



SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT OF SUBSTANCE USE DISORDERS

DEPARTMENT OF PUBLIC HEALTH, SUBSTANCE ABUSE PREVENTION AND CONTROL (SAPC) SUBSTANCE USE DISORDER SYSTEM TRANSFORMATION AND THE DRUG-MEDICAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) WAIVER

COMMENTS AND QUESTIONS FROM THE STAKEHOLDER PROCESS AUGUST 13, 2015 THROUGH SEPTEMBER 9, 2015

The following are questions and recommendations received during the regional stakeholder meetings and via the online survey or other written comments. SAPC intends to have a more extensive stakeholder meeting/workgroup process throughout the course of implementing the substance use disorder (SUD) system transformation. Therefore, most comments and questions will be addressed as the implementation plan/application to be submitted to the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) is operationalized, rather than in the implementation plan/application itself. For this reason, responses to questions may change in the future.

As a reminder, until the County's DMC-ODS application is approved and the new contract between the State and County is executed, the current DMC rules still stand and the new benefits will not be reimbursable.

BENEFICIARY ACCESS LINE

Questions from the Regional Stakeholder Meetings

1. *How will beneficiaries be referred for services? How will preferential treatment between providers be avoided?*

After the initial triage assessment and determination of provisional level of care (LOC), access line staff will pull the list of appropriate providers, and provide the information to the patients who will ultimately make the choice on which treatment facility best meets their needs.

2. *What are the qualifications for staff who answer the access line?*

SAPC expects staff will at minimum be certified addiction specialists. However, SAPC will continue to evaluate if this is the most effective approach, especially as this line is not intended as a hotline but rather a screening and referral line.

3. *How will calls be managed during holidays, weekends and after-office hours?*

The automated system would keep a log of the calls and staff will contact patients the next business day. SAPC will evaluate this approach, however, given stakeholder concerns that a delay in response and referral could reduce likelihood of ultimate admission in services.

4. *Will there be accommodations made for patients who speak other languages or are hard of hearing?*

The access line is required to provide translation services at least in Spanish, and other threshold languages as needed. In Los Angeles County, this includes Arabic, Armenian (Eastern), Chinese (Mandarin/Cantonese), Farsi, Khmer (Cambodian), Korean, Russian, Spanish, Tagalog, Thai and Vietnamese. Accommodations will also be made to serve patients who are hearing impaired.

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5. *Since the access line will operate 24 hours a day and 7 days a week, does that mean that the services will need to be available those times as well?*

No, service delivery is based upon the facilities' regular business hours and in accordance with requirements in the "Access" section of the application. However, now that substance use disorder (SUD) services have become a medical entitlement, it is incumbent upon agencies to develop a business model that competitively caters to the needs and availability of patients served, which may include extending hours of operation.

6. *Will the access line replace the Community Assessment Service Centers (CASC)?*

Beneficiaries can continue to access services directly at program sites, the access line is not the only mechanism for referral or enrollment. SAPC has not determined whether the access line will be directly operated or subcontracted out with a single agency to handle calls for the entire County.

7. *Will there be an established waitlist?*

To the extent it is required, the access line will maintain a waitlist for LOCs within the service continuum. Since SUD services are a medical entitlement under the DMC-ODS and there will not be a cap on providers' DMC contract allocation, agencies should expand capacity in the long-term thereby reducing the need for waitlists, particularly for outpatient services.

8. *Will there be a workgroup for the establishment of the access line?*

Yes. SAPC will continue stakeholder meetings/workgroups throughout the implementation process on this and numerous other topics critical to successfully transforming and improving the SUD system.

Questions from the Online Survey

9. *Will assessments be conducted over the phone by a County employee or by an employee of the treatment center the client is being referred to?*

The access line will only conduct triage assessments to determine the provisional level of care referral. Contractors will conduct the full assessment at the program site.

10. *What is the time period for when clients will get placed?*

Access line staff will refer beneficiaries to the appropriate LOC at the time of the call or immediately upon when a call is returned. Every effort will be made to refer a beneficiary to a program that is able to assess and admit immediately or at minimum within 72 hours of referral.

11. *Will the access line place the individual seeking treatment at a specific contracted SUD network provider? Will the access line notify the contracted SUD network provider that they have referred an individual to their site? Will clients accessing the access line be given a confirmation code or ID# that they can use when contacting a contracted SUD network provider?*

Access line staff will refer a beneficiary seeking treatment to a contracted provider based on that individual's needs and preferences, and in accordance with the ASAM based triage assessment. Access line staff will coordinate with the program (see also Q10) regarding the referral. Therefore, a confirmation code is unlikely but that has not been finalized at this point.

12. *What happens if a person is in crisis and calls this line, particularly after hours, how will these patients be directed?*

The access line is not intended as a hotline. The voice message will include instructions on how to contact medical/psychiatric emergency services (e.g., 911) and non-emergency assistance (e.g., 211).

13. *Will individuals contacting this access line be referred to contracted SUD network providers within a geographically reasonable location? Will the individuals contacting this access line be given a time frame to which they are to report to a contracted SUD network provider?*

See Questions 10 and 11.

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14. Does this automated system refer to something the providers need to maintain? Or is the county going to operate an automated system that shows appointments for all providers?

SAPC would develop and maintain the automated system and providers would be required to utilize this system and train staff accordingly.

15. How and by whom will the access line be staffed?

See Question 2.

Recommendations from the Regional Stakeholder Meetings

- A. Access line staff and providers need to be trained on the use of the American Society of Addiction Medicine (ASAM) Criteria for determining clients' LOC. Not everyone has historically used ASAM Criteria or has been trained in the same way.
- B. Access line staff need to provide counseling services beyond their regular screening and referral duties. Clients who call may not be ready for treatment right away, but nonetheless, may need some initial counseling.
- C. The provider lists used by access line staff should include details on each programs' specialties and strengths to improve how clients are matched to services.
- D. SAPC needs to provide the screening tool which will include a justification for the provisional LOC being utilized by access line staff. This information should be provided to the client for presentation to his/her preferred provider so that the provider will have a better understanding of the assessment decision; this will be especially helpful for youth.
- E. Over-the-phone assessment will not always be sufficient for determining appropriate LOC. Often times, counselors can identify issues by a client's appearance which will help determine appropriate care needs. Providers will have to be prepared to refer/transfer clients to other services after their own assessment.
- F. SAPC may want to consider learning from or collaborating with the Department of Mental Health (DMH) which has established automated systems that update available program slots in real-time.
- G. An evaluation plan needs to be developed to ensure accountability that referrals are made without preference toward any providers. In the past, metrics were provided on a regular basis to all providers for accountability.
- H. A clear timeline to accessing care after contacting the access line should be shared with providers. Also, a clear timeline for moving to other LOCs would be useful.
- I. There should be second-party verification to evaluate screening standards during the access line intake. Errors in this process should be documented.
- J. Other individuals (e.g., parents, siblings or partners) should be allowed to call on behalf of clients, and confidentiality issues need to be resolved.
- K. Adherence to Code of Federal Regulations Title 42, verbal consent, and other pertinent rules should be observed.
- L. Recommend standardized training to the staff who will be taking calls for placement.
- M. The access line needs to have clinically trained SUD staff to make determination of LOC.
- N. Clinically trained substance abuse treatment staff should conduct the initial assessments.
- O. Clinically trained staff to make assessment and referral is recommended.
- P. We need to see the questions that will be asked and ensure that if a person feels more comfortable with a women's only or gay/lesbian friendly program those are the referrals that are provided.

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- Q. Assessments should be done rapidly. Also, only one assessment (as opposed to three) should be conducted that providers and referring agencies can use.
- R. I do not feel that an over the phone assessment will be effective in determining appropriate LOC causing significant need for replacement services.
- S. As long as the appointments are not given about 5 -10 days after the initial call, there shouldn't be a problem.
- T. Capacity, languages, follow up - engagement is important may be an issue with no shows to appointments.
- U. Having an access line can be helpful as it can serve as the first line of contact for clients, providers, and communities. In our experience, adolescents, parents, school counselors, etc., contact us for help and speaking to them on the phone and giving some type of advice and intervention is crucial in order for them to convince the adolescent to get help. Therefore, the phone access line's staff ability/ skills would be critical in helping the callers to obtain and access resources.
- V. With no face to face contact, I believe there may be a disconnect for the clients and getting him/her into treatment services.
- W. It should be required that the referring agency provide a summary discharge statement to the client to enable the new agency in planning the next LOC needed for continuum of care.
- X. In a competitive marketplace, there will be questions of fairness and equity regarding number and frequency of referrals from the access line to specific providers. There needs to be guidelines and accountability for both the County and providers built into this.
- Y. If it works, I worry whether we will have an adequate network of providers to support the calls.
- Z. We need more information on how programs will be chosen. Residential takes clients from all SPAs, so that might impact referrals.

Comments from the Online Survey

- AA. SAPC should not underestimate the work involved in developing capacity to operate a call center and assessment center that can handle the volume of calls and assessments anticipated. If incorrectly designed and managed this could become a single point of failure that could make SAPC the focal point. Better to tie the beneficiary access line to existing CASCs and provide technical assistance to them so that they are able to meet the demand. SAPC's role in authorizing residential services and conducting utilization management is enough to tackle.
- BB. Provide referral to "live" services for persons who are suicidal, on the verge of overdose, or have an emergency situation.
- CC. It should be made clear to the public if this access line truly qualifies them or not, if it does not, that should be made clear.
- DD. How the automated system will work to schedule appointments and how a third party will schedule admissions for various facilities.
- EE. Automated scheduling of appointments poses many issues with the nature of this clientele, the no-show rate is very high and it is in our experience that clients are more likely to show up with initial personal contact from provider with imperative follow-up. The access line does not allow enough personal interaction, maybe feeling like everything else in society, voice mail, wait-in-line, just a number so-to-speak.
- FF. Schedules regarding assessments change frequently at treatment programs. People show up late, do not show up at all, or show up unannounced.
- GG. Patients can become irritated if they have to go through a lengthy process at the Beneficiary Access line, and again at the provider level. I understand the need to have a provisional LOC determination, and it is my hope that the time for this process at the Beneficiary Access Line level would be kept to a

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minimum. It will be important for staff operating the line to be well trained and for an appropriate, brief screening tool to be used.

HH. Clients should be referred to a SUD and meet with someone personally, because it is more personable.

II. This line is a step in the right direction. Will require close monitoring.

JJ. I think it will be effective if there are sufficient staff to cover calls, especially since screenings can be time consuming.

KK. When a referral is made, the contact person should be emailed.

LL. There is a possibility that people will/will not open up to the phone line staff to allow effective screening. The 211 experience may be informative as the phone lines are ramped up. Their staff manage to assess, locate and recommend services for people with multiple social service needs (e.g., housing, food assistance, counseling).

MM. Well, I can tell by experience that we have to start updating the list of the telephone numbers of the participating providers in this hot line because my clients in the past call the hot line of [SAPC] and the phone numbers and the information that they get from the access line are out of service or they are sent from one number to another and they find very difficult what route to take. The information in this toll free numbers should be very accurate guiding our clients in a short process to the right point where they have to start.

NN. There should be some staff on the weekends as we expand our continuum of care. The above only states-staffed weekdays. This will limit some of the population from getting assessed/receiving services.

OO. While the costs are a concern; the hours of the access line should be extended to a minimum of 7 am to 10 pm on weekdays and 9 to 5 pm on weekends. The use of messaging service is not as effective as speaking to a live operator. To reduce costs, maybe the Access Line could share operators with other Health Care Department Access Lines, especially in the evenings and on weekends (due to the merger of all three health departments). The focus on the wellbeing of the clients and their needs vs. the needs to collect detailed accurate data about client calls is an important concern. Quality Assurance data collection, and reporting activities often become more important than the effectiveness and quality of the actual services. The proposed system and the "scripts" developed for interaction with clients have to reflect an awareness of that.

PP. Clients should be referred to a SUD and meet with someone personally, because it's more personable.

QQ. This line is a step in the right direction. Will require close monitoring.

RR. The referral system should take full advantage of secure, web-based, mobile technology.

SS. This process provides a heads-up for the agency to follow-up with the client to ensure that they show up since the appointment does not always mean that they will come in for admission/enrollment.

TT. Additional metrics should be added to include percent of calls the access line returns, where the access line is unable to reach the original caller (disconnected phone, no answering machine, access line's messages not returned after due diligence, etc.).

UU. Concerns about access line - Let's say an individual contacts the access line, and the screener determines the individual is not DMC eligible, screener may by-pass a SUD provider not knowing that provider could place individual in need of services in a different program they may have. Individual loses out and provider loses out.

VV. I can imagine it being difficult to arrange appointments for providers via the access line. The system would have to be a uniform electronic system. Also, the evaluation is being done over the phone, I would want to make sure the staff managing the access line were competent and knowledgeable with addiction and possess no bias towards one treatment over another. For instance, with the CASC system, many individuals who were most appropriate for Narcotic Treatment Programs (NTP) services often were not referred there because of the stigma of the treatment and the personal bias of the assessor.

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- WW. In past experience with the CASC system, NTPs were not treated fairly regarding getting referrals. I had a Proposition 36 contract which got no referrals, so I returned the contract.
- XX. Ideally, with enough providers and training, the client flow will improve. Standardized training for the staff who will be taking calls for placement is recommended.
- YY. The role of the CASC and appropriate training for the assessor should be identified better.
- ZZ. I would recommend this be centralized, not a CASC at multiple locations. There needs to be an appointment line, initial screening, and referral.
- AAA. It should go through CASC for more of a connection between referral and services.
- BBB. The CASC should become the access line. The CASC system has been around for 15 years. The CASC has been doing, screening interviews, conducted bio-psychosocial assessments, made provisional determination of necessary treatment and referred clients to the appropriate LOC. The CASC has also referred clients to other treatment modalities and social service networks, such as, medical, dental, homeless shelters, HIV/AIDS/STD testing and treatment providers, etc.
- CCC. The CASC has been using automated systems for data collection and billing for years. Adding another system will not be a difficult task. Providers are not used to utilizing an automated referral system and I do not think it would meet the needs of either the access line/CASC. To call providers on the phone is a system that is in place and providers know that if the CASC is calling they will need to give us, right then and there, a date and time for a client intake. It is also easier, on the phone, to get a moment to moment update of what LOC openings providers have. If a client can come through any door, the access line/CASC or off the street, or through a referral from another provider, how fast and accurate can these types of up-dates be in an automated system?
- DDD. Not all providers take all kinds of clients. Sometimes there are language barriers, diagnostic variables like co-occurring (mental health and substance abuse and/or medical issues), or providers who cannot provide specific services like victims of violence, culturally appropriate treatment or homebound treatment, etc. The CASC is very aware of the specific treatment modalities and capabilities of their providers. We have built relationships with them. To remove the CASC and develop an access line system would disrupt the flow that already exists between the CASC and providers.
- EEE. I would like to see the clients go through CASC for assessment and the beginning of the "flow through treatment system of care", a face to face is more of personal experience. I think for the clients contact with SAPC represents authority.
- FFF. We need a fluid system from access line (the CASC) to treatment providers at every level. That said we need a variety of providers able to provide all ASAM levels of care across the county. Not just in a few places around the county, but throughout every SPA a fluid system would need to have all levels of care within an identified one hour radius (by car or bus) from a person's home.
- GGG. The implementation plan makes no mention of the network of CASCs. The investment made in the network of relationships that SAPC, CASCs and providers have developed over the years should not be abandoned.
- HHH. Training of assessors on NTP services specifically.
- III. Communication between hotline and provider. Enrolling help seekers in MediCal.
- JJJ. Potential barriers could be: 1) difficulty in communicating between the access line and service provider and 2) difficulty in communicating between appropriate programs when transferring clients.
- KKK. The "no wrong door" approach is excellent and so is creating the access line as well as keeping the direct admissions pathway via the providers.
- LLL. Barriers may be minimized by allowing clients to gain access to programs via multiple treatment systems as well as the CASC or directly from the provider.
- MMM. The access line is one point of entry. In the community at large, knowledge of SUD treatment services and providers is very limited, and most experience a fragmented system with services varying widely from

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provider to provider. Access line is important, and the challenge will be to have it widely known as a starting point, and have it be reliable and effective for the public to have confidence. For example, 211 is widely known in the human services arena, and not so much outside of those looking for social services. However, many that access 211 express having difficulty being able to access the services they need in a timely manner. Then there is the issue of treatment capacity.

NNN. Money for staffing if needed.

OOO. Programs should have a 24 hour call in line to answer calls that may come in.

ADOLESCENT AND ADULT BENEFIT PACKAGE

Questions from the Regional Stakeholder Meetings

16. *How is aftercare or recovery support defined? What will be included in its services?*

The California Department of Health Care Services (DHCS) has not provided a definition for recovery support. However, SAPC is proposing a minimum of six months of recovery check-ups.

17. *What are the limits on the length of stay in treatment? What if a client does not finish the maximum days allowed per episode, can his or her remaining days be rolled over to the next allotted episode?*

For outpatient treatment, there are no set limits. For residential, adults are allotted up to a 90-day (with an option to request a 30-day extension) stay in a treatment facility for 2 non-consecutive episodes within a 12-month period. SAPC does not expect that unused days will be allowed to rollover but will raise this issue with the State. All admissions will be based on medical necessity.

18. *What would be considered a break in care for episodes to be considered non-continuous?*

DHCS has not defined what is considered a break in care for residential treatment. SAPC will need to also explore how this could be defined to avoid unintended consequences and/or practices.

19. *What happens when clients are issued a court order to stay a certain number of days in treatment? How is the requirement to use the ASAM Criteria applied in this situation?*

Treatment services must be based on medical necessity and the ASAM Criteria. A court order does not equal medical necessity. SAPC has, and will continue to have, discussions with judicial and court staff to ensure understanding of how services will be determined under the new benefit package.

20. *Will DHCS be able to process DMC applications in a timely manner?*

SAPC was told that DHCS has hired many new staff to process the applications, and has automated some of the application processes.

21. *Can providers conduct services in the field? How does that relate to site certification?*

The DMC-ODS will expand opportunities to conduct field based services without specific site certification as long as they are associated with a certified site. This expands opportunities to provide services in the community, at schools, in clients' homes, and other locations outside of their primary facility.

22. *How do we deal with residential treatment facilities that will not accept clients who are receiving Methadone treatment?*

We expect a cultural shift with the approval of more medication assisted treatment (MAT) options. More work needs to be done, however, to educate on the benefits of MAT and overcome obstacles particularly for clients in residential treatment.

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23. Do the medical director and the licensed practitioner of the healing arts (LPHA) have to conduct assessments in person?

They can provide assessment service face-to-face or through telehealth.

24. While we transition to the new system, will we be required to use the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)?

Meeting the DSM criteria for a substance use disorder is necessary in order to meet medical necessity criteria for treatment, so providers will be required to use the most current version of the DSM.

25. What is the cap on withdrawal management services? How many beds do we have available within our network?

The DMC-ODS does not outline a limit on withdrawal management (WM) services. Currently there are 107 residential medical withdrawal management (formerly termed detox) beds funded by SAPC in Los Angeles County, and SAPC is currently evaluating potential withdrawal management needs. The ASAM WM designation level are not yet available for these facilities.

26. Will SAPC allow blending of LOCs like clients in residential treatment being able to access outpatient services?

It is unlikely this will be possible due to concerns around duplication of services/billing.

27. What do we do with homeless individuals who need treatment services but do not meet medical necessity for residential program?

Medical necessity drives determination of LOC. The ASAM Criteria has a dimension on living environment that may apply to homeless individuals and will be factored into placement decisions, but housing should not be the determining factor for residential placement. For homeless individuals who need treatment but do not meet medical necessity for residential programs, they should be placed in an appropriate level of non-residential care and every effort should be made to connect them to sober living or housing support options.

28. Can adolescents receive withdrawal management services?

Adolescents who require WM services will have access to these services. According to the ASAM Criteria, WM is not a standalone LOC for adolescents; therefore, these services would be integrated into other LOCs where appropriate. Inpatient WM may be available through the fee-for-service Medi-Cal system in general, chemical dependency and psychiatric hospital settings.

29. Are there any limits on adolescent treatment episodes? Are there any empirical basis for determining such limit?

According to DHCS, DMC will reimburse up to a 30-day stay in residential treatment for adolescents, which is renewable for another 30 days as indicated by medical necessity. No information has been provided on how the 30-day limit was determined and if this is based on specific research.

30. What age range is considered as adolescents for the purpose of the benefit package?

The adolescents benefit package applies to those 12 through 17 years of age.

31. Has there been any discussions on issuing adolescent treatment licenses during DHCS' Provider Enrollment Division (PED) meetings?

For now, DHCS sees adolescent treatment licensing as outside its jurisdiction as it is conducted by the Community Care Licensing (CCL) division of the California Department of Social Services (CDSS).

32. What is the caregiver's responsibility especially in the adolescent residential treatment setting?

We encourage family members and caregivers to be involved as much as possible in adolescents' residential treatment. When this is not clinically advisable, minor consent services are still available for the clients' protection.

Questions from the Online Survey

33. What makes a client eligible for this program/process?

All individuals seeking SUD services will have access to the same benefit package regardless of funding source (e.g., DMC, CalWORKs, AB 109). However, DMC eligible beneficiaries (including those who are also eligible for other programs such as CalWORKs, AB 109) will soon receive the DMC reimbursable services exclusively at DMC certified providers. Only if an individual is ineligible for DMC (e.g., non-US citizens) will they be referred to a non-DMC certified provider for the services outlined in the DMC-ODS Implementation Plan/Application.

34. What does recovery monitoring entail?

See Question 16.

35. How is "improvement" defined? The Addiction Severity Index (ASI) was a good tool for determining progress and improvement because the client had feedback to the process.

The ASAM Criteria is a comprehensive framework for assessing clients and determining progress and improvement from a multidimensional, biopsychosocial perspective. As with any clinical encounter, there should be opportunity for client feedback regarding their treatment, and the use of the ASAM Criteria provides opportunities for this feedback as well.

36. For adolescents, parents/caregivers play a major role in our assessment and admission process, thus I'm wondering how this plays out with ASAM/LOC?

Parents and caregivers will continue to play an important role in the treatment services for adolescents, as appropriate, and there will be additional reimbursable opportunities for services such as family counseling. The ASAM Criteria includes a dimension on Recovery/Living Environment, which includes the role of family/caregivers. ASAM trainings will also continue to be provided and SAPC will continue to explore how these can be tailored to address the unique needs/concerns regarding services for minors.

37. Regarding the following statement, "beneficiaries who no longer meet medical necessity." Individuals referred to [this agency] via criminal justice systems may not meet the criteria for medical necessity according to ASAM criteria. Similarly, individuals referred to treatment from the Department of Children and Family Services may not meet the criteria for medical necessity. How will these individuals access treatment? Moreover, the majority of clients in treatment will no longer meet the criteria for medical necessity after a short period once they are stable. To what extent will the ASAM criteria be utilized in determining treatment duration and level of care?

Medical necessity will drive the duration of services and LOC placement not a court order or preferences of staff associated with the criminal justice or social services systems. SAPC and its providers will need to educate referring partners on the transition of the SUD system of care to a specialty health plan model. If an individual no longer meets medical necessity for a particular LOC, they should be stepped-up or down as appropriate, even if this means referring the individual to another provider or transitioning the individual to recovery support services as appropriate. The assessment/evaluation process will determine length of stay.

38. Are linkages for essential supportive services part and parcel of a program's budget?

Case-management will be a reimbursable service under the DMC-ODS Waiver and SAPC will negotiate rates with DHCS. This is a service requirement so providers will need to consider this within their program design, including the staffing plan and budget.

39. Are the minimum 6 months recovery monitoring covered?

Recovery support services will be a reimbursable service under the DMC-ODS Waiver and SAPC will negotiate rates with DHCS. This is a service requirement so providers will need to consider this within their program design, including the staffing plan and budget.

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40. *If clients are shown to be improving, are they expected to step down from residential to outpatient? Or are they expected to receive aftercare at residential as they transition out? In other words, does LOC refer to only those that are not showing improvement, or does it go both ways?*

Beneficiaries should be served at the lowest LOC that best meets their current needs. Clinical staff should be continually evaluating beneficiaries' progress to determine if it is necessary to step-up or step -down the LOC. Therefore, it is likely that an individual would step down within the residential services continuum (e.g., ASAM 3.5 to ASAM 3.1) and again to the outpatient continuum (e.g., ASAM 1.0 or ASAM 2.1). Similarly, and individual may step up from outpatient to residential based on medical necessity.

41. *Will contracted SUD providers need to have 24 hour 7 day a week staff available for an intake or will 8am-6pm weekdays be sufficient?*

The ability to conduct intakes at all times is not required. A minimum standard has not been established at this time although it is currently expected that intakes occur during regular business hours.

42. *What happens when a client reports misinformation in the evaluation and is determined not appropriate when arriving at the contracted SUD network provider?*

The triage assessment will only determine the provisional LOC. Providers are responsible for conducting the assessment and transferring the beneficiary to the appropriate LOC where appropriate and based on medical necessity.

43. *How will frequent users of SUD services be served?*

SUD services will now be managed as a chronic condition and not an acute condition. Therefore, individuals may step-up/step-down services regularly and/or receive on-going recovery support if the individuals do not meet medical necessity for an ASAM LOC. Use of NTP/MAT services should also be recommended when appropriate. SAPC still needs to determine how this will affect the admission and discharge process.

Recommendations from the Regional Stakeholder Meetings

- A. SAPC needs to guide providers through stepping clients down the continuum of care. Given that there are currently limited residential spots, providers will have a challenge planning clients' treatment discharge.
- B. Funding for transitional housing should be considered.
- C. The threshold for requiring site certification should be defined. For instance, DMH sets the certification requirement once a provider reaches a certain number of practitioners working at a particular site.
- D. In terms of certifying service sites, it is helpful to set thresholds as high or flexible as possible particularly at schools where the need is and where adolescents are mostly found. There is also a need to expedite processing of sites, and change guidelines on room certification for schools. DMH standards may be used as a reference.
- E. SAPC needs to continue advocating with DHCS regarding MAT and DMC application approvals as the current procedure is quite tedious and cumbersome.
- F. Allow treatment groups services for clients who have been admitted to the hospitals for withdrawal management (WM). While clients who are undergoing in-hospital WM may have their physical health taken care of, they are not provided with corresponding behavioral health interventions at the same time during their stay. Once their WM program is over, they leave the hospitals tending to feel better and disinterested in further treatment. Due to untreated underlying behavioral health issues, they tend to circulate back to using and then accessing WM, which only unduly burdens our system of care.
- G. While not often utilized, WM is also needed for adolescent clients. There needs to be public outreach about this service if not yet made as an official part of SAPC's adolescent treatment package.

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- H. SAPC needs to closely coordinate with the criminal justice system regarding court orders for treatment length of stay. It is a challenge to work with special populations who will not attend treatment services even with transportation accommodation. Often, it is the court order that compels them to get into treatment, and now that it needs to give way to ASAM Criteria's determination of LOC and corresponding length of stay, we need to make sure that we do not lose clients' motivation to get treated.
- I. A treatment strategy is needed for clients who had been in jail and had momentarily been sober during their stay. These clients may not meet medical necessity for treatment per the ASAM Criteria but nonetheless need rehabilitation services. This could be a big hole in the system that needs to be planned for right now.
- J. The 30-day limit for adolescent residential treatment is insufficient, unrealistic, and a cause of serious concern. Adolescents should either be given up to 90 days just like in the adult treatment package, be accommodated according to medical necessity per the ASAM Criteria, or be treated for as long as needed. Improvements happen after 30 days in treatment, and adolescents are more resilient and will stay in treatment longer than adults. When clients are younger, it makes more sense to provide them with ample time in treatment to prevent them from further utilizing SUD services in adulthood.
- K. There needs to be a strategy for outpatient service utilization among adolescents. Outpatient may be more challenging for adolescents to access as it requires working parents to take time off their jobs to accompany their children to the facility.
- L. Barriers would be allowing the providers to do their own screening of potential clients. When this is done there is an immediate disincentive for the worker to work with many clients or with difficult clients. Screening should be done by regional navigators, or by objective staff who are not involved with the ongoing treatment and have no natural disincentive to work.
- M. A barrier could be the non-trust from the client and the SUD professionalism.

Recommendations from the Online Survey

Business/Network Related

- N. This represents a huge change from our current system of care. It makes sense logically and practically; however, this will be difficult for many organizations to implement. We need to make sure there is funding to invest in training and develop the infrastructure needed to support this type of system and workflow.
- O. Money will be a provider-level barrier! Providers will have to spend a great deal of money to assess whether their system of care actually meets ASAM requirements and if not to develop a system that does. Most providers do not have the financial core to do this. SAPC needs to support providers, financially and logistically, to build their treatment services around multiple levels of care. SAPC monitors can guide their providers to develop the specific treatment modalities needed in their community/SPA. Unless this happens, LA County will lose their small neighborhood treatment providers who fill niche services, cultural, language, diagnostic, etc. It would be a shame to lose these providers because they do not have the resources to improve their system of care to meet DMC standards and it would be antithetical to the principle of community based services the county has tried to develop.
- P. The initial package appears comprehensive. However June 30, 2018 to some clients will be an eternity. There has got to be a way to make this happen sooner.
- Q. I believe that spending enough time with participants is the best way to recovery, but with the new system there will be more paper work and less time for contact with participants.
- R. Making costs and payments transparent or easier to understand for clients will be a barrier and opportunity. With the fragmented payment streams coming together it will be important to expect the system to make it easier to get covered services covered rather than to expect the client to figure it out.
- S. Enough providers and staffing to serve increased client flow; from what I have heard, the Certification process with the State is lengthy at best. Expedited Certification is recommended for new agencies as

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well as training/webinars in how to both complete the application process, and, in establishing the policies / procedures needed to operationalize.

- T. We need assurance that there are enough resources along the continuum.
- U. We appreciate the ambitious timeline. We assume that terms like "complete inclusion" as used with addiction medications and Level 2-WM will not limit those organizations that are capable of moving ahead at earlier dates. We prefer that the same "complete inclusion" language is used with the implementation of telehealth so that its use is not delayed by organizations who can use it to expand access to care.
- V. It's a big transition, so the time frame is appropriate.
- W. Level of staff training could be a barrier. Quality control mechanisms should be closely monitored.
- X. It should contain some exceptions in special cases for patients with special needs that they need treatment or other kind of benefit before 2017 or 2018.
- Y. Cultural competence should be added.

Outreach/Accessible Related

- Z. The treatment system of care should be advertised on television and radio, with lots of transparency, including what the benefits are exactly, how it is determined if one qualifies, and how exactly to access them.
- AA. Extensive marketing of the access line to targeted populations is critical to the success of the access line. This marketing campaign will require use of electronic media, online media, community outreach in at-risk centers of population, and outreach to the "influencers" of the targeted populations. In addition, public relations contacts with L.A. TV stations for SAPC staff member interviews will also ensure that clients are directed to the access line.
- BB. Treatment providers should be required to be involved in multilevel coalitions to refer clients should the LOC be different after 14 days of initial Assessment.
- CC. Having a clear coordination process with the providers and the access line will help keep things more in sync.

Assessment and Intake Related

- DD. If possible, a more detailed timeline of initial assessment and referral would help outline the initial placement into treatment and flow of care.
- EE. It is important that all clients coming into the system clearly understand and agree to the steps noted above. I would like an outline or guidelines that define "a more intensive psycho-social clinical assessment". Staff will need to be trained to complete a more intensive psych social assessment.
- FF. Usually clients don't trust anyone at the beginning of the any recovery process, therefore the process it may be a lengthy one, before the client can open up to the counselor.
- GG. Cultural and social norms are excluded from assessment as well as client syntax when done other than face to face interviews.
- HH. Normally, some linkage can occur from the referral of a client for services and their appearance for screening. To reduce this impact of this point of vulnerability, [this agency] will return a call to any potential client within two hours and will, if required, arrange for transportation and child care so that the screening process can begin within 24 hours of the initial call. Again, the use of Motivational Interviewing is an evidence-based practice that will reduce the risk of "no shows."
- II. A number of "steps" will be added to the current "client flow" in order to, hopefully, further strengthen outcomes for the multiple-risk clients whom we will serve. As demographic data indicate, [this agency] serves SUD clients whose risks are elevated by younger age, minority ethnicity, number of prior treatment attempts, cultural barriers to sobriety, primary and secondary use of substances that research reveals has lower probability of continued sobriety, and other variables. Thus, after the initial screening interview to determine Medi-Cal eligibility, [this agency] will utilize Motivational Interviewing as a step in

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the client flow. Second, after the initial SUDs screening based upon the ASAM criteria, [this agency] will also utilize additional tools in order to construct a Risk Quotient to support the provisional level of care placement. These additional client flow steps will not extend the period from intake to service initiation.

JJ. Clients should have more leverage of involvement in the intake process.

KK. There should be patient participation in the development of the process.

LL. Financial benefits navigation assistance should be provided.

MM. We need a good team of professionals who really can identify both adults and adolescents for appropriate LOC. Also, there should not be a lot of red tape in the process for applying for services. This process should be fast and efficient. Most of the time, the candidates who are ineligible for treatment are on waiting lists.

NN. As you are aware, a number of instruments exist that can be used to assess whether social and/or medical detoxification is needed. For the alcohol, the 10 item CIWA-AR (Sullivan et al 1989) is fairly standard. With cocaine, the Cocaine Selective Severity Assessment (CSSA) (Kampman et al 1998) only takes ten minutes to complete. Other instruments are available for other substances. The explicit specification of detoxification instruments may strengthen the structure of the program. Additionally, the inclusion of at least one social model, residential detoxification program may also strengthen the service continuum.

Level of Care and Services Related

OO. A lack of the understanding of where the client has been for care or the kind of intervention previously provided could be a barrier. As a result, each new admission is perceived as new client. Most clients are often not forthcoming as to the care or number of previous episodes or encounters.

PP. The availability of treatment resources along the continuum will be a challenge.

QQ. Often times, in attempting to aid a client in transferring to a higher level of care, facilities state they are at capacity & have long waitlist or they require a high out of pocket cost that makes the continuity of care immensely difficult.

RR. Time is always a barrier. Clients want/need services now! A barrier for us is that clients in addition to the addiction and the waiting, complete intensive psych social, the question is asked "where am I going to sleep tonight?" Clients are frequently poverty struck with no funds for transportation, to eat, and/ or in need of urgent medical care. This happens too often. If there were residential programs that would release (with supervision) the client to come to our NTP for daily dosing, this would solve a major problem. But then we get into the billing for 2 services at the same time. A difficult problem.

SS. Making sure there are enough resources available depending on the type of treatment being required is important. We have very limited detox and residential beds available, which creates delays and not always making this option possible.

TT. Clarify that MAT includes methadone, buprenorphine and oral naltrexone

UU. Detox is a very important part of the treatment process. LA County must have many more Detox facilities. Medical hospitals do not seem to have the proper resources to provide substance abuse Detox services. They assess a client, and if the client meets a hospital level of care, maybe give them a bed for a day or two and put them on Benzos – this is not the type of Detox we need. Most of the clients seen at the CASC do not meet the criteria for hospital detox. Yes, they need detox but they are not critical enough to warrant being in a hospital setting.

VV. We need many more detox facilities. Four facilities for the entire LA county area is not enough. Detox facilities must follow the rules and not demand extra money in order for a Medi-Cal client to enter treatment. Clients should not have to sign a promissory note and if they don't pay that off during the first treatment period – they shouldn't be asked to pay that and the new fees before they can get into detox. If you want to really have a "No Wrong Door" policy, detox should not be a Wrong Door because of fees.

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WW. The biggest issue I see is mentioned documentation and the issues of residential treating the chronically homeless population, referrals from law enforcement. Most programs do not use a step down step up concept and they will lose a lot of clients in transition.

XX. Very happy that the waiver includes residential services with no bed limits, and that these services are included in the initial phase of the County's implementation. I heard at the stakeholder meetings that outpatient "programs" will be certified, not just the site/location. This will allow for services to take place in non-traditional settings, such as senior centers or retirement homes for the elderly. If this is correct, I am quite satisfied with this particular feature!

YY. The residential treatment for adolescents should be extended to a minimum of 90 days (on a par with adults), with 30-day updates of the treatment plan (line 108).

ZZ. Describe the different levels of residential care.

AAA. One major client barrier to this is the client's motivation level and readiness. Clients can one day be ready for making the change, but resources may not be available (i.e. residential treatment bed), and the delay in waiting can become a barrier that may lower client's readiness level. Not requiring documented previous treatment history for entering treatment programs. Since many patients do not have access to their past treatment record.

BBB. Regarding last sentence..."beneficiaries who no longer meet medical necessity criteria for SUD treatment services or prematurely exit the SUD system of care, will receive recovery monitoring services for a minimum of 6 months by the last treatment provider of care, who will re-engage the individual in treatment if needed. This requirement is quite onerous, not feasible, and a huge burden on staff who already face challenges in keeping active patients/clients engaged in treatment. Having to provide "recovery monitoring" (1x/month) over a six month period would also be costly as the number of patients in the system grows. This seems like a higher standard than what's required from my primary care physician. At minimum, the six month requirement should be reduced to perhaps 3 follow-up attempts to re-engage a patient who exits early, but even this is difficult to maintain. One to three follow-ups to ensure a client who transitions to a different level of care actually reaches the next level of care should also be sufficient. Once it is documented that the person has engaged with the next provider, no more follow-ups or "recovery support" services should be required of the previous provider.

CCC. The mandatory "recovery monitoring services" for six months (lines 120-122) should have some leeway for the clients to change the provider at this stage and go somewhere else, especially if they dropped out of a program because they did not like it, or its staff.

DDD. Clarification on what "recovery support" means and what is required to qualify, for provider and consumer.

EEE. Aftercare is missing.

FFF. There will be challenges with recovery monitoring for those who prematurely exit treatment (they generally don't want to be followed up with) and the lack of inter-rater reliability on the ASAM criteria.

GGG. Linkage should be provided as necessary.

HHH. Transportation for patients should be provided.

III. Transportation.

JJJ. Transportation or lack of, Medical intervention needed, living situations that are not conducive to recovery.

KKK. I do not recall what the benefits package for OP or IOP services is now, but the current DMC OP services does not provide drug screenings or weekly case management. This package does not provide enough stability for clients to remain drug/alcohol free.

ACCESS TO SERVICES

Questions from the Regional Stakeholder Meetings

44. How can providers serve diverse clients when current rates do not reimburse for needed languages?

Under the new system, at least Spanish competency will be required for all treatment programs. Now that clients can go to any facility of their choice based on their needs, particularly with the advent of SUD services becoming a medical entitlement, it would be in the best interest of the providers to prioritize efforts to make sure services meet clients residing within their catchment area. SAPC will also negotiate new DMC rates with DHCS which should assist as well.

45. Is there any discussion about LA Care, Health Net or Medi-Cal providing transportation access to clients?

Currently there is no discussion on this topic but SAPC can inquire.

46. With service access assured only with providers becoming DMC-certified, will DHCS notify SAPC of approved DMC applications?

DHCS does not inform the Counties when DMC applications are in-process or approved. Therefore, it is recommended that providers inform SAPC via their contract program auditors when certification letters are received.

Recommendations from the Regional Stakeholder Meetings

- A. Scheduling of appointments within 72 hours is reasonable but may pose a challenge for smaller providers. Provider staff need to be well trained to quickly complete steps from client intake all the way to actual scheduling of appointments. Staff need to be trained for the new system's client flow and corresponding protocols, the ASAM Criteria, and the evidence-based practices (EBP). They also need to have fiscal and program qualifications for accurate billing. It will take time for providers to get up to speed with these new requirements.
- B. Requiring outpatient services to stay open for six days should be made optional. Providers will face staffing challenges and added operational costs, especially when client inflow could not be guaranteed.
- C. SAPC needs to address challenges in providing services in multiple languages within its network of providers.
- D. SAPC needs to reconsider its Waiver requirement on referring clients to facilities that are within one hour travel time from where they live. This requirement is especially challenging to meet for providers in Service Planning Area (SPA) 1 where travel time by public transportation may take more than one hour. Refer to the DMC-ODS application, page 9, lines 401-406.
- E. Since access can only be assured through a sufficient number of DMC-certified providers, DHCS will need to guarantee timely processing of DMC applications.
- F. SAPC needs to coordinate with different universities regarding a new curriculum for certification.

Recommendations from the Online Survey

- G. If additional care arises that are not necessarily part of the category, access to additional funding can be available to meet all needs of the client until discharge.
- H. Sometimes contracts very limited in that only a certain group of people can have access to certain services. For example, undocumented individuals often are not eligible.

TRAINING AND TECHNICAL ASSISTANCE

Questions from the Regional Stakeholder Meetings

47. Who will conduct pertinent trainings for providers as we transition to the new SUD system of care?

SAPC's Office of the Medical Director and Science Officer will oversee the provision of several trainings, including ASAM Criteria, Cognitive Behavioral Therapy (CBT), and Motivational Interviewing (MI), documentation, data integrity, cultural competency, and medication-assisted treatment. There will also be opportunities to receive administrative capacity building training from the California Institute for Behavioral Health Solutions (CIBHS).

Recommendations from the Regional Stakeholder Meetings

- A. Providers' management teams need training on how to manage and market their services under the new SUD system of care as funding will now depend on how many clients choose and come into the facilities.
- B. Trainings for CBT should be population-specific and geared toward counselor-level staff.
- C. Providers need training on telehealth services.

QUALITY ASSURANCE AND UTILIZATION MANAGEMENT

Questions from the Regional Stakeholder Meetings

48. Will there be any standardized Quality Assurance (QA) form that SAPC will distribute among its providers to use?

SAPC is currently working on a Quality Assurance and Utilization Management (QA/UM) Program Plan that includes input from providers. This workgroup will also develop standardized forms as needed.

49. Will SAPC's Office of the Medical Director include SUD specialists?

SAPC's medical director is a psychiatrist with specialization in SUD, and he has been hiring qualified nurses and behavioral health specialists to join his team.

50. Who will monitor the contracts? Who will conduct treatment program reviews? Will there also be peer reviewers?

SAPC's contract program auditors (CPA) will do the contract monitoring and SAPC's QA/UM team will conduct the program reviews. Peer reviews will be conducted as well.

Recommendations from the Regional Stakeholder Meetings

- A. SAPC may want to consider collaborating with DMH to incorporate its agenda and include its providers into its ongoing collaborative meetings conducted within each SPA.
- B. SAPC needs to establish peer review mechanism as it has been effective in facilitating the exchange of best practices and program ideas between providers.

Recommendations from the Online Survey

- A. Our funding as currently structured does not support this model. This will require new types of staff - UR staff, QI staff, etc.

EVIDENCE BASED PRACTICES

Questions from the Regional Stakeholder Meetings

51. Will SAPC create a list of approved EBPs?

The Waiver requires that providers implement at least two of the designated EBPs. SAPC will require use Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI). Beyond that, providers are encouraged to use other EBPs as they deem appropriate for their target population.

Recommendations from the Regional Stakeholder Meetings

- A. Add Seeking Safety as an EBP for traumatized clients to the minimum requirement alongside MI and CBT.

ASSESSMENT

Questions from the Regional Stakeholder Meetings

52. Do we all need to use the ASAM Criteria to determine LOC?

Yes, this will be required for all admissions upon approval implementation of the DMC-ODS.

53. Will providers be required to have medical directors?

All DMC providers will be required to have a medical director for at least 8 hours per month, in accordance with State requirements.

Recommendation from the Online Survey

- A. The hardest thing is determining the LOC by use of the ASAM. Most programs have a community based referral source folks who have been through the program, other CBO's that you network with will not be aware of the process, this new process will intimidate and confuse a lot of those folks, peoples knowledge of how to document and utilize the ASAM criteria will be crucial.
- B. Screening utilizing the ASAM Criteria together with LOC placement criteria is still very vague and unclear for most of staff; I think there still needs to be some concrete trainings on the use of both, and with adolescents as well.
- C. Level of Commitment to Recovery should be assessed.
- D. Providers must continually assess client level of care and if a client meets the criteria for higher or lower level of care, they must be willing to move that client quickly. The county must mandate this continuity of care and assure that providers are either capable of providing the appropriate level of care or that they are refer them to another provider who has the needed level of care. Providers keep clients too long on the books in the hopes clients will embrace treatment without looking at whether the level of care they offer meets client needs.
- E. Accommodations will need to be considered for clients referred through the courts for outpatient services that do not necessarily meet the medical necessity criteria for different levels of care.
- F. CASCs could become care coordination hubs that facilitate initial placement and transfers among organizations and levels of care.

TELEHEALTH

Questions from the Regional Stakeholder Meetings

54. Can providers conduct assessment through telehealth?

The initial determination of medical necessity can be determined via telehealth by a Medical Director, Licensed Physician, Licensed Practitioner of the Healing Arts (LPHA).

55. Can providers offer online courses or group sessions through telehealth?

Outpatient services can be provided in-person, by telephone, or by telehealth. DHCS' standard terms and conditions to not indicate if family counseling sessions with individuals in residential treatment can be conducted by telehealth.

56. Will SAPC provide technical assistance on telehealth, data encryption and other related services?

Yes, SAPC plans to provide such assistance but a date has not been determined yet.

Recommendations from the Regional Stakeholder Meetings

N/A

CONTRACTING

Questions from the Regional Stakeholder Meetings

57. How will DMC affect General Relief, CalWORKS and other traditional funding streams? How can we all reconcile each one's unique funding requirements?

We expect that some County counterparts like the Department of Public Social Services (DPSS) will remove much of its funding since many services will be covered by DMC. There will be one benefit package available to all clients regardless of funding source. SAPC will need to work with County departments and contractors to streamline reporting and funding requirements where possible.

58. Will there be any bridge funding as providers transition to the new SUD system of care? Who will it be for? What will be the conditions for applying? What will it intend to cover?

Yes, SAPC has initiated the process for current contractors to request bridge funding to purchase unallocated residential treatment slots (particularly small and medium-sized facilities) and/or to aid providers in developing or improving their technological infrastructure and/or building their staff capacity in order to meet the new system's service requirement. Those approved for funding will need to commit to applying for DMC certification and to assign a senior manager to participate in required trainings conducted by CIBHS.

59. Will the bridge funding be an augmentation to providers' current contract?

It would be an augmentation.

Recommendations from the Regional Stakeholder Meetings

N/A

ADDITIONAL MEDICATION ASSISTED TREATMENT

Questions from the Regional Stakeholder Meetings

60. *What codes will be used to reimburse for MAT services?*

This has not been determined at this point.

Recommendations from the Regional Stakeholder Meetings

- A. SAPC needs to clarify procedures and address gaps in delivering MAT services at the providers' level as staff are not able to provide MAT at a residential facility. Clients then would need to leave to obtain their medication and return later for counseling.

RESIDENTIAL PRIOR AUTHORIZATION

Questions from the Regional Stakeholder Meetings

61. *How do providers know that they need to secure authorization? What client eligibility applies in this process?*

Prior authorization is only required for residential services, along with re-authorization for DMC eligibility every 6 months for all LOCs other than Opioid Treatment Programs (OTPs/NTPs), in which re-authorizations need to occur annually.

62. *Who can assess clients on the providers' end? Who ultimately approves authorization for residential treatment?*

Any LPHA professionals including medical directors (MD), nurse practitioners (NP), physician assistants (PA), registered nurses (RN), registered pharmacists (RP), licensed clinical psychologists (LCP), licensed clinical social worker (LCSW), licensed marriage and family therapists (LMFT), licensed professional clinical counselor (LPCC), and other appropriately supervised licensed-eligible practitioner can conduct client assessment and consequently establish medical necessity for residential treatment. Providers will then have to forward their recommendation for clients' residential treatment to SAPC's Office of the Medical Director and Science Officer, which has a QA/UM team of clinicians to review recommendations and issue authorizations for residential treatment placement within 24 hours.

63. *Will clients be automatically given authorization for maximum length of stay? What if clients request a particular LOC?*

SAPC's Office of the Medical Director and Science Officer will authorize services based on medical necessity and will authorize residential lengths of stay in pre-defined increments according to the SAPC's Quality Assurance and Utilization Management (QA/UM) Plan. The expectation will be that clients are continually re-assessed throughout their residential stay to ensure they are transitioned to an appropriate lower level of care as soon as is clinically appropriate. Therefore, agencies will need to provide sufficient justification for the initial length of stay and continually assess the client as outlined in SAPC's QA/UM Plan to support on-going participation at that LOC. Client preference does play a significant role in placement decisions, but it must also be supported by medical necessity and the ASAM Criteria.

64. *What happens when disagreements occur between providers' assessment and SAPC's authorization? Will there be a process to forward appeals?*

Yes, there will be a complaints/grievances/appeals process, which will be outlined in SAPC's Quality Assurance and Utilization Management Plan. If there continue to be disagreements between the

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provider's assessment and SAPC's authorization decision, there will also be a State Fair Hearing process to address disputes that cannot be resolved at the local level.

65. Can providers proceed with client admission to treatment while awaiting authorization and be reimbursed accordingly if approved?

The terms and conditions require prior authorization for residential admissions. SAPC will explore whether it is possible for DMC claims to be submitted retroactively to the date of admission if authorization is ultimately granted, assuming an agency is willing to incur the financial risk of admitting a client prior to the authorization decision. SAPC will make every effort to respond to residential prior authorization requests in timely fashion, prior to the 24-hour requirement.

66. What if clients call and are assessed on the weekend or holiday? How can SAPC assure authorization within 24 hours?

SAPC will need to explore the degree to which admissions occur off business hours and what can be done to support efficient authorizations, when needed.

Questions from the Online Survey

67. If provisional placement screening indicates residential treatment, what happens to the client during the 24 hours pre-authorization period?

See question 65.

68. Are the courts and law enforcement on board with this?

SAPC has been discussing the issue of medical necessity driving what and how services are delivered. Additional education needs to continue, however, through the implementation process to aid in the transition of the SUDS system of care to a specialty health plan model. See Questions 19 and 37.

69. With most programs operating under timeline contracts how is that going to impact Residential operations? Can a facility have all 3 levels of residential?

All ASAM residential levels could be available within a single facility for adults or adolescents, and residential programs should apply for as many LOCs as possible to improve availability of services that meet beneficiary needs. SAPC will need conduct contract amendments and/or reopen the Request for Service Qualification (RFSQ) and Work Order Solicitation (WOS) process to add new ASAM LOCs so more information will be provided at a later date regarding contract duration etc.

Recommendations from the Regional Stakeholder Meetings

- A. SAPC needs to assure immediate and expedited response to authorizations requests, which could mean granting of approval within the same hour, business day or even by phone call. Providers may lose clients and their interest for treatment with lag time, or endanger clients' wellbeing particularly those needing urgent treatment care.
- B. Providers should be able to reimburse for the time spent to hold and keep clients engaged while waiting for SAPC's authorization.
- C. Providers should be able to admit clients into treatment while waiting for authorization to be granted. It is medically and clinically inappropriate to turn away clients when providers have already assessed them meeting medical necessity for residential treatment.
- D. Providers should be given preliminary authorization during weekends and holidays when SAPC may not be able to process requests until the next business day. SAPC may consider adopting related guidelines from managed care and insurance plans which allow pre-authorization and issuance of authorization number in order to track and keep clients on the queue until the next business day. SAPC may also consider developing an electronic system with programmed ASAM Criteria information so that authorization can be generated immediately without manpower, especially during weekends and holidays.

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Recommendations from the Online Survey

- E. We need to be able to gain approval within the first 24 hours for residential beds.
- F. Residential Authorization MUST be processed immediately, without the 24 hour wait period (line 103). Clients that are ready to be admitted, but instead have to leave the admissions office may and (mostly do not) come back.
- G. Longer waiting period for clients who need services for treatment, the more obstacles a client has the less likely they will receive treatment. If the process is quick and smooth a client will be more willing to accept the help offered and obtain treatment needed.
- H. Availability of beds; a coordinated effort to link participants to other providers if their LOC is different from what the initial agency can offer. It would be very helpful to provide assistance to providers in developing the program protocols for this updated system.
- I. My concern is when initial screenings are completed. There needs to be a way to see what providers have open beds to send clients to the appropriate location in a short timeframe. Also, when a full assessment is completed at the provider level and the client is not accepted for various reasons, there is a way to refer a client to a different level of care based on needs not captured.
- J. The no-preauthorization placement in outpatient services is a great idea, but the residential authorization has to be accelerated. Many clients are still "on the fence" and ambivalent about entering treatment; after having gone to the admissions office and being mentally ready to enter treatment, they might (and often do) change their mind if they have to go back home and wait. Therefore, the pre-authorization for residential treatment has to be immediate, without the 24 hour wait.
- K. Clients needing services are already at a vulnerable stage, so any delay of services such as the 24 hours preauthorization may turn out to be harmful or even deadly to a client.

BARRIERS TO INITIAL (1 YEAR) BENEFIT PACKAGE FOR ADULTS

Questions from the Online Survey

- A. Ensuring adequate training opportunities and technical assistance throughout this process would mitigate any issues.
- B. Providers have not demonstrated readiness to implement screening for substance use. There is some motivational enhancement still needed amongst providers in addition to providing them with orientation to standardized screening.
- C. First year will be very crucial because is something that it has to be adjusted in the next years. In the first year will be learn to be familiar what include and what not include in the benefit package for adults.
- D. The most challenging barriers are staffing and funding - a) ensuring that chemical dependency or substance abuse counselors that are certified can be included on the approved staff list eligible to be paid (some Medi-Cal categories limit the eligible staff to exclude SUD counselors); b) when requiring DMC services of a physician/psychiatrist (medical necessity diagnosis, treatment plans), the funding for these services has to be provided separately and/or by being included in a higher rates that are currently too low from DMC to actually support all the required services, plus accounting, reporting, staffing, etc.
- E. Some of the potential barriers are the deadlines implemented by the state approvals.

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- F. Provider level barriers to implementing and expanding 1st year benefit package: Providers are not prepared to provide all level of services and SAPC needs to become the Spear Point to helping providers implement and expand the 1st year benefit package. It is not enough to tell a provider that they don't meet the DMC clinical needs of this or that LOC.
- G. It is another to help them implement new methods of treatment they already deliver and expand into treatment areas needed by the SPA. This can only be done with SAPC's financial and technical support but it may take longer than the time line allows.
- H. Steep learning curve, adding layers of process, standardization, quality assurance and quality of care costs while under the current rate structure. Many providers may be doing the thinking and planning now, and waiting for clearer answers before actually hiring the necessary staff and adding costs.
- I. Workforce issues related to understanding LOC criteria / ASAM.
- J. Except that based on the DHCS "Certification" some providers are not certified to dispense medication. However, they could collaborate services with other MAT providers.
- K. Difficulty in obtaining medical doctor for Medi-Cal application for smaller providers.
- L. I feel very strong about this, with no individual- only group counseling, clients do not have the opportunity to get any counseling or connect though counseling.

AREAS OF IMPROVEMENT IN COORDINATION OF CARE FOR CLIENTS WITH MILD-MODERATE MENTAL HEALTH CONDITIONS

Questions from the Online Survey

70. *How will we exchange protected health information?*

With the establishment of a Health Agency model to enhance coordination of services between the Departments of Health Services, Mental Health, and Public Health, as well as increased collaboration with the managed care plans, exchanging protected health information will be a critical factor to ensure better care coordination and improved outcomes. SAPC will keep contractors informed and engaged in this process, as feasible and appropriate.

71. *Who will be responsible for providing transportation for those individuals receiving services at a contracted SUD network provider and needing services at one of the two mental health county plans?*

Currently, transportation is not a covered benefit under the DMC-ODS. SAPC will look into this topic further during the implementation process. However, providers will also need to consider whether this is an important component in their program design as well.

72. *Health Net and LA Care. Where are they?*

Memorandums of Understandings (MOUs) will be established between LA Care and Health Net for the DMC-ODS in order to facilitate enhanced collaboration and coordination of care for clients that are shared across systems.

73. *I believe more needs to be done to improve Mental Health Care, especially with SUD beneficiaries, so addressing this issue is vital. My concern lies with the coordination of 2 such large agencies and the efficiency with which anything can be accomplished. Is there an exact plan in place between the 2 agencies to coordinate and this major undertaking and train the people involved? Will the coordination allow for the right hand knowing what the left hand is doing?*

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There is a clear recognition of the need to better address the needs of individuals with co-occurring SUD and mental health (MH) needs. To that end, SAPC is dedicated to enhancing the MH capabilities of its SUD providers, and working with providers to ensure they have the tools to provide MH services, when feasible (e.g., trainings, workforce enhancement). Concurrently, the DMH is also expanding its ability to address SUDs in their co-occurring population. While coordinating care between agencies as large as those in Los Angeles County poses challenges, there are efforts to better collaborate between agencies, specifically as it relates to exchanging health information and the establishment of a Health Agency model.

74. Ensuring there are no issues with any authorizations for services, referrals, or medication. Need to determine how crisis mental health situations be handled. What happens if a client is in need of greater mental health care following a crisis episode? Will there be any issues with continuation of services for homeless or incarcerated clients? How will homeless client needs be addressed?

Individuals with mild to moderate mental health needs will receive services through the health plans, whereas individuals with severe mental health conditions will be served by DMH. Therefore, programs serving these populations will need to have established policies and procedures to ensure delivery of services, especially when a crisis occurs. Providers will need to design programs that meet the health and social needs of their clients, including those who are homeless or recently incarcerated.

75. Will the clients already have been enrolled in Health Net or LA Care prior to coming to one of the contracted SUD network providers?

Many clients will already be enrolled in Health Net and LA Care and thus may already be eligible to receive DMC-ODS services. The assessment and enrollment process, however, will need to include steps to determine insurance coverage as DMC eligible clients will only be able to receive DMC reimbursable services at a DMC certified site.

76. Will there be a wait list for these clients to receive DMH services or will they be top priority to be seen?

At this time, there are no plans for the health plans or DMH to prioritize mental health appointments for individuals receiving SUD treatment services.

Recommendations from the Online Survey

- A. This requires a response that goes beyond what can be answered in this survey. MOUs between DMH, SAPC, and the Health Plans are necessary but are not sufficient to address the problem. There must be care coordination at the provider level. DMH has programs like FSP that give providers the resources that begin to address the need. SAPC needs the equivalent. Ultimately, provider organizations need to have the resources to do whatever it takes to serve this population - the aim of [full service partnership].
- B. Because [this agency] offers services to youth through both DMH and SAPC, smooth transitions can occur. However, the use of the CASC system as a coordinating unit may be able to further advance service coordination when a provider does not have both DMH and SAPC youth SUD contracts.
- C. It will be important for providers to learn to work with the new benefits and not just refer out when a client is dual diagnosis.
- D. Mental health providers should realize that treating clients with SUD disorders along with mental disorders is treating the client as a whole. SUD professionals should attend staff and case management meetings.
- E. Many of these clients cannot care for themselves. Many are homeless, alcoholic, addicted to opiates.
- F. Cultural competence and support for agencies that are already providing that (for example, better buildings, more tools, more staffing).
- G. Describe how clients will be distinguished based on different mental health conditions and how they will be directed towards different agencies.
- H. Clear roles and responsibilities between DPH SAPC and DMH.

**COMMENTS AND QUESTIONS FROM THE STAKEHOLDER PROCESS
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- I. Addressing the issue of sharing information between the SUD provider and MH provider. How will patient enrollment into either health plan be handled.
- J. To reduce potential barriers for communication- releases of information should be included up front.
- K. Whatever organizations and SAPC will be very efficient and clear in this kind of services. It will take a good team work to achieve this goal.
- L. DMH does not adequately address substance use treatment in the same way SAPC organizations do. I think it would be very beneficial to allow SAPC funded agencies work with clients who have co-occurring disorders and provide higher rates and salary increases to hire the appropriate clinical staff to address the more severe mental health conditions. We already serve this population and end up paying out of pocket to operate this type of program.
- M. The merger of all three health care agencies in LA County will affect the coordination and the plans. As they are designed and implemented now, they appear to work well for the benefit of the clients, but it is hard to say about the merger and its consequences.
- N. Clear communication between the agencies, the state and the providers regarding expectations will be vital to improve coordination.
- O. Coordination with Mental Health: Given the history of separation in the county between MH and SA the idea of coordination between the two organizations seems daunting. There is going to be a great deal of work, not just from the position of DMH or SAPC upper management staff, but from grass roots providers of both services. Recently some of our larger providers, both DMH and SA, have begun to implement Co-Occurring disorders treatment into their systems of care. Philosophically, however, we have a long way to go for providers to embrace both and MH and SA issues as part of the bio-psycho-social level of client care needed in both systems. That said – DMH and SAPC monitors must review Co-Occurring guidelines with their providers and assure that these are being embraced. This will involve developing a holistic perspective of client needs with an eye toward developing treatment that meets the client where they are and develops treatment plans or referrals that take MH, SA, and Medical issues, etc., into consideration by Medical, DMH and SAPC providers.
- P. Training on how to collaborate and integrate services to have a greater chance of success.
- Q. SAPC and DMH need to provide more flexibility to providers who currently administer both MH and SUD programs so that it really is seamless.
- R. For clarification, there is a need to better define the requirements and stipulations for providers to delineate boundaries of care.
- S. Make sure HMOs are not a barrier to clients seeking services.
- T. I would like to see Mental Health and Substance Use Disorder working together in the client's interest and just NOT referrals.
- U. Clear guidelines to help determine clients level of severity between moderate and severe clients.
- V. Being undocumented and having limited Medi-Cal coverage can be a barrier to accessing DMH services. Funding for Indigent Care is quite limited.
- W. Have not had good experience with coordination of care so far. Currently the health plans each have a different process and criteria for mental health services. It is very difficult to refer patient for mental health care. Even the trainers in this area are confused and do not have a good grip on the coordination of care issues. The current process is inefficient, unclear and time consuming. Practitioner will not have time during a patient office visit to untangle this confusing process and patient will not be able to navigate it.
- X. Open more clinics and contract with more qualified professionals in the Mental Health Field.
- Y. Strong need for a greater coordination of services and training on both ends to ensure coordination is done effectively.

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- Z. Our agency has contracts with SAPC and DMH for both substance abuse and mental health for adolescents; however, we do not have specific contracts for mental health for adults and are just starting the work to become fully certified in this area.
- AA. An appropriate screening process for screeners needs to be coordinated and the staffing levels required for reimbursement needs to be clarified.
- BB. As is the case in any collaborative effort, the communication (and possibly integration) of the agencies is always a challenge.
- CC. Biggest issue will be the limitation of 1 Medi-Cal service per day. For integrated care, patients will likely need both SUD and MH services in the same day. State seems to see this as inconveniencing the patients unnecessarily while in practice it is usually the contrary.
- DD. HMOs have a way of classifying treatments, telling Doctors what to treat or is necessary. If they are allowed to define treatment options, then most clients will never have their needed care provided.
- EE. When giving a referral to Mental Health, they do not have availability most of the time for 20-30 days from contact.
- FF. We recently went to a training organized by the LA County Health Plan. Our staff came out of that training sensing it was not helpful and a waste of time. The Plans each have a different process and criteria for referral. The lack of consistent system amongst them is a significant barrier. Lack of efficient, simple and clear system for referral is a barrier for the practitioner and the patient.
- GG. Identifying those potential clients.
- HH. Reimbursement.
- II. The rates that Health Plans pay for mild to moderate mental health services are woefully inadequate to attract the resources needed for these services. Until that changes, the group of providers able to address these needs will be very limited.
- JJ. Their capacity to handle high volume of calls and their response time.
- KK. For SUD professionals to attend staff and case manager meetings.
- LL. Ensuring releases of information are in place for on-going communication.
- MM. All the health plans participants should accept this kind of services in a very fast and easy way so the clients can get their treatment right away and don't have to be waiting a long period to be accepted.

IMPROVING COORDINATION OF CARE FOR CLIENTS WITH PHYSICAL HEALTH CONDITIONS

Questions from the Online Survey

77. Who will determine eligibility for either of these managed care plans?

Eligibility for physical health services will be determined by the responsible health plan. The SUD provider will determine the appropriate LOC for SUD treatment services based on medical necessity.

78. Is there a universal form? Follow up? Who is responsible?

SUD providers will need to develop procedures to coordinate physical health services with the assigned health plan and physician for beneficiaries receiving SUD services. This includes identifying when referrals for physical health services are appropriate, assisting the client in coordinating the appointment where needed, and following up with the beneficiary to ensure the connection was made or exploring reasons for lack of follow-through if the beneficiary is ambivalent.

**COMMENTS AND QUESTIONS FROM THE STAKEHOLDER PROCESS
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Recommendations from the Online Survey

- A. MOUs between county agencies and Medi-Cal managed care plans will not change the incentives that keep carved out-to-county behavioral health and physical health care on separate track. DPH-SAPC and DMH must engage with the IPAs / Medical Groups that LA Care and Health Net contract with to have an impact on integration. There a few very large IPAs / Medical Groups that SAPC needs to engage with to make an impact on integration with physical health care providers.
- B. How to exchange HIPPA protected info in a reasonable time. Level of training of case managers handling SUD treatment decisions.
- C. The co-location of [service at the] emergency room and chronic care at one time improved care coordination. This model could support stronger integration in this case also.
- D. Clear branding and messaging, public messaging that matches services offered.
- E. Ensure that clients are under the care of a physician.
- F. We are a licensed primary medical clinic and have not had a single referral. Why? Because we also do NTP.
- G. Better case management for proper referrals.
- H. Family members input.
- I. Clear roles and responsibilities between DPH SAPC, DHS and the health plans.
- J. Addressing the issue of sharing information between the SUD provider and Physical health provider. How will patient enrollment into either health plan be handled.
- K. Similar language to ensure all parties are on the same page.
- L. The lapse of time to approve the services should take too long to have the approval to access the services.
- M. Educate and train the health care plans about the nuances of working with a very vulnerable population and make sure reimbursement rates and allowable services are able to provided that match the needs of the client and not be limited due to cost.
- N. Clients benefit from the shortest possible pathway to receiving additional services. Data sharing and permissions (consents) for joint client charts, for instance, are needed to accomplish that. For clients already enrolled in residential substance abuse treatment and having had a physical with a healthcare provider, direct referrals to healthcare providers, without going through additional levels of screenings and assessments are essential for the timeliness and effectiveness of services. With a more complex HMO-type administrative structure, the actual healthcare service providers are further detached from their clients and are focused on administrative/data reporting aspects of their jobs, instead of helping clients in their health issues.
- O. An established clear coordination plan will have to be created and reviewed to be able to make an informed opinion at this point providers are not privy to that information.
- P. Health care service providers should have methods for screening clients for Mental Health and Substance Abuse.
- Q. Once a client is identified as having a possible MH or SA need, the medical provider should encourage and even call the Access line for the client to get an appointment for a screening/assessment. The CASC used to have a mental health specialist who would help identify clients who needed MH services and then they would refer the client to a MH provider by calling the provider and helping the client make an appointment. It might behoove SAPC to contract with the CASC to hire a MH assessor to determine client MH needs if they come in with both MH and SA issues.
- R. It will need to be done at the provider level.

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- S. As yet, there has been no contact from these health plans demonstrating the coordination described in these lines.
- T. Priority should be given to clients being referred by SUD providers for physical health problems.
- U. All providers must have a WORKING relationship not just a resource.
- V. Establishing clear lines of communication with physical health providers and SAPC providers would be helpful in order to have smooth operations in treatment.
- W. Cal MediConnect has not been a successful project.