The Addiction Treatment Landscape:

The California Transformation to a Managed Care Model

Beyond The Bench Conference
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CIBHS DMC ODS Waiver Forum

Funded by Blue Shield Foundation of California

DMC-ODS Waiver Forum creates a collaborative learning environment to support county behavioral health and substance use disorder leaders and administrators in the planning and implementation of the DMC–ODS 1115 Waiver in California

- There have been six forums and three webinars
- Web site access to the white papers and other information at

  https://www.cibhs.org/dmc-ods-waiver-forum
- County Staff Resource Library
- Adolescent Continuum of Care Design Summit held in November 2017

The SUD Landscape prior to 2015

- Institute of Medicine publishes *Crossing the Quality Chasm: A New Health System for the 21st Century in 2001* calling for fundamental changes in service delivery and focus on coordinated care.
- Most state public sector delivery systems have been inadequate for the safety net population funded only by the Substance Abuse Prevention and Treatment Block Grant and Discretionary Grant Awards
- Most state Medicaid addiction programs have minimal services, have insufficient provider networks, and few standards for this type of care.
- Mental health and SUD services are mandated as one of ten essential health benefits covered under the ACA in 2010.
- In 2015, California received approval for a Waiver Demonstration Project to provide a continuum of care for SUD services

Historic reforms have transformed criminal justice processes in California.

2011: AB 109 – Public Safety Realignment	• Transfer of responsibility of "non-non-nons" from the State to counties; Post-Release Community Supervision (PRCS) supervised by Probation.
2012: Proposition 36 – The Three Strikes Reform Act	• Limited the imposition of third strikes to serious/violent offenses. Authorized resentencing for less serious/non-violent third strikers.
2014: Proposition 47 – The Reduced Penalties for Some Crimes Initiative	• Reduced seriousness of certain lower-level drug and property offenses. Many could apply for early release.
2016: Proposition 57 – The California Parole for Nonviolent Criminals and Juvenile Court Trial Requirements Initiative	• Expanded eligibility criteria and opportunities to earn sentence credit for good behavior and rehabilitative program participation.

Criminal Justice Population Changes

- Criminal justice populations are characterized by high rates of physical and mental health problems. A Washington State study in 2007 found risk of death was almost 13 times higher for former inmates in the two weeks following their release compared to the general population.
- Health and medical costs now form a major part of most corrections budgets, totaling about a fifth of all corrections expenditures nationwide and 31% in California.
- The "greying" prison population (age 50+) is growing and are far more costly to incarcerate compared to younger cohorts, and prisons and jails are among the most expensive places to deliver care. State Prison population over 50 years-old grew from 4% to 21% between 1990 and 2013.
- Jail and Community Corrections have seen a dramatic increasein mental health needs
- Drug of choice have changed as have available treatments. Opiois and Heroin on the increase.
- Organic brain damage is recognized and there has been an increase of Co-Occurring Disorders

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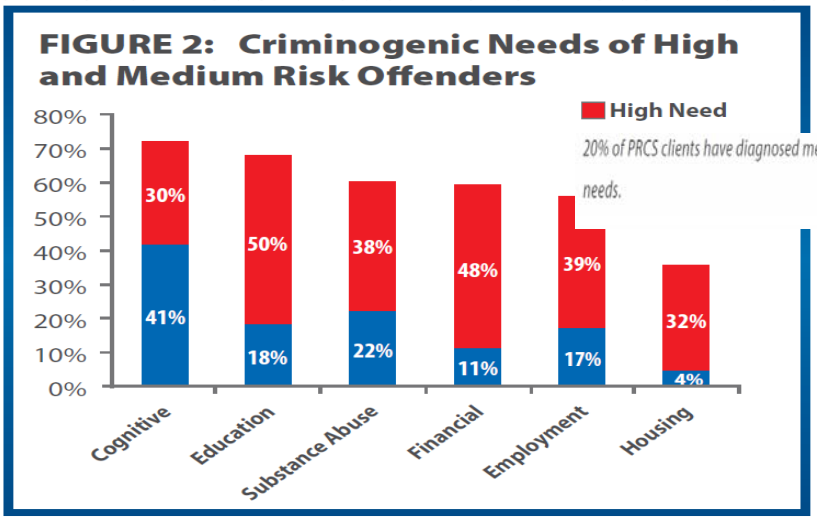
Initial Risk Profile of PRCS



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Mentally Inmates Released from Prison – 70% of these may present with be co-occurring alcohol and /or drug problems

Mentally Ill Releases from Prison in 2015

	PRCS		Parole	
DMH-ICF	36	0.2	58	0.3%
Acute	16	0.1%	75	0.4%
MH Crisis	41	0.2%	55	0.3%
CCCMS	2,985	16.3%	3,264	17.5%
EOP	442	2.4%	868	4.7%
Total Mentally Ill	3,520	18.8%	4,320	22.6%
Total Non-MI	14,761	82.2%	14,334	77.4%
Total Release	18,281	100%	18,654	100%

Source: CDCR

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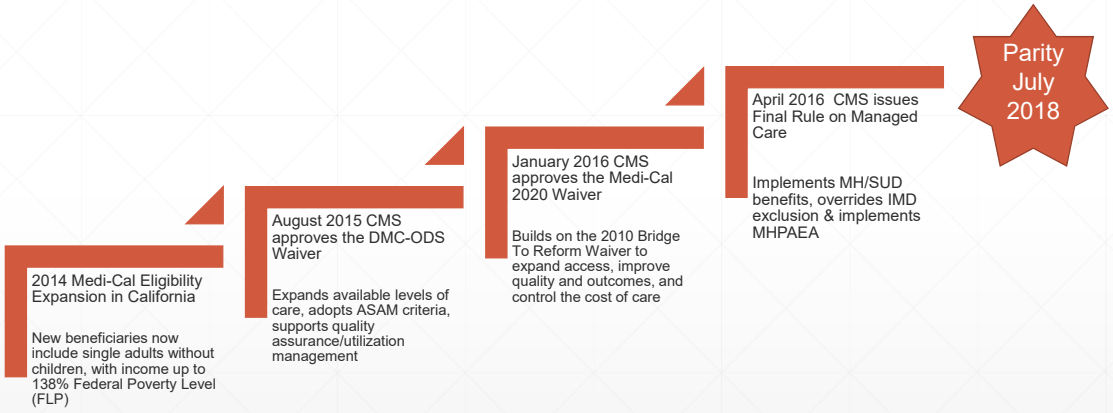
The Patient Protection and Affordable Care Act Accelerated Pathway to Transforming Health Care



California Medi-Cal 2020 Demonstration DMC-ODS 1115 Waiver Amendment *(Medi-Cal 2020 pages 89-123)*

- Authorizes DHCS to test a new design for the organized delivery of health care services for Medi-Cal eligible individuals with a substance use disorder
- Authorizes the implementation of a new SUD evidenced-based benefit design covering a full continuum of care, requiring providers to meet health industry and Medi-Cal standards.
- Seeks to demonstrate how organized substance use disorder care will increase the health outcomes and success of Medi-Cal beneficiaries while decreasing other system health care costs.
- County Fiscal Plan must calculate all funds and expenditures, both federal and matching local funds and include all other funding including SAPT Block Grant, Realignment and DUI programs
- *CREATES AN ORGANIZED DELIVERY SYSTEM FOR MEDI-CAL BENEFICIARIES*

DMC-ODS Implementation To Date

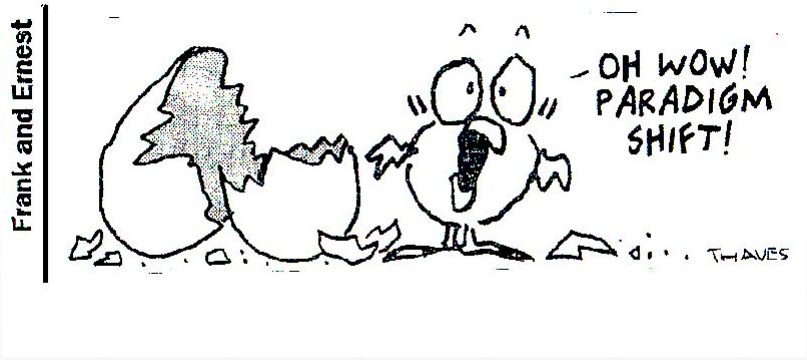
DMC-ODS is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program *California Medi-Cal 2020 Demonstration*

- Riverside, San Mateo, and Marin County started service delivery in April 2017
- Contra Costa, Los Angeles, Santa Clara, and San Francisco started in July 2017
- A total of 41 counties have opted to participate in the Waiver, covering 85% plus of the state Medi-Cal population. Most will implement in 2018.
- 8 of these northern small counties are forming a regional model with Partnership Health Plan as allowed in the Special Terms & Conditions
- DHCS has started implementation discussion with Tribal & Indian Health Providers

Waiver Special Terms and Conditions – Intersection with Criminal Justice System

- *Beneficiaries involved in the criminal justice system often are harder to treat for SUD. While research has shown that the criminal justice population can respond effectively to treatment services, the beneficiary may require more intensive services which may include:*
  - *Eligibility: Counties recognize ad educate staff and collaborative partners that Parole and Probation status is not a barrier to expanded Medi-Cal SUD treatment services if the parolees and probations are eligible beneficiaries. Currently incarcerated inmates are not eligible to receive federal matching dollars (FFP) for DMC Services.*
  - *Lengths of Stay: Counties may provide extended lengths of stay for withdrawal and residential services for offenders if assessed for need (up to 6 months RT with a one-time 30 day extension) if found to Medically Necessary.*
  - *Promising Practices: Counties utilize promising practices such as Drug Court Services.*

Prepaid Inpatient Hospital Plan – Managed Care !



Key Administrative Elements

- American Society of Addiction Medicine Criteria (ASAM) for program structure, client placement, utilization management, and transition to the appropriate level of care based on a prescribed Level of Care Assessment & Medical Necessity
- Counties have the authority to selectively contract with providers following managed care methodology to create a provider network based on network adequacy
- Counties must establish a continuum of care that will meet the need/demand for services and allow adequate and timely access – managed through a county wide access system (walk ins allowed)
- Like Specialty Mental Health Services, Counties are required to coordinate SUD services with the Medi-Cal Managed Health Plans; however unlike SMHS there is no legislative mandate
- DHCS retains Drug Medi-Cal Provider Certification authority through the Provider Enrollment Division – the process is lengthy and may take up to 12 months
- Counties retain quality assurance and utilization management through contracts with providers and prescribed Quality Assurance & Utilization Review mandates

- Policies and procedures for the selection, retention credentialing and re-credentialing provider agencies
- Pre-Authorization of residential services and recovery housing services
- Beneficiary Access Number/System and defined service Referral process
- Care Coordination – MOU – with Managed Care Plans
- State-County contract with detailed requirements for access, monitoring, appeals process etc.
- County Implementation and Fiscal Plans required
- Culturally competent services
- Fidelity to defined evidenced-based practices
- Billing systems that meet managed care standards
- Compliance with Medicaid Final Rule Section 438
- Annual review by External Quality Review Organization (EQRO)

County

Responsibilities as a Prepaid Inpatient Hospital Plan (PIHP)

42 CFR 438.2

Key Service Elements Creating a Continuum of Care

- Chronic Disease Model and Approach using Levels of Care based on *Medical Necessity*
- Each SUD clinic shall have a licensed physician designated as the substance use disorder medical director.*(Title 22, § 51000.70)*
- Expansion of the role of Licensed Practitioners of the Healing Arts in assessment and other SUD treatment activities consistent with their scope of practice
- Reimbursement for SUD Residential Treatment (defined lengths of stay)
  - *Medi-Cal does not allow reimbursement for room and board paid using SAPTBG funds*
- Integration of Medication Assisted Treatment into all levels of care
- Reimbursement for Recovery Residences and Recovery Support Services
  - *Medi-Cal does not allow reimbursement for room and board paid using SAPTBG funds*
- Reimbursement for Case Management Services
- Requirement for the use of established SUD Evidence-Based Practices

What Defines the Level of Care

The Clients

- As defined by ASAM Criteria six assessment dimensions
- As diagnosed under DSM-IV or DSM 5

The Treatment Setting

- Outpatient –Residential –Hospital

The Staffing and Services Offered

- Scope, Duration & Intensity
- Counseling vs. Therapy
- Medical and Medication Interventions

Licensed Practitioners of the Healing Arts (LPHA)

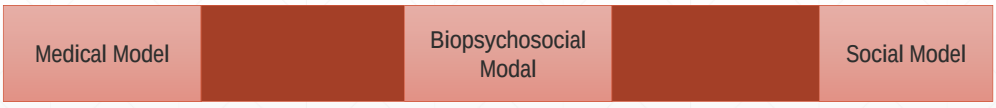
- Physicians - including DMC Medical Directors
- Nurse Practitioners
- Physician Assistants
- Registered Nurses
- Registered Pharmacists
- Licensed Clinical Psychologist (LCP)
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed-eligible practitioners working under the supervision of licensed clinicians

SUD Staffing – Foundation of Change

The Waiver diversifies the composition of disciplines within the specialty SUD system

"Professionalizing" SUD the workforce does NOT mean moving *to* the medical model, it means moving *toward* the medical model, with the final destination being a **Biopsychosocial Model** of services.

Spectrum of SUD Delivery Models



All specialty SUD providers, including counselors, should be considered and think of themselves as health professionals

DMC-ODS Benefits required – ASAM Levels of Care

Service	Required	Optional
Early Intervention 0.5	Provided & funded by MCP	
Outpatient Services Intensive Outpatient	Required level 1.0 Required level 2.1	Partial Hospitalization 2.5
Residential	At least one level in year 1 Level 3.1, 3.3, 3.5, 3.7 within 3 years 4.0 provided & funded through FFS or MCP	Additional ASAM Levels
NTP (rates set by DHCS)	Required County Contract	
Withdrawal Management	At least one level of five service levels	Additional ASAM Levels
Recovery Services	Required	
Case Management	Required	
Physician Consultation	Required	

Certification status is granted by the DHCS to provider agencies that have exceeded the minimum levels of service quality and are in compliance with the AOD Certification Standards. In addition to AOD Certification, providers must demonstrate that they meet the ASAM designation for Level 1.0 Outpatient Level of Care and Level or 2.1 Intensive Outpatient Level of Care respectively.

The OP benefit includes:

- < 9 hours per week for adults
- < 6 hours per week for youth
- Family Therapy, Patient Education Services and Medication Services

The IOP benefit at a minimum includes:

- 9 – 19 hours per week for adults • 6 – 19 hours per week for youth

Certified Outpatient 1.0 and Intensive Outpatient 2.1

Residential Treatment 3.1, 3.3 and 3.5

Organized treatment services that feature a planned and structured regime of care and activities in a 24-hour residential setting. All level 3 programs serve individuals who, because of specific functional limitations, need safe and stable living environments and 24-hour care and supervision. The IMD exclusion has been waived for counties opting into the DMC-ODS.

All residential programs must meet the ASAM requirements for 3.1-3.5 Level of Care and must receive a designated by DHCS certifying that the program is capable of delivering care consistent with ASAM Criteria Guidelines. The ASAM designation is now specified on the Facility License.

The County Pre-Authorized Residential Benefit includes:

- • 60 day length of stay for adults - two allowable residential admissions a year
- • 30 day length of stay for youth - two allowable residential admissions a year (EPSDT applies)
- • One 30 day extension for each allowable admission

Withdrawal Management

Interventions to address intoxication and/or withdrawal both physiological and psychological based on Dimension 1:Acute Intoxication and/or Withdrawal Potential

- previously called "detoxification services" – the liver detoxifies, clinicians manage withdrawal
- Includes – Intake – Observation – Medication Services – Discharge Services

Level 1-WM Ambulatory Withdrawal Management without on-site monitoring

Level 2-WM Ambulatory Withdrawal Management with extended on-site monitoring

Level 3.2-WM Clinically Managed Residential Withdrawal Management

Level 3.7- WM Medically Monitored Inpatient Withdrawal Management

Level 4-WM Medically Monitored Intensive Inpatient Withdrawal Management

Medication Assisted Treatment (MAT)

The use of medications, in combination with counseling and behavioral therapies, to comprehensively treat substance use disorders and provide a whole-patient approach to treatment that includes addressing the biomedical aspects of addiction.

Current Drug Medi-Cal authorized medications include Methadone, Buprenorphine, and Disulfiram

Pharmacy Benefit in Regular Medi-Cal include Naltrexone Tablets, Naltrexone Injection, Vivitrol for criminal justice population, Acamprosate, and Naloxone

Providers must have established partners for linkage/integration for beneficiaries requiring medication assisted treatment. Provider staff will regularly communicated with practitioners of clients who are prescribed these medications unless client refuses to sign release of information.

Case Management

A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individuals' and family's comprehensive health needs through communication and available resources to promote quality and cost effective outcomes.

- Services can be provided at DMC provider sites, county locations, regional centers, or as outlined in the county Implementation Plan.
- Assistance in accessing medical, educational, vocational, social and other services
- May include:
  - Client service plan development
  - Client advocacy
  - Linkages to physical and mental health care
  - Transportation

Recovery Support Services

Non-Clinical, post-treatment services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals.

Incorporate a broad range of support and social services that facilitate recovery, wellness, and linkage to and coordination among service providers.

Similar to how patients see the primary care provider for periodic health checkups even when healthy, RSS can be viewed as aftercare or continuity of care in SUD treatment.

Recovery Support Services may include:

- Counseling
- Recovery monitoring
- Substance abuse assistance and support groups
- Ancillary Services

Evidenced Based Practices (EBP)

A clinical approach that applies to the best available research results to inform health care decisions. Health care professionals who perform evidence-based practice use research evidence along with clinical expertise and patient preferences. Staff must attend DHCS/County approved trainings and agencies must maintain records of compliance with these requirements.

The provider agency will be required to implement at a minimum the two EBPs:

- Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT).
- Other EBPs include Relapse Prevention, Trauma Informed Treatment, and Psycho-Education.

Currently DHCS offers no guidelines or no specific standards for certification or licensure of programs for the forensic population.

What is this about for SUD . . .

- Expanding availability of SUD treatment by expanding the network of selected service providers
- Creating a defined and accessible continuum of evidenced-based SUD services
- Improving outcomes in the recovery management and maintenance of the gains achieved in treatment
- Adopting standards of practice with improved consistency and quality of services
- Implementing managed care administrative methodology to meet the PCACA Triple AIM Goals
- Development of a sustainable and viable financing structure and reducing costs

Statewide SUD Treatment Capacity

Residential Treatment

- Total Residential Treatment Facilities = 610
- SUD Residential Treatment Beds = 20,126
- Self-Designated Dual Diagnosis Beds = 275
- Out-Patient Treatment
- Non-Residential Treatment Facilities = 874

Source: DHCS Licensing and Certification Status Report 2016139

What is this about for Criminal Justice - Established Referral and Funding Pathways Have or Will Close

Next Steps: Understand The New Structure - Its Opportunities and Its Impact

- County Implementation Planning convened stakeholders in development of the plan. Many counties included judges, probation, district attorneys, public defenders, drug court liaisons, and sheriffs.
- Innovative programs, approaches and targeted assessment are in several plans.
- Evidenced based practices selected for engaging criminal justice population.
- Local collaboration occurring at the Community Partnership Planning Level in some counties or directly with Sheriff to embed SUD counselors.
- Once changes are understood new referral workflows are needed across both systems.
- Gap analysis is needed based on changes and then policy and funding developed accordingly.

New Connections & Pathways Needed for Cross System Referrals – What is available and What is not

Incremental Change in Uncertain Enviroment

I. Each Drug Court must plan and establish new referral and administrative pathways.

II. Continue or initiate local collaborative work including codified workflows; fact sheets; collaborative learning; planning system changes and enhancements

III. Convene a Joint Action Advisory Committee of DHCS and Key State Level Stakeholders' to vet the opportunities and challenges that would support incremental progress and maximize positive outcomes for clients

IV. Build a treatment infrastructure that provides co-occurring services