

*Joint Informational Hearing: Stakeholders' Experiences with Pilot Projects  
Preliminary Comments on the Drug Medi-Cal Organized Delivery System, Hub and  
Spoke and Waiver Standard Terms and Conditions (STCs)*

March 13, 2019

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## Recommendations for Improving California's Drug Medi-Cal - Organized Delivery System

Albert M. Senella  
Chief Executive Officer, Tarzana Treatment Centers  
President, California Association of Alcohol and Drug Programs Exec.

As part of the upcoming renewal process of California's 1115 waiver, and specific to the Drug Medi-Cal Organized Delivery System (DMC-ODS), the California Association of Alcohol and Drug Program Executives, Inc. (CAADPE) has several preliminary recommendations to share with the Senate and Assembly Health Committees.

### Payment Reform

- California must begin to look at new ways to purchase SUD (substance use disorder) services beyond the current DMC settle to cost approach. Payment reform has been an ongoing discussion in the field and the legislature should not only join the discussion but be both a catalyst for and the place for determining and adopting new models that drive outcomes and improve care. Additionally, until such time as payment reform is a reality, we must standardize cost reporting and settlement practices. The process and practices for DMC are substantially different than those for mental health services when, in fact, the settlement process should be aligned.

### Service and Workforce Capacity-Building

- Access to SUD services for those suffering from SUD has been vastly improved under the transition from standard Drug Medi-Cal to an Organized Delivery System. (DMC-ODS). But, access to care is still far too limited. There are insufficient treatment sites for residential treatment, Withdrawal Management (WM), and youth services. While the needs may vary county by county, CAADPE recognizes this as an unmet need in all counties.

- The SUD workforce is seriously suffering. There was a time that the SUD workforce was only in demand within the SUD field; it is now in demand in hospitals, health plans, mental health, primary care, schools and beyond. The field lacks a sufficient labor pool to meet the demand for care and a stable certifying process because the state has delegated to non-governmental entities what should be the function of a single state agency. California went from 10 private non-governmental certifying entities to two. The two remaining organizations struggle to review and certify counselors in a timely manner. The lack of a certified workforce to meet treatment and care demands, in addition to other restrictions imposed on providers, limit the ability of SUD treatment agencies to expand access and, more importantly, to maintain current access to treatment services. It is in a crisis state. We need a single state agency to assume certification functions and we need to create a career ladder to further build this vital workforce. Lastly, we need to stop adding additional administrative burdens to the workforce and to suspend education and training requirements in excess of state requirements, at least until such time as we work past this workforce crisis.

We must clarify that Recovery/Peer Support Services cover a broader array of social support/socialization services. We must also clarify that Recovery Peer Support services are best performed by individuals with lived experience. Currently recovery/peer support services are part of individual or group sessions. These sessions are facilitated by LPHA (Licensed Practitioner of the Healing Arts) or SUD registered and certified counseling staff. However, recovery/peer support covers a broader range of activities. Recovery/Peer Support Services may and should include activities coordinated and facilitated by Recovery/Peer Support staff that is neither LPHA's nor registered or certified counselors. While the waiver allows for reimbursement of Recovery/Peer Support services, the required training, with state approval is the responsibility of the counties. Because counties indicate they do not have the capacity to develop their own training programs, they require the recovery/peer support functions and services be performed by registered or certified counseling staff or LPHA staff. Required utilization of certified counselors and LPHA's to perform and deliver peer support services further drains core treatment workforce resources. Recovery/peer support or recovery support staff should not be required to enroll in counselor certification

## **STANDARDIZE KEY COMPONENTS OF SUD SERVICES**

### **Standard Documentation Requirements**

- While the DMC-ODS is implemented on a county-by-county basis, each county implements different county requirements for the same waiver item, based on each county's interpretation. Standardization at the state level is needed on what is required to document medical necessity for admission and for ongoing treatment services. This guidance and requirements should be the same statewide and should not vary county by county.

### **Treatment Staff Credentialing**

- Treatment staff credentialing completed by one county should be accepted by all counties. The same staff should not need to be credentialed by each individual county. Mandatory ASAM and other required training performed and documented in one county should meet the mandatory requirements for all counties.

### **Group Size**

- The waiver's Standard Terms and Conditions (ST&C) identify group size for clinical services at a minimum of 2 and a maximum of 14. Yet, the DMC-ODS implementation efforts have capped group size at 2 to 12. We can find no amendments or change to support this lower number. We are aware the 2 to 12 number is in state regulations, but the waiver was to supersede this.
- From a management and resource standpoint, we recommend at a minimum that DHCS and counties immediately align with the current group size in the ST&C of 2 to 14. We would further strongly recommend in the waiver renewal adjusting the size to 2 to 16. With the significant workforce constraints such a change would have a real impact on access to care and would not negatively impact the quality of care.

### **Standardize Minimum Number of Service Hours for Residential Treatment**

- Standardize the minimum service hours across all participating counties consistent with the 20-hour requirements spelled out in the residential licensing regulations. This will help eliminate the county-by-county decisions to increase service hours based on 3.1, 3.3, 3.5 levels of care which in some counties are set at higher than state levels creating additional management issues for treatment providers.

## **IMPROVE AND STRENGTHEN THE ORGANIZED DELIVERY SYSTEM (DMC-ODS) THROUGH THE WAIVER RENEWAL APPLICATION**

### **ASAM (American Society for Addiction Medicine) Criteria**

- Add ASAM 0.5 Levels and SBIRT Services  
ASAM level 0.5 (Early Intervention) and SBIRT services should be reimbursable services to DMC providers, who often engage the community in early screening and detection of substance use disorders (SUD).
- Expand ASAM Levels 3.7 and 4.0  
Increase efforts to make ASAM 3.7 and 4.0 withdrawal management (WM) services more readily accessible. ASAM 3.7 and 4.0 are hospital-based WM services and to get access to these hospital beds requires paying the prevailing rates at least equal to FFS Medical or Medicare PPS hospital rates.

### **EPSDT Benefits**

- EPSDT (Early and Periodic Screening, Diagnosis & Treatment) services should be better used and more effectively woven into DMC-ODS. This is particularly important for the delivery of youth services. The DMC system is crafted and designed around an adult system of care.

### **Implement Telehealth**

- Require all counties participating in the DMS-ODS to fully implement the use of phones and telehealth vehicles for the delivery of treatment services. Counties should not be able to pick and choose services that they will or will not implement when those services are already authorized under the Standard Terms and Conditions (STC). They were included because they are needed tools to improve access to care.

### **EHR Systems**

- Rather than having individual counties require providers to use the counties' selected EHR system, counties need to respect provider-selected EHR systems. Counties must plan for and provide needed interfaces with provider systems, to secure data exchange. The current practice by most counties requires double or triple entry of the same data, the need to train staff to use multiple systems and a heavy administrative burden on providers which drains limited resources.

### **Case Management**

- Clarify within Terms and Conditions that case management services are a benefit for all ODS levels of care.

### **Eliminate the Restrictions on Residential Care**

- We recommend the elimination of restrictions on residential care, which currently limits care to two separate 90-day treatment stays within a 12-month period which, in fact, can be exhausted with two short stays never reaching 90 days of care. Allow treatment stays to be driven by medical necessity rather than predetermined timeframes which further vary county by county.

### **Medications for Addiction Treatment (MAT)**

- Continue to expand the efforts to fully incorporate medications for addiction treatment (MAT) throughout the ODS continuum of care. There remains a significant need to increase provider capacity to accommodate MAT and there remains stigma around MAT both in the SUD field and beyond, that we must collectively work to address.

### **County of Residence vs. County of Service**

- County of residence versus county of service continues to be an ongoing problem in the delivery of care. Each ODS participating county is considered a health plan and there are no out of network benefits. The only way an individual who resides and is registered in Medi-Cal in one county can access care in a different county is through providers who hold direct county contracts in multiple counties. While there has been significant improvement as a result of help from DHCS with counties, significant barriers remain. Those barriers can be further reduced, if the state requires counties to have an out of network benefit or we develop a reconciliation process at the state level.

### **HUB AND SPOKE MAT SERVICES (H&SS)**

- California, through DHCS efforts, has been a leader in implementing expanded MAT services under its federal grants to help address the opiate crisis. These services coupled with the DMC-ODS are significantly improving MAT access. The H&SS grants provide far more flexible resources to reach out to nontraditional and non-DMC providers in this effort. To lose H&SS resources would have a serious negative effect on reaching and sustaining this expansion. While we are all hopeful the Feds will renew funding for these grants, the California legislature and the administration must be prepared to step in and provide continued resources to maintain these vital services, in the event the federal government decides not to provide renewed funding.

CAADPE appreciates your consideration of these comments and recommendations

Thank you