The Addiction Treatment Landscape:

The California Transformation to a Managed Care Model

California Association of Collaborative Courts
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Objectives

- Understand the catalysts shaping health care & behavioral health care today
- Understand the new county role as a PIHP in managing the network of service
- Outline the AOD provider standards under the DMC-ODS
- Outline the impact on the Criminal Justice System

CIBHS DMC ODS Waiver Forum
Funded by Blue Shield Foundation of California

DMC-ODS Waiver Forum created 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

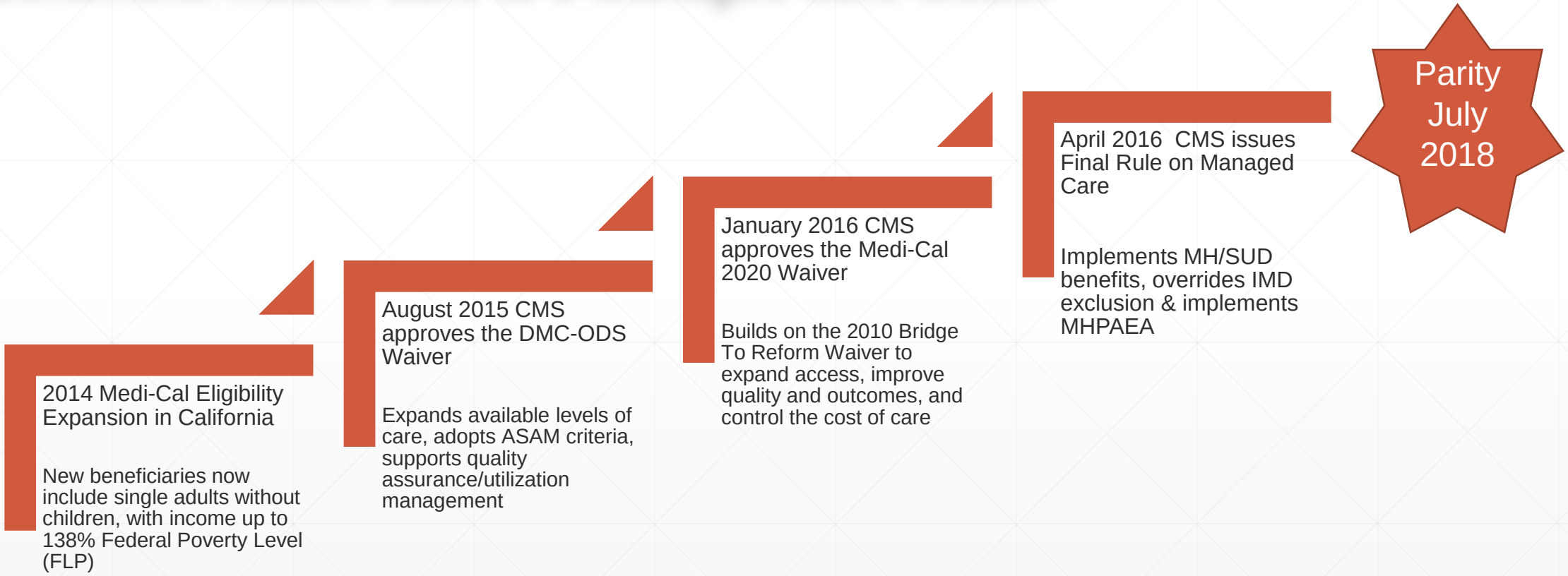
- Eight forums and five webinars
- Web site access to the white papers and other information at

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

The Alcohol and Drug Service 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 all health service delivery and focuses on coordinated care.
- Most state public sector AOD 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 alcohol and drug programs have minimal services, have insufficient provider networks, and few standards for this type of care.
- **Mental Health and Substance Use Disorder services are mandated as one of ten essential health benefits in the Patient Protection & Affordable Care Act of 2010.**
- **In 2015, California received approval for a Waiver Demonstration Project to provide a continuum of care for "Substance Use Disorder" services in counties that OPT IN.**

The PCACA Accelerated the Transformation of Health and Behavioral Health Care to a Managed Care Model



California Medi-Cal 2020 Bridge To Reform Waiver

- Improve health care quality and outcomes for the Medi-Cal population
- Strengthen primary care delivery and access
- Build a foundation for an integrated health care delivery system that incentivizes quality and efficiency
- Address social determinants of health and improve health care equity
- Use CA Medicaid Program as an incubator to test innovative approaches to whole-person care

2018-2019 California State Budget Focus: The Integration of Physical and Behavioral Health

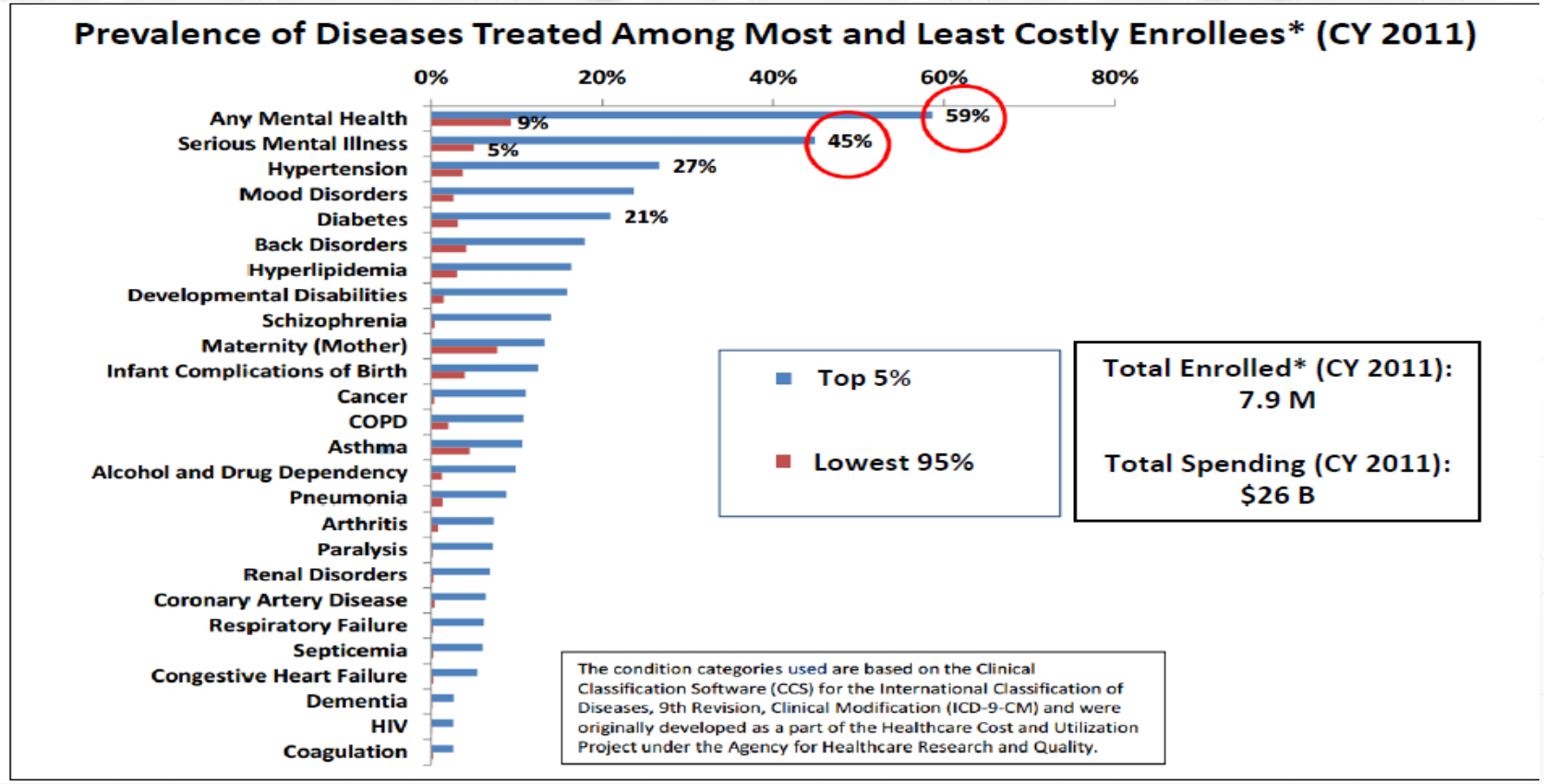
- With the elimination of the Department of Mental Health and the Department of Alcohol and Drug Programs, oversight of county-operated community behavioral health programs shifted to the Department of Health Care Services.
- This transition encouraged programs to work together to address a person's whole health—physical health, behavioral health, and substance use disorders.
- In addition, substance use services have been expanded in Drug Medi-Cal and at the county level as part of the Organized Delivery System Waiver.
- Reflected in Whole Person Care Grants; Care Coordination Initiative and Patient Centered Health Homes innovations

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.
- The required County Fiscal Plan must project population demand and calculate utilization of all funds and expenditures, both federal and matching local funds including the Substance Abuse Prevention and Treatment Block Grant, BHS Realignment and DUI programs. It does not include AB 109 Public Safety Realignment funds.

CREATES AN ORGANIZED DELIVERY SYSTEM OF CARE FOR MEDI-CAL BENEFICIARIES

Behavioral Health Illnesses are some of the most commonly treated conditions among the entire Medi-Cal population



Source: Understanding Medi-Cal's High-Cost Populations, DHCS, March 2015.

Managed Care and Health Care Landscape

- **Enrollment:** Medi-Cal enrollment has increased over the past decade from 8.5 million to 1.3 million persons served. Medi-Cal now covers 1 in 3 Californians

- **Spending:** Medi-Cal costs have grown nearly threefold over the last 10 years and today total $1.2 billion in total annual expenditures

- **Managed Care:** The Medi-Cal program overwhelmingly relies on the managed care delivery system, with over 80% of all beneficiaries enrolled in managed care; certain services, such as behavioral health services for individuals with severe conditions and substance use disorders, are carved out of managed care.

- **Carve Outs:** beneficiaries enrolled in managed care with mental health needs and/or SUD needs must navigate three separate care delivery systems: the county mental health plan; the DMC-ODS; and the Medi-Cal managed care plan.

Managed Care Carve-outs: Behavioral Health Services

County Mental Health Plans

Services: Range of interventions to assist beneficiaries with serious emotional and behavioral challenges, including acute psychiatric inpatient care, treatment from psychiatrists and psychologists, and a host of rehabilitation services.

Medi-Cal Managed Care

Services: Beginning in January 2014, interventions to assist beneficiaries with mild to moderate needs, including psychotherapy, psychological testing when clinically indicated, psychiatric consultation, substance use screening and brief intervention for adults.

Funding: Medi-Cal spending on mental health services was estimated to be $3.3 billion in FY 2012-13 from federal, state, and county funding sources.

Memorandums of Understanding (MOUs): In each county, the mental health plan and Medi-Cal managed care plan(s) are required by their respective contracts with the state to have an MOU specifying roles and responsibilities for coordinating the delivery of mental health services.

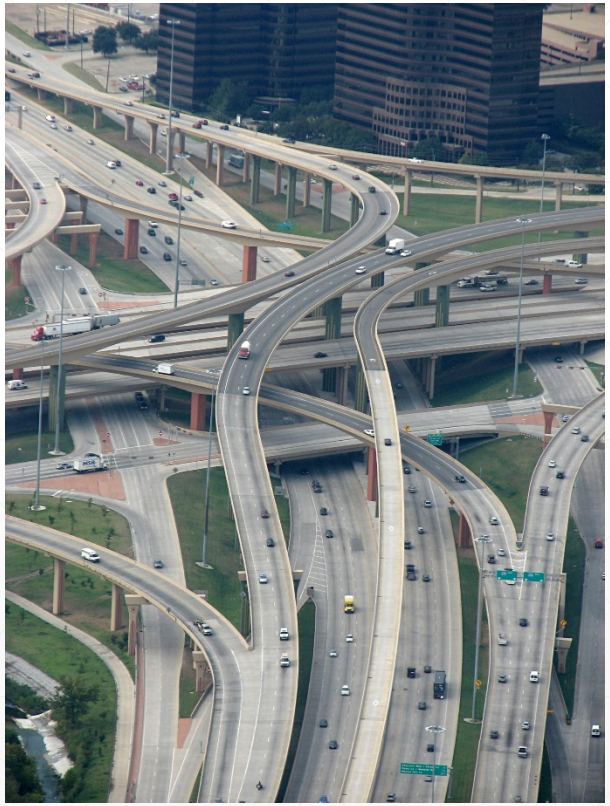
DMC-ODS Implementation

Regional Partnership	8
Non-Waiver	18
Waiver – Live	18
Waiver - In Process	13

SUD Carve Out: Prepaid Inpatient Hospital Plan (PIHP)

- Counties that opt into Waiver participation must execute a State-County Interagency Contract that defines them as a **Prepaid Inpatient Hospital Plan (PIHP).**
- American Society of Addiction Medicine Criteria (ASAM) for program structure and design, client placement, utilization management, and transition to the appropriate level of care based on a prescribed Level of Care Assessment & **Medical Necessity and SUD Diagnosis for Adults**
- Counties have the authority to selectively contract with providers following **managed care methodology** to create a provider network based on **federal network adequacy criteria**.
- 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**.
- 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 or longer.

For Criminal Justice - Established Referral and Funding Pathways Have or Will Close



Pre-DMC-ODS Flow of Funding Streams

SAPTBG
DUI
General Fund
DMC

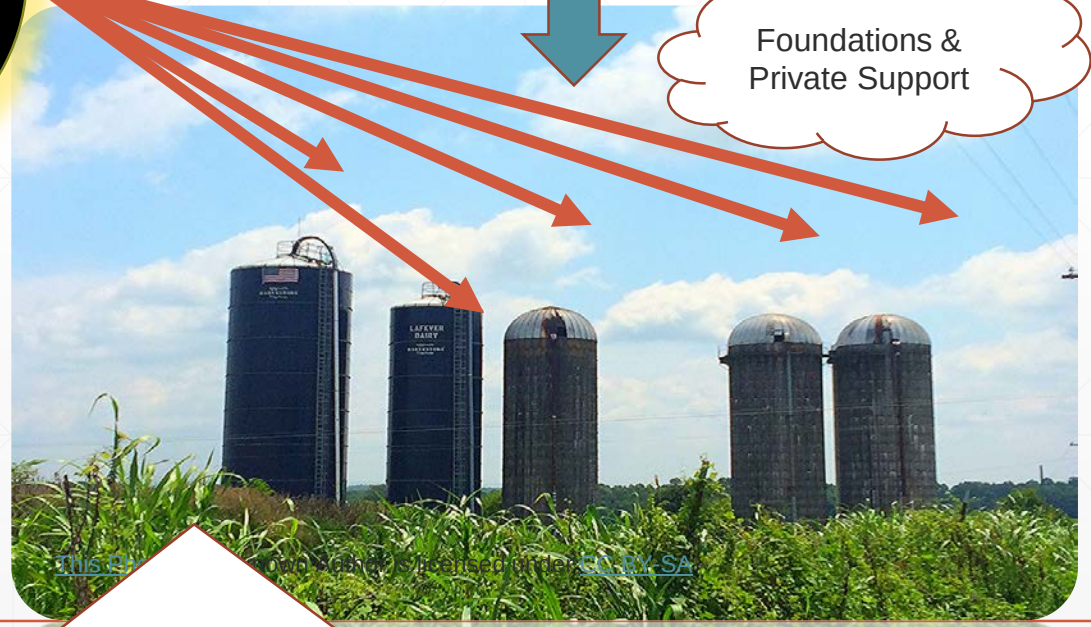
County CJ Grants

CDCR

Federal CJ Grants

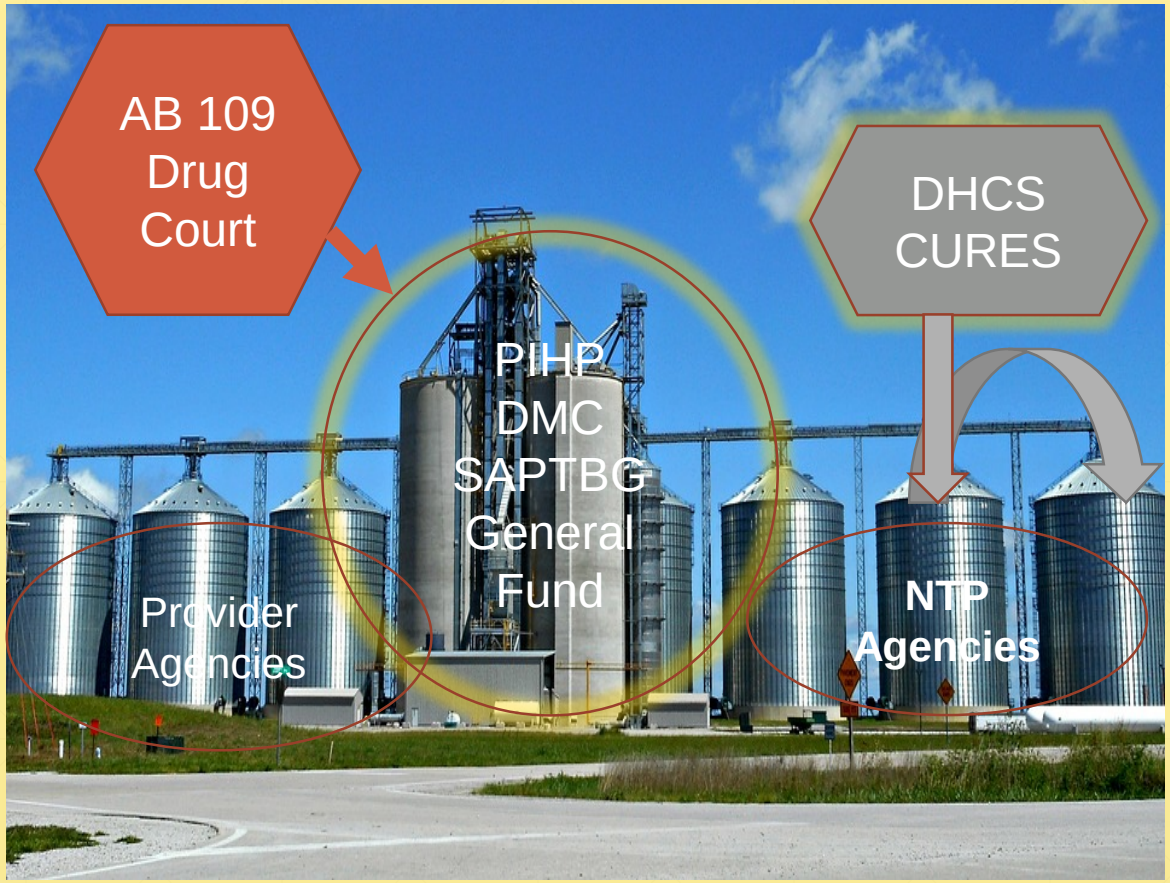
Foundations & Private Support

AB 109 Drug Court



Commercial Insurance

Impact of DMC-ODS on Funding Structures



County CJ Grants

Federal CJ Grants

CDCR

New Federal Funds

BSCC Proposition 47 Grants

Transformative Changes in the Criminal Justice System

2011: AB 109 – Public Safety Realignment	• Transfer of responsibility of lower level offenders from the State to counties; Post-Release Community Supervision (PRCS) by County 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

New Criminal Justice Vision, Policies, Structure, and Approaches: Projected Proposition 57 Impact

Increase demand for county service

Table 1b. Institution and Active Parole Population with the Estimated Effects of Proposition 57, June 30, 2007 through June 30, 2021

	Institution				Active Parole	
June 30	Female	Male	Total	Percent Change	Total	Percent Change
Actual						
2007	11,888	161,424	173,312		126,330	
2008	11,392	159,581	170,973	-1.3%	125,097	-1.0%
2009	11,027	156,805	167,832	-1.8%	111,202	-11.1%
2010	10,096	155,721	165,817	-1.2%	94,748	-14.8%
2011	9,565	152,804	162,369	-2.1%	90,813	-4.2%
2012	6,471	128,852	135,323	-16.7%	69,435	-23.5%
2013	5,995	127,019	133,014	-1.7%	51,300	-26.1%
2014	6,306	129,294	135,600	1.9%	44,499	-13.3%
2015	5,857	123,325	129,182	-4.7%	45,473	2.2%
2016	5,769	122,874	128,643	-0.4%	43,814	-3.6%
Projected						
2017	*5,924*	*123,948*	*129,872*	*1.0%*	*45,501*	*3.9%*
2018	*5,609*	*119,713*	*125,322*	*-3.5%*	*48,828*	*7.3%*
2019	*5,423*	*117,742*	*123,165*	*-1.7%*	*50,693*	*3.8%*
2020	*5,293*	*116,649*	*121,942*	*-1.0%*	*51,333*	*1.3%*
2021	*5,288*	*117,444*	*122,732*	*0.6%*	*48,597*	*-5.3%*

Impact on PRCS FY 17/18	
Enhanced Credit Earnings	**Proposition 57 impact**
443	1058

CDCR Inmate Population 6-21-2017

- Total Inmates inside a CDCR prison:115,015
- Prison Designed Capacity:85,083
- 135% above designed capacity

CRCR Weekly Population Report for 6/21/2017

Criminal Justice Population Changes

- Drugs of choice have changed as have available treatments. **Opioid** and **methamphetamine** use, emergency room admissions and related deaths are on the increase.
- **Criminal justice populations are characterized by high rates of physical and mental health problems**. 18% - 20% of PCRS have serious mental illness and 70% of these have substance use disorders.
- **Organic brain damage** is recognized and there has been an increase of co-occurring disorders.
- **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.

National Drug Early Warning System – San Francisco

- Indicators again suggest increasing **methamphetamine**-related morbidity and mortality in the City and County of San Francisco (CCSF). Substance use disorder (SUD) treatment admissions for methamphetamine continued to consistently rise, as did hospitalizations and emergency department visits involving methamphetamine and deaths including methamphetamine as a causal agent. •
- Increase in **heroin** use in CCSF. The proportion of all SUD treatment admissions involving **heroin** continued to increase, and anecdotal reports suggest that, notwithstanding treatment-on-demand, there are many out-of-treatment heroin users in CCSF.
- Prescription opioids remain an uncommon reason for SUD treatment admissions, and there is evidence to suggest declining street use of these agents. Data from the California State prescription drug monitoring program (CURES) show an ongoing decline in the monthly number of **opioid prescription** and the morphine milligram equivalent per patient in CCSF, and overdose deaths involving prescription opioids have steadily declined since 2010.

National Drug Early Warning System – Los Angeles

- Continuing increases in 3 indicators for **methamphetamine**. Number 1 in 2016 for primary drug at treatment admission and for drug reports from the National Forensic Laboratory Information System (NFLIS) with increases in percentages for 2016 over 2015. Increase in the number of Los Angeles County medical examiner cases testing positive for **methamphetamine.** Los Angeles Criminal Information Clearinghouse (LA Clear) indicated decreasing prices for methamphetamine, with smaller quantity wholesale amounts available.
- Indicators suggest mixed trends with increases in Los Angeles County medical examiner cases with **opioids** (not including heroin/morphine) but stable or slightly decreasing trends in 2016 as compared with 2015 for the category of prescription opioids in other indicators. Within this class of substances, the number of Los Angeles County medical examiner toxicology cases testing positive for **fentanyl** doubled from 2015 to 2016.
- Treatment admissions for primary heroin use remained high (ranked number 2) in 2016 with a slight decrease from 2015; the percentage of NFLIS reports for **heroin** also decreased, whereas reports increased among Los Angeles County medical examiner toxicology cases.

Effective Treatments for Methamphetamine Abuse

Cognitive Behavioral Therapies

- The Matrix Model, a 16-week outpatient approach that combines behavioral therapy, family education, individual counseling, 12-Step support, drug testing, and encouragement for pro-social activities

Contingency Management

- interventions, which provide tangible incentives in exchange for engaging in treatment and maintaining abstinence
- Motivational Incentives for Enhancing Drug Abuse Recovery (MIEDAR), an incentive based method for promoting cocaine and methamphetamine abstinence,

No Medications

- *there are currently no medications that counteract the specific effects of methamphetamine or that prolong abstinence from and reduce the abuse of methamphetamine by an individual addicted to the drug.*
- NIDA has prioritized pharmaceutical clinical trials for an antimethamphetamine antibody

- **State-County Intragovernmental** Agreement details requirements for access, monitoring, process for appeals & denials
- **Beneficiary Access System** with defined service referral process
- Policies and procedures for the selection, retention **credentialing** and re-credentialing of provider agencies (clinic based)
- **Pre-authorization** of residential services and recovery housing services based on medical necessity criteria
- **Care Coordination** – MOU – with Managed Care Plans
- Implementation of the National **Culturally and Linguistically Appropriate Services** Standards
- Monitoring of fidelity to defined **evidenced-based practices**
- **Billing and claim systems** that meet managed care standards
- Compliance with **Medicaid Final Rule Section 42 CFR 438**
- Annual review by **External Quality Review** Organization (EQRO)
- Three year IG based on county Implementation and Fiscal Plans with **provisional rates**

County DMC-ODS

Responsibilities as a Prepaid Inpatient Hospital Plan (PIHP)

Intragovernmental Agreement incorporating 42 CFR 438

DMC-ODS Service Elements

- **Chronic Disease Model** using **Levels of Care** based on ***Diagnosis and Medical Necessity for Adults (or At Risk for Youth)***
- 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** (with 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**
- Reimbursement for **Field Based Services**

Service Elements for Beneficiaries Involved in Criminal Justice System

- ***Beneficiaries*** *involved in the criminal justice system often* ***are harder to treat for SUD …*** *the beneficiary may require* ***more intensive services*** *which may include:*

  - ***Eligibility:*** *Counties recognize and 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 management and residential services for individuals involved in the criminal justice system up to 6 months RT with a one-time 30 day extension) if services are found to be* ***Medically Necessary.***
  - ***Promising Practices:*** *Counties utilize promising practices such as* ***Drug Court Services****.*

DMC-ODS Program Admission Criteria – Medical Necessity

- Enrolled in Medi-Cal,
- Reside in a participating county, and
- Meet medical necessity criteria:
  - Adults must present with one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders;)
  - Meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria
  - If applicable, must meet the ASAM adolescent treatment criteria. beneficiaries under **age 21** are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Nothing in the DMC-ODS Pilot overrides any EPSDT requirements

SOURCE: Special Terms and Conditions (STCs) for California's Medi-Cal 2020 section 1115(a) Medicaid Demonstration

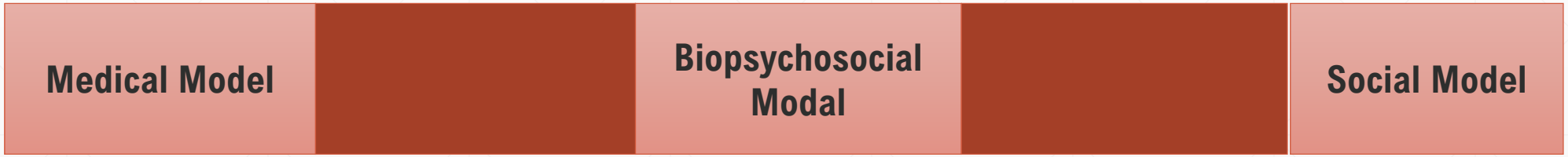
DMC-ODS Benefits – ASAM Levels of Care

Service	Required	Optional
Early Intervention 0.5	Provided & funded by Managed Care Plans	
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
Narcotics Treatment Program	Required County Contract	
Withdrawal Management	At least one level of four	Additional ASAM Levels
Recovery Services	Required	
Case Management	Required	
Physician Consultation	Required	

Engine of Program Change - Staffing Requirements

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 Clinical Model (Behavioral Health)** of services.



Licensed Practitioner of the Healing Arts (LPHA) and SUD Treatment Professional

LPHA includes physicians, nurse practitioners (NP), physician assistants (PA), registered nurses (RN), registered pharmacists (RP), licensed clinical psychologists (LCP), licensed clinical social workers (LCSW), licensed professional clinical counselors (LPCC), licensed marriage and family therapists (LMFT), and licensed-eligible practitioners, registered with Board of Behavioral Health Services and working under the supervision of licensed clinicians.

- Provides medically necessary, clinical services prescribed for beneficiaries admitted, registered, or accepted for care by the substance use disorder clinic
- LPHA must enroll in Medi-Cal Program using DHCS 6010 form

SUD Treatment Professional includes an intern registered with BBS or with Board of Psychology and/or an alcohol and other drug (AOD) counselor that is registered or certified pursuant to Title 9

DHCS AOD Certification

ASAM Certification for Level of Care based on:

- Setting
- Staffing
- Support Services
- Therapies

The OP benefit includes

- < 9 hours per week for adults / < 6 hours per week for youth

The IOP benefit includes:

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

The PH benefit includes:

- 20 hours per week of more

Certified Alcohol and Drug Outpatient Programs

ASAM Level 1.0 - Outpatient

ASAM Level 2.1 - Intensive Outpatient

ASAM Level 2.5 – Partial Hospitalization

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.

The ASAM designation is 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
- Reassessment of medical necessity every 30 days

Licensed and Certified Residential Programs

ASAM Level 3.1 – Low Intensity

ASAM Level 3.3 - High Intensity for Cognitively Impaired Populations

ASAM Level 3.5 – High Intensity

Interventions to address intoxication and/or withdrawal both physiological and psychological based on ASAM Dimension

1: Acute Intoxication and/or Withdrawal Potential

- previously called “detoxification services” – the liver detoxifies, clinicians manage withdrawal
- includes – Intake – Observation – Medication 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

Withdrawal Management and Intoxication Management

- Withdrawal syndrome can be managed safely
- Maintain client in continued treatment that will lead to sustained recovery

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.

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

Pharmacy Benefit in Fee-for-Service Medi-Cal includes 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.

Medication Assisted Treatment (MAT)

One Componenet of the Treatment and Recovery

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 in coordination with partners.

- 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, justice related activities and other services
- May include:
  - Client service plan development
  - Client advocacy
  - Linkages to physical and mental health care
  - Linkages with parole and/or probation
  - Transportation

Case Management

Care Coordination

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

Recovery Support Services

Post Treatment Services

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.

Evidenced Based Practices (EBP)

Minimum of Two

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 to the health care system

Designed to assess four key areas of beneficiary access, outcomes, utilization, health care costs and integration and coordination of care utilizing a comparison between comparable populations in opt-in counties and others

- ✓ Impact of providing intensive outpatient SUD services in the community
- ✓ Effectiveness of drug based SUD treatments
- ✓ Impact of providing residential SUD services
- ✓ Whether the length of stay of residential services affects the impact of such services
- ✓ Whether residential treatment methods affect the impact of such services

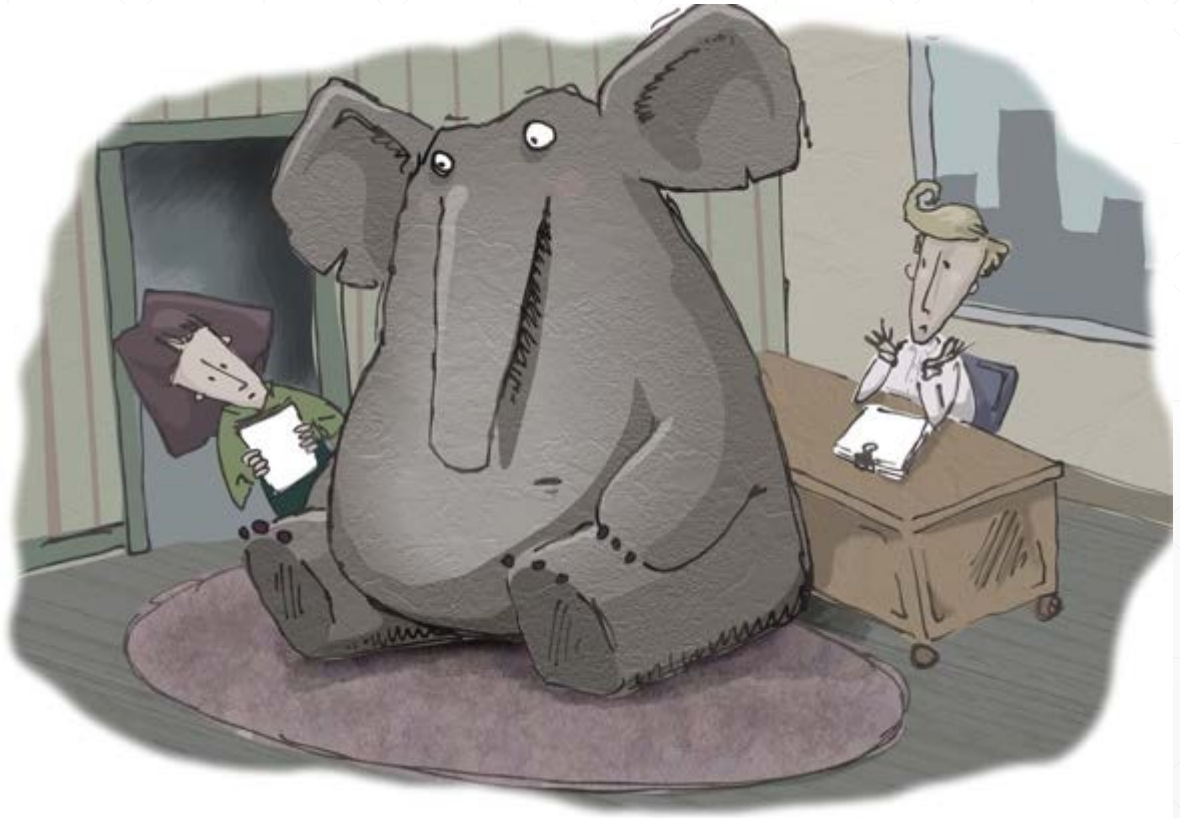
DMC-ODS Evaluation

University of California. Los Angeles

Integrated Substance Abuse Programs

The Elephant in the Room – Thing 1 - Sharing Protected Patient Information

Need to establish data collection, and information sharing guidelines and mechanisms, consistent with state and federal data privacy and security laws, to provide for timely sharing of beneficiary data, assessment, treatment information.



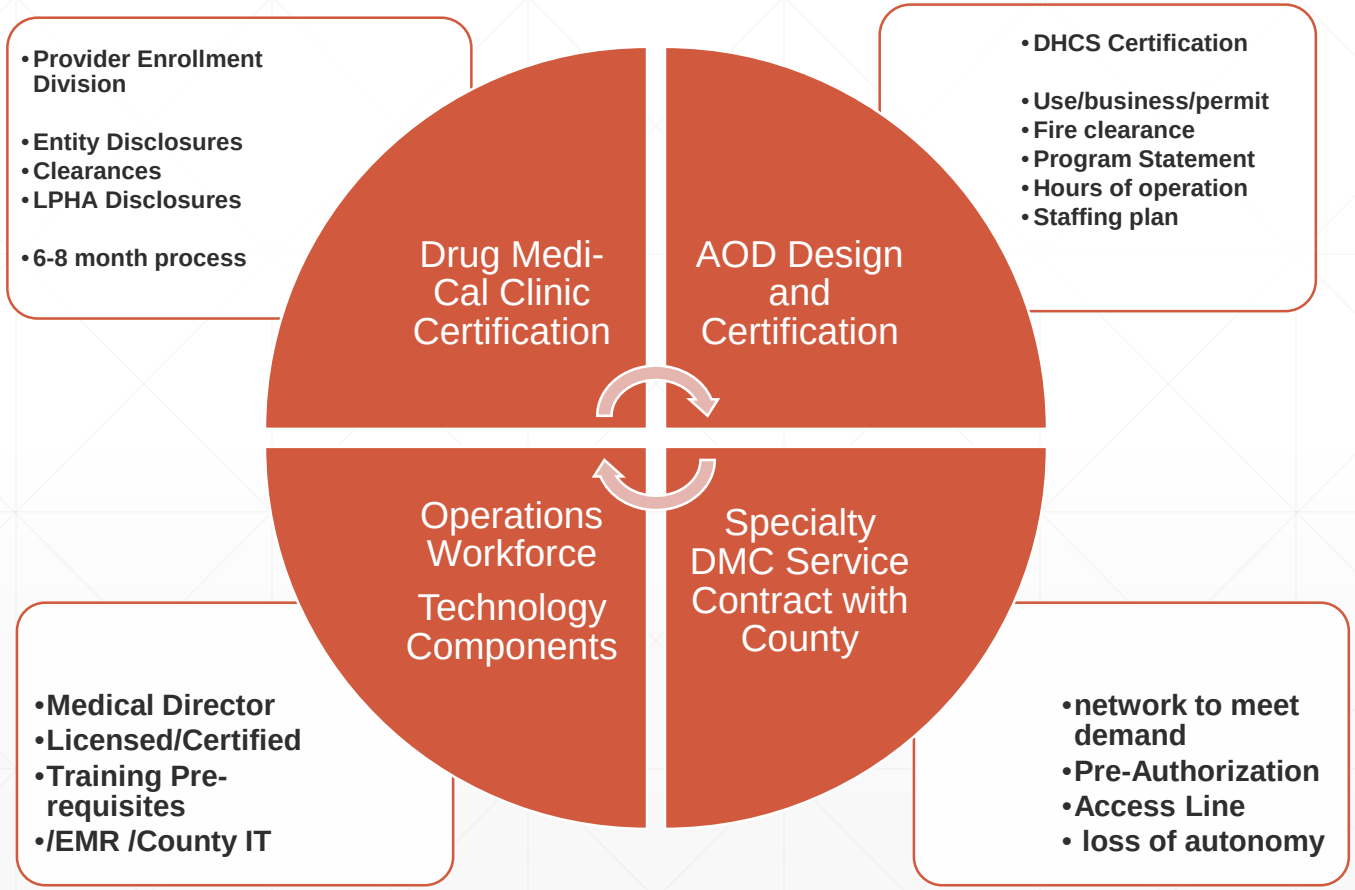
Current Statewide SUD Licensed and Certified Program Capacity – Thing 2

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

The Provider Challenges and Complexity



Pathway to Licensing, Certification and Selective Provider Contracting

Residential Programs

- AOD License & Certification MHSUDS, SUD Compliance Division
- ASAM Level Designation
- DMC Certification Provider Enrollment Division
- Incidental Medical Services Certification MHSUDS, SUD Compliance Division

Outpatient and Intensive Outpatient

- AOD Certification MHSUDS, SUD Compliance Division
- DMC Certification Provider Enrollment Division

There is no uniform pathway for those providers which are not currently licensed or certified by DHCS

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

Understanding the Structure and the Incremental Pathways - Opportunities and 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 working with courts and probation 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 in jails.
- Once changes are understood new partnership agreements and referral workflows are needed across multiple systems.
- Gap analysis is needed for the reentry population based on changes, followed by policy and funding decisions.

Incremental Change in Volatile Environment

I. Each Collaborative Court must plan and establish new administrative partnerships and SUD System referral 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**

Good Intentions - Unintended Consequences

Helpful Resources

California Department of Health Care Services

http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx

National Drug Early Warning System

https://ndews.umd.edu/sentinel-sites/sentinel-sites-reports-and-community-contacts

National Institute on Drug Abuse

https://www.drugabuse.gov/

Council on Criminal Justice and Behavioral Health

https://sites.cdcr.ca.gov/ccjbh/

Board of State and Community Corrections

http://www.bscc.ca.gov/