asked the state to remove the expansion of residential substance use services to all populations and the provision of inpatient voluntary detoxification in other settings in its state plan amendment (SPA) because of the Institutions for Mental Disease (IMD) payment exclusion, which is discussed in greater detail later.

Medi-Cal Substance Use Disorder Services. Substance use disorder services are provided through both the Drug Medi-Cal program and also through Medi-Cal managed care and fee-for-service.

Drug Medi-Cal program services include:

- **Narcotic Treatment Services** – An outpatient service that utilizes methadone to help persons with opioid dependency and substance use disorder diagnoses detoxify and stabilize. This service includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions.

- **Residential Treatment Services** – These services provide rehabilitation services to persons with substance use disorder diagnosis in a non-institutional, non-medical residential setting. (Room and board is not reimbursed through the Medi-Cal program.) Prior to SB 1 X1 this benefit was only available to pregnant and postpartum women. Although, SB 1 X1 expanded this benefit to the general population, it is only currently being provided to pregnant and postpartum women as the state has not yet received federal approval to expand this benefit due to the IMD payment exclusion.

- **Outpatient Drug Free Treatment Services** – These outpatient services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with a substance abuse diagnosis in an outpatient setting. Services include individual and group counseling, crisis intervention, and treatment planning.

- **Intensive Outpatient Treatment Services** – These services include outpatient counseling and rehabilitation services that are provided at least three hours per day, three days per week. Prior to SB 1 X1 this benefit was only available to pregnant and postpartum women and children and youth under 21.

Other Medi-Cal SUD benefits, that are not included in DMC, include:

- **Medication-Assisted Treatment** – This service includes medications (e.g., buprenorphine and Vivitrol) that are intended for use in medication-assisted treatment of substance use disorders in outpatient settings. These medications are provided via Medi-Cal managed care or Medi-Cal FFS, depending on the medication.

- **Medically Necessary Voluntary Inpatient Detoxification** – This service includes medically necessary voluntary inpatient detoxification and is available to the general population. This service is provided via Medi-Cal FFS.

- **Screening and Brief Intervention** – This service is available to the Medi-Cal adult population for alcohol misuse, and if threshold levels indicate, a brief intervention is covered. This service is provided in primary care settings. This service is provided via Medi-Cal managed care or Medi-Cal FFS, depending on which delivery system the patient is enrolled.

DMC Budget. The 2014 Budget Act includes $246.6 million ($63.6 million General Fund) for DMC. See the following table for DMC funding summary. Funding for Medi-Cal substance use disorder benefits varies, depending upon the services provided and the Medi-Cal population

receiving the substance use disorder services. For example, state General Fund is used as a match to federal funding for the expanded Drug Medi-Cal benefits (as a result of federal health care reform and discussed above) and federal funds (100 percent) are used for the Medi-Cal optional expansion population, as a result of federal health care reform. Although General Fund was budgeted for Residential Substance Use Disorder Services, this benefit has not yet been expanded to the general population.

The estimated caseload for DMC in 2014-15 is about 168,000 individuals. The Medi-Cal program is projected to cover 11.5 million individuals in 2014-15 and has a budget of $90.3 billion ($17.3 billion General Fund).

Table: Drug Medi-Cal Program Funding Summary (dollars in thousands)

	2013-14				
Service Description	**General Fund**	**County Funds**	**Federal Funds**	**Total Funds**	**Caseload**
Narcotic Treatment Program	-	$26,740	$28,877	$55,617	25,124
Residential Treatment Services*	-	$471	$874	$1,345	277
Outpatient Drug Free Treatment Services	-	$27,886	$18,914	$46,800	42,914
Intensive Outpatient Treatment Services**	$8,183	$7,416	$21,006	$36,605	23,257
Provider Fraud Impact	-	($27,050)	($27,050)	($54,100)	-
Drug Medi-Cal Program Cost Settlement	-	$393	$3,036	$3,429	-
Annual Rate Adjustment	-	-	-	-	-
County Administration	-	-	-	-	-
3rd Party Validation of Providers	$125	-	$125	$250	-
Total	**$8,308**	**$35,856**	**$45,782**	**$89,946**	**91,572**
	2014-15				
Service Description	**General Fund**	**County Funds**	**Federal Funds**	**Total Funds**	**Caseload**
Narcotic Treatment Program	-	$17,052	$24,583	$41,635	31,454
Residential Treatment Services*	$36,913	$631	$74,506	$112,050	32,507
Outpatient Drug Free Treatment Services	-	$25,468	$26,378	$51,846	57,793
Intensive Outpatient Treatment Services**	$20,321	$6,830	$46,267	$73,418	46,617
Provider Fraud Impact	-	($27,050)	($27,050)	($54,100)	-
Drug Medi-Cal Program Cost Settlement	-	$393	$3,036	$3,429	-
Annual Rate Adjustment	($248)	($2,426)	($2,359)	($5,033)	-
County Administration	$6,620	$3,314	$16,409	$23,343	-
3rd Party Validation of Providers	-	-	-	-	-
Total	**$63,606**	**$24,212**	**$161,770**	**$246,588**	**168,371**

*Previously named "Perinatal Residential Substance Abuse Services"
**Previously named "Day Care Rehabilitative Services"

Institutions for Mental Disease (IMD) Exclusion. In preparing to implement the newly expanded residential DMC benefit for all adults, as required by SB 1 X1, DHCS encountered an issue with the Institutions for Mental Disease (IMD) federal Medicaid payment exclusion. IMDs

are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness.

The IMD exclusion prohibits federal financial participation (FFP) from being available for any medical assistance under federal Medical law for services provided to any individual who is under age 65 who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. The IMD exclusion was designed to ensure that states, rather than the federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group. The IMD exclusion is unusual in that it is one of the very few instances in which federal Medicaid law prohibits FFP for care provided to enrolled beneficiaries.

Based on CMS current interpretation of the IMD exclusion, DHCS is prohibited from using federal funds to reimburse for any Medi-Cal service when a Medi-Cal beneficiary is receiving SUD services in residential facilities larger than 16 beds. In February 2014, DHCS indicated that there are 783 licensed SUD residential treatment facilities in California, with a total statewide licensed capacity of 18,155 beds. However, because of the federal IMD exclusion, DHCS estimates that only 1,825 beds (of the 18,155 licensed beds) are reimbursable under Medi-Cal.

Additionally, federal funding is not available for facilities that provide inpatient voluntary detoxification that are chemical dependency treatment facilities or freestanding psychiatric facilities, as the IMD payment exclusion applies to these facilities.

DHCS requested that CMS employ a different interpretation of the IMD exclusion that recognized California's unique market. However, CMS did not approve the request. Consequently, the residential benefit has not yet been expanded and voluntary detoxification can only be provided in general acute hospitals.

Drug Medi-Cal Program Integrity. In July 2013, an investigation by the Center for Investigative Reporting (CIR) and CNN uncovered allegations of widespread fraud in California's DMC program. The investigative report alleged that, over the past two fiscal years, the DMC program paid $94 million to 56 drug and alcohol rehabilitation clinics in Southern California that have shown signs of deceptive or questionable billing. Most of the examples of alleged fraud occurred in Los Angeles County and ranged from incentivizing patients with cash, food, or cigarettes to attend sessions, to billing for clients who were either in prison or dead. Most of the providers that were the focus of the investigation primarily offered counseling services and rely on Medi-Cal as the sole payer for services.

The reports suggested that the state's oversight and enforcement bodies were not working well in tandem: county audits of providers identified a number of serious deficiencies, but failed to result in terminated contracts or prevent the problems from continuing.

The California State Auditor released a report on August 19, 2014, that substantiated many of the reported problems with the current DMC system. DHCS agreed with the Auditor's findings and recommendations. Key recommendations from the audit include that DHCS:

- Ensure providers are reimbursed only for valid services and that it coordinates with counties to recover inappropriate payments and that it develops and implements new procedures for routinely identifying and initiating recovery efforts for payments it authorizes to decertified providers and to deceased beneficiaries.

- Prevent certifying ineligible providers by instructing staff to identify inadequate program applications by comparing them to disclosure statements, conducting required database searches, and designating risk levels for applicants.

- Ensure that it appropriately and consistently reviews provider applications by following its procedures to screen provider applicants' eligibility and retain documentation to support its certification decisions.

- Strengthen coordination between DHCS and the counties to address gaps in their collective monitoring efforts and improve coordination between its divisions and branches to ensure it addresses fraud allegations timely.

Since these investigations, the DHCS has instituted a number of reforms to improve program integrity. For example, DHCS is requiring all DMC providers to become recertified in order to continue to participate in the program. DHCS has conducted field reviews and has suspended over 68 providers and made referrals to the California Department of Justice for criminal investigation and prosecution. While this has helped to ensure that fraudulent providers and practices are terminated, it has also resulted in lengthy delays in the capacity expansion necessary to meet needs for new populations. For instance, existing providers who have not been found to have engaged in these practices have reported that it takes several months for approval of new treatment slots.

Medicaid Waivers. Medicaid waivers provide states the opportunity to experiment with new or existing approaches to the healthcare delivery system and allow CMS to waive certain program rules. Waivers must be time-limited (three to five years), cost neutral, and align with the aims of the Medicaid program. California has used Medicaid waivers to provide additional services to specific groups of individuals who were not eligible for FFP, to limit services to specific geographic areas of the state, and provide medical coverage to individuals who may not otherwise be eligible under Medicaid rules. An example of a provision of Medicaid law that is waived is the federal "freedom of choice" requirements. Waiving this requirement allows California to require Medi-Cal beneficiaries to receive benefits through managed care plans.

The criteria used by the federal government for approval of Medicaid waivers are generally based upon policy, rather than solely on federal law. The most significant federal requirement is that of cost-effectiveness or budget neutrality. The proposed program changes are required to be "budget neutral" meaning the cost to the federal government cannot be more than the expected Medicaid costs for the traditional Medicaid population under the same time period.

DHCS' WAIVER PROPOSAL

DHCS is pursuing a DMC Organized Delivery System Waiver as an amendment to the current Section 1115 Bridge to Reform Demonstration Waiver. DHCS proposes that this amendment would demonstrate how organized substance use disorder care increases successful outcomes for DMC beneficiaries. DHCS convened several stakeholder meetings in 2014 to discuss the current DMC delivery system and ways to improve it.

DHCS released draft Special Terms and Conditions (STCs) in mid-July and has solicited comments on this proposal. This document describes the STCs as released in July 2014. On Friday, October 17, 2014, DHCS released revised STCs (the changes to the July version are marked in the revised STCs). The financial provisions of this proposal have not yet been released.

DHCS states the waiver will give state and county officials more authority to select quality providers to meet drug treatment needs. DHCS indicates the waiver will support coordination and integration across systems, increase monitoring of provider delivery of services, and strengthen county oversight of network adequacy, service access, and standardize practices in provider selection.

Key Elements of Proposed Waiver. Key elements of the proposed waiver amendment include:

- **Continuum of Care:** Participating counties will be required to provide a continuum of care of services available to address substance use, including: early intervention, physician consultation, outpatient treatment, case management, medication assisted treatment, recovery services, recovery residence, withdrawal management, and residential treatment.
- **Assessment Tool:** Establishing the American Society of Addiction Medicine (ASAM) assessment tool to determine the most appropriate level of care so that clients can enter the system at the appropriate level and step up or step down in intensive services, based on their response to treatment.
- **Case Management and Residency:** Case management services to ensure that the client is moving through the continuum of care, and requiring counties to coordinate care for those residing within the county.
- **Selective Provider Contracting:** Giving counties more authority to select quality providers. Safeguards include providing that counties cannot discriminate against providers, that beneficiaries will have choice within a service area, and that a county cannot limit access.
- **Provider Appeals Process:** Creating a provider contract appeal process where providers can appeal to the county and then the State. State appeals will focus solely on ensuring network adequacy.
- **Provider Certification:** Partnering with counties to certify DMC providers, with counties conducting application reviews and on-site reviews and issuing provisional certification, and the State cross-checking the provider against its databases for final approval.

- **Clear State and County Roles:** Counties will be responsible for oversight and monitoring of providers as specified in their county contract.
- **Coordination:** Supporting coordination and integration across systems, such as requiring counties enter into memoranda of understanding (MOUs) with Medi-Cal managed care health plans for referrals and coordination and that county substance use programs collaborate with criminal justice partners.
- **Authorization and Utilization Management:** Providing that counties authorize services and ensuring Utilization Management.
- **Workforce:** Expanding the pool of Medi-Cal eligible service providers to include licensed practitioners of the healing arts for the assessment of beneficiaries, and other services within their scope of practice.
- **Program Improvement:** Promoting consumer-focused evidence-based practices including medication-assisted treatment services and increasing system capacity for youth services.

Voluntary County Opt-Into Demonstration – Not Statewide Proposal. DHCS indicates its proposed waiver will only be operational in counties that elect to opt into this organized delivery system. Counties that opt into this waiver will be required to meet specified requirements, including implementing selective provider contracting (selecting which providers participate in the program), providing all DMC benefits, monitoring providers based on performance criteria, ensuring beneficiary access to services and an adequate provider network, using a single-point of access for beneficiary assessment and service referrals, and data collection and reporting. In a county that does not opt-in, there will be no change in services from the current delivery system.

Funding for Service Based on County of Residence. Under this proposal, funding for service will be based on the county of residence of the individual instead of the county of service, unlike under the existing DMC program.

Likely Continuation of "Carve Out" of DMC Benefits from Physical Health Care. Under this proposed waiver, a county could chose to create an organized delivery system that is separate from Medi-Cal managed care or as DHCS has indicated (although it is not in the draft proposal released to stakeholders in July) counties could also have the ability to contract with Medi-Cal managed care plans to provide the DMC benefits.

Potential Relief from IMD Payment Exclusion. DHCS has also indicated that it has received informal approval from CMS that under this waiver proposal, the IMD payment exclusion would not apply for counties that opt-into this demonstration. Consequently, federal funds would be available to provide residential treatment services to all eligible adults and inpatient voluntary detox in chemical dependency treatment facilities and freestanding psychiatric facilities.

ISSUES TO CONSIDER

While many elements of this proposal address the fragmented and uncoordinated nature of the existing DMC program, several key concerns remain.

DHCS Waiver Authority is Unclear. DHCS' current authority to seek a Section 1115 waiver is an area of dispute between legislative staff and the Administration. DHCS cites as its current legal authority a provision of existing law that requires DHCS to prepare and submit amendments to its Medicaid state plan and apply for any necessary waivers in order to obtain FFP to implement DMC treatment program provisions. DHCS argues this provision enables it to seek a broader waiver, while legislative staff have argued that this waiver provision was intended to be limited to obtaining FFP, and a Section 1115 waiver can be used to obtain FFP but that the other changes DHCS seeks as part of the waiver (such as selective provider contracting) are not necessary to obtain FFP and are therefore beyond the scope of this grant of authority.

Integrate SUD Services with Physical Health vs. Integrate SUD Services with Specialty Mental Health. Research shows that when an individual's substance use disorder and physical health needs are addressed more holistically, overall health outcomes are better.[1] Additionally, this integration can lead to reduced costs such as hospitalization rates, inpatient days, and emergency room use decrease.[2] This is also consistent with the movement towards a health home that provides care coordination.

The proposed continued separation of SUD services and physical health care through separate delivery systems (the county system and the Medi-Cal managed care plans) makes it difficult to integrate and coordinate care. Additionally, the continued carve out of DMC services continues the likelihood of disputes between counties and managed care plans about who has responsibility for particular services, and requires patient to access care from separate plans. By including DMC services as a benefit within Medi-Cal managed care health plans, health plans would have the financial incentive to manage all conditions for the best health outcomes.

Although DHCS' has indicated that it has revised its July proposal to allow counties to contract with Medi-Cal managed care, this optional provision would not ensure integration statewide.

DHCS argues for the continued carve out because it finds that many individuals receiving specialty mental health services provided by county mental health plans have co-occurring SUD diagnosis. DHCS contends that the co-location of the existing specialty mental health delivery system and the proposed DMC organized delivery system in the counties is a preferred model because it would target those with severe mental illnesses.

While this may be the case, it continues the separation of delivery systems for persons with SUD diagnosis and mild to moderate mental health illnesses as Medi-Cal managed care covers mild to moderate mental illness services. National data indicate that there is a higher rate of co-occurring diagnosis with mild to moderate mental health illness and SUD diagnosis than with severe mental illness and SUD diagnosis. In a national survey in 2013, 3.2 percent of all adults aged 18 or older (7.7 million adults) had both SUD and any mental illness and one percent of all adults

[1] "Integrating Primary Care with Addiction Treatment," Constance Weisner, Jennifer Mertens, Sujaya Parthasarathy, Charles Moore, Yun Lun, Journal of the American Medical Association, October 10, 2011, Vol. 286, No. 14
[2] "Utilization and Cost Impact of Integrating Substance Abuse Treatment and Primary Care," Sujaya Parthasarathy, Jennifer Mertens, Charles Moore, Constance Weisner, National Institute for Health Research, May 2005.

aged 18 or older (2.3 million adults) had co-occuring SUD and severe mental illness[3]. Consequently, it would appear that more individuals would benefit from the integration of DMC and physical health services than the integration of specialty mental health and DMC.

Additionally, while DHCS indicates that 56 of the 58 counties have Behavioral Health Departments which include both mental health programs and substance use disorder services programs, the largest county with the largest Medi-Cal population, Los Angeles County, maintains two separate departments (a mental health department and a substance use prevention and control department).

On the other hand, some providers and experts have argued that managed care plans do not yet have experience with the SUD population or services as they are primarily a physical health care delivery system. They support DHCS' approach because it builds on the existing county infrastructure and service provider network, provides an opportunity for the development of a more organized SUD benefit and could eventually be integrated with managed care plans over time.

In addition, many providers have stated that a key component of preventing relapse is the ability to provide services at the first point of contact and that a system that requires referrals, such as through a managed care plan or primary care provider will not be as successful.

County Mental Health Plan Infrastructure Not a Model System. DHCS indicates that counties have the infrastructure and experience to implement this organized delivery system because they operate the Medi-Cal Specialty Mental Health (SMHS) waiver through county mental health plans. However, the federal government has significant concerns with county mental health plans including concerns about (1) timely access to services; (2) the availability of interpreter services, especially for Spanish speaking beneficiaries; and (3) significantly elevated rates of non-compliance observed during DHCS compliance system reviews of mental health plan operations, External Quality Review Organization reviews, as well as the continuing high rates of claim disallowance resulting from both outpatient and inpatient medical record reviews.

CMS sent DHCS a letter dated June 27, 2013, approving DHCS's SMHS Waiver Renewal Application for a two-year period, rather than the five-year period which DHCS had requested. The letter states that:

> *".....CMS harbors concerns about access challenges faced by some County Mental Health Plans… CMS will be carefully analyzing the State's monitoring activities and corrective action plans to ensure all necessary actions are implemented and improvement occurs."*

Given these concerns by the federal government, the basis for modeling the proposed DMC organized delivery system on the specialty mental health system is unconvincing.

[3] "The 2013 National Survey on Drug Use and Health: Overview of Findings," Substance Abuse and Mental Health Services Administration, September 4, 2014.

Proposed Selective Contracting Could Limit Access to Certain Services. Narcotic treatment providers (NTP) are concerned with DHCS' intent to purse a waiver. These providers find that a waiver of federal law could limit access to NTP services and could remove entitlement protections for these services.

Currently, SUD providers can obtain DMC contracts with a county or the state as a result of the *Sobky v. Smoley* lawsuit in 1994. Prior to *Sobky v. Smoley*, counties chose whether to contract with a DMC provider, which created a coverage gap for beneficiaries living in counties without methadone providers. In 1994, DMC was found in violation of Medicaid statute, and was ordered to provide prompt access to treatment evenly throughout the state. Consequently, if counties deny a DMC contract with a provider, DHCS can directly contract with the provider. For example, the state directly contracts with NTP providers in San Diego County as the county has chosen to not contract with NTP providers. It is not clear how the state would ensure access to services if a county has full discretion on whether or not to contract with providers.

Additionally, these providers find that a single-point of entry at counties for DMC services could impose a barrier for individuals who show-up at a narcotic treatment provider seeking immediate services.

Statewideness of DMC Benefit and Organized DMC Services is Unlikely. Under this proposal, counties would have the ability to opt-into this demonstration. For those that do not opt-in, DMC services would be provided as they are today. Consequently, no improvements or organization in the DMC program would be realized in the opt-out counties.

Additionally, the expansion of residential treatment to all adults and voluntary inpatient detoxification in certain settings would not be available in the opt-out counties. For individuals who need services but do not live in a county that has chosen to opt-into this demonstration, it is not clear how certain services (such as residential treatment), would be accessed.

Complete Waiver Proposal—Including Financial Provisions—Not Available. A key piece of this proposal that has not yet been released is the financing provisions. DHCS has indicated that it will distribute the financial provisions to stakeholders and hold a meeting to discuss prior to submittal to the federal government. Without this information, it is unknown if counties would opt-into this demonstration and how the financial incentives align to encourage better health outcomes for Medi-Cal enrollees.

QUESTIONS

Questions for DHCS

1. Why is DHCS proposing to deliver DMC services through a county-based organized delivery system versus through Medi-Cal managed care plans?

2. How will DHCS' Organized Delivery System proposal ensure that substance use disorder services are integrated? What are examples of substance use disorder services that are integrated with medical services?

3. When will the financing for the Drug Medi-Cal waiver be released?

4. How does DHCS plan to address provider rates in Drug Medi-Cal? Will counties be able to set their own rates, will the state still determine rates, and will the current rates be a floor that counties cannot pay less than?

5. The current financing of Drug Medi-Cal varies, depending upon whether the service was a covered DMC service prior to 2014. How does DHCS intend to finance Drug Medi-Cal under its proposal? In the event county funds are inadequate because of higher benefit/treatment costs or caseload increases, will the state or counties be responsible for the additional cost?

6. Does DHCS have the authority in existing law to pursue a federal Medicaid waiver for purposes of implementing a county-based Drug Medi-Cal treatment system?

7. What statutory changes does DHCS need to implement its proposed Drug Medi-Cal waiver?

8. Please explain the policy and fiscal rationale for changing to a county of residence (versus county of service) funding formula? How is this change likely to affect residents in counties that have few providers?

9. What is the status of the state's efforts to waive the "IMD exclusion" to draw down federal Medicaid matching funds for patients in a facility with more than 16 beds?

10. Will the state's efforts to waive the IMD exclusion only apply in those counties which "opt in" to the Drug Medi-Cal system? If patients live in a county that does not opt in, can they receive residential treatment services in another county if there are no residential treatment providers in their county?

11. If a county does not opt in, should the Drug Medi-Cal benefit be the current fee-for-service benefit as it exists today, or should the benefit be provided through the Medi-Cal managed care plans in the county?

12. How does DHCS propose to ensure access to care when counties have selective provider contracting authority? Will there be network adequacy standards? How will they be enforced?

13. How will prescription medications used to treat substance use disorders be reimbursed? Will they remain a fee-for-service benefit and be subject to a treatment authorization request (TAR)? Will counties be at risk for prescription medication used to treat substance use disorders?

14. How does DHCS plan to measure and monitor the outcomes from this demonstration proposal?