INITIAL STATEMENT OF REASONS

Background

The California Department of Health Care Services' (Department) mission is to provide Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care. In support of this mission, the Department administers many health care programs including California's State Medicaid program, which is known as the Medi-Cal Program.

Welfare and Institutions Code (WIC) Section 14113 authorizes the Department to enter into agreements with other state departments to administer Medi-Cal funding and requirements for services particular to their fields of expertise. In 1980 the Department entered into an agreement with the California Department of Alcohol and Drug Programs (ADP) to administer the Drug-Medi-Cal (DMC) program. In July 2012, pursuant to Assembly Bill 106 (Chapter 32, Statutes of 2011), administration of the DMC program was transferred from ADP back to the Department.

The DMC program offers a range of services including outpatient counseling and therapy, residential services for pregnant and postpartum women and medication services for opiate addicted beneficiaries. The Department oversees county and provider compliance with State and Federal statutes, regulations and other requirements. A part of this oversight is the Department's performance of postservice postpayment (PSPP) reviews of providers, which, among other things, focus on whether services provided to beneficiaries are medically necessary.

In July 2013, the Department began performing targeted field reviews of DMC providers suspected of committing fraud and abuse. (*See* Department news release entitled, "DHCS Tightens Oversight of Drug Medi-Cal Centers," July 18, 2013, which is available at http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/2013/13-07DHCS-DMC7-18-13.pdf). As of early April 2014 the Department was still conducting targeted field reviews.

In addition to the targeted field reviews, the Department's Audit and Investigations Division conducted a review of the DMC program, and prepared a report entitled, "Drug Medi-Cal Program Limited Scope Review," November 2013, which is available at http://www.dhcs.ca.gov/dataandstats/reports/Documents/DMCLtdScopeRvw.pdf. Among other things, this review focused on the lack of sufficient regulatory authority to ensure program integrity and ensure providers meet performance expectations. This review resulted in a series of recommendations and the Department prepared a plan to implement those recommendations. (*See* "Implementation Plan for Drug Medi-Cal Program Limited Scope Review," which is available at http://www.dhcs.ca.gov/dataandstats/reports/Documents/ImpPlanforAuditRecom.pdf).

Related Existing Laws and Regulations

Welfare and Institutions Code Section 14021(c) authorizes the Department to provide outpatient substance use disorder services. (*See* also WIC Section 14131) Welfare and Institutions Code Section 14132(u) authorizes the Department to provide

comprehensive perinatal services. Welfare and Institutions Code Section 14124.24(a) and (b) defines the substance use disorder services offered by the DMC program, which must be consistent with the California State Medicaid Plan and approved Plan amendments. (The services offered by the DMC program include perinatal services.)

Welfare and Institutions Code Section 14124.26(c) authorizes the Department to adopt emergency regulations to implement Article 3.2, Chapter 7, Part 3, Division 9 of the WIC, which includes Section 14124.24. So, the Department has authority to adopt emergency regulations that implement the DMC program services set forth in WIC Section 14124.24.

Title 22, California Code of Regulations (CCR) Section 51341.1 is the primary implementing regulation for the DMC program. It addresses numerous topics including the substance use disorder services offered by the program; provider requirements; PSPP reviews of providers by the Department; and the basis for recovery of payments from providers. In some instances ambiguities in the regulations have inhibited Department enforcement efforts.

Welfare and Institutions Code Section 14043.75 authorizes the Department to adopt and amend regulations to prevent and curtail fraud and abuse by Medi-Cal providers. Fraud and abuse are defined in WIC Section 14043.1. Fraud is defined as "an intentional deception or misrepresentation," knowingly made to obtain an unauthorized benefit. Abuse is defined as either "Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the federal Medicaid and Medicare programs…"; or "Practices that are inconsistent with sound medical practices and result in reimbursement by the federal Medicaid and Medicare programs … for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care."

Statement of Purpose/Problem to be Addressed

This regulatory action amends Title 22, CCR Section 51341.1 to address abusive and fraudulent practices identified during the targeted field reviews and PSPP reviews conducted by the Department. The regulations also implement some of the recommendations contained in the "Drug Medi-Cal Program Limited Scope Review" and remove ambiguities from the regulations that have inhibited Department enforcement efforts in the past. Additionally, the amendments implement, interpret and make specific the DMC services, which are defined in WIC Section 14124.24(a) and (b) and described in the California State Medicaid Plan, State Plan Amendments 12-005 and 11-037b.

Anticipated Benefits of the Regulations

This emergency regulatory action is authorized by and implements WIC Section 14043.75. The purpose of Section 14043.75 is to authorize the Department to take steps to prevent and curtail provider fraud and abuse through the adoption of regulations. The Department anticipates that the proposed regulatory amendments will enhance the fiscal integrity of the DMC program by curtailing and preventing provider

fraud and abuse. More specifically, the amendments will enhance provider accountability and the Department's ability to enforce the requirements.

This regulatory action is also authorized by WIC Section 14124.26 and implements WIC Section 14124.24. The purpose of WIC Section 14124.24(a) and (b) is for the Department to administer delivery of the specified substance use disorder services to Medi-Cal beneficiaries. The Department anticipates the regulatory amendments will clarify provider obligations, which should make it easier for providers to comply with program requirements. In addition, the amendments will improve the effectiveness of some treatments and enhance physician oversight.

Stakeholder Involvement in Preparation of the Regulations

In late March 2014 the Department provided a copy of the proposed amended regulations and a chart summarizing the amendments to the following organizations:

- California Society of Addiction Medicine
- California Alcohol and Drug Program Executives
- California Opioid Maintenance Providers
- County Supervisors' Association of California
- California Mental Health Directors' Association
- County Alcohol and Drug Program Administrators' Association of California

These organizations are substance use provider associations and county associations that have an interest in the proposed amendments.

The Department subsequently received comments and made adjustments to the proposed amendments in the following specific areas: elimination of the requirement for physician and beneficiary contact at admission and when the provider reassesses each beneficiary to determine whether continued services are necessary; and elimination of the requirement for a current beneficiary physical examination upon admission to treatment or a physician waiver. A summary of the stakeholder comments are included in the rulemaking file.

Specific Purpose and Rationale for the Proposed Amendments

The specific purpose and rationale for the proposed amendments to Title 22, CCR Section 51341.1 are discussed below. Non-substantive amendments that were repeated throughout the regulations are grouped together and discussed, beginning on page 21.

Subsection (a)

The term "are" is replaced with the phrase "shall be" for consistency.

Subsection (b)

Subsection (b) - Paragraph (2)
"Beneficiary" is not defined in the existing regulations. Although the term is understood by the substance use disorder community, it is defined for clarity and is consistent with the definition specified in Title 22, Division 3, Chapter 3, Article 1, Application and Enrollment, Section 51000.2.

Subsection (b) - Paragraph (3)
"Calendar Week" is not defined in the existing regulations. This definition is necessary to implement the requirements under Subsection (h)(3)(B) regarding progress notes for day care habilitative and perinatal residential treatment services. This definition is consistent with the definition found in the Merriam-Webster's Dictionary.

Subsection (b) - Paragraph (5)
"Counselor" is not defined in the existing regulations. Although the term is understood by the substance use disorder community, it is defined for clarity and is consistent with the definitions used for certification of counselors in Title 9, CCR Sections 13005(a)(2) and 13005(a)(8).

Subsection (b) - Paragraph (8)
The phrase "or in the postpartum period" has been amended. This is necessary to be consistent with the amended definition of "postpartum" under Subsection (b)(22).

Subsection (b) - Paragraph (10)
"Face-to-Face" is not defined in the existing regulations. This definition is necessary to clarify the meaning of the term as used in the regulations and to be consistent with "SPA 12-005, Supplement 3 to Attachment 3.1-A, Pages 3, 3a and Supplement 3 to Attachment 3.1-B, pages 1, 1a." The definition further specifies that this meeting shall occur at a certified facility in order to qualify as a reimbursable service. This is necessary since some providers have in the past billed for services at non-certified locations (i.e. hospital visits).

Subsection (b) - Paragraphs (11) and (12)
"Group counseling" and "individual counseling" are amended to require counseling be conducted in a confidential setting. When conducting PSPP reviews and targeted field reviews, the Department has observed counselors conducting two or more group counseling sessions in one open area. For group counseling sessions to be effective, it is necessary for them to be conducted in a confidential setting. Counselors recognize that trust is a cornerstone of the counseling relationship. Counselors aspire to earn the trust of clients by creating an ongoing partnership, establishing and upholding appropriate boundaries, and maintaining confidentiality. Participants in group counseling sessions establish trust with members of their group because they meet on a regular basis. Because of this trust they are able to make personal comments in the sessions. When participants' comments can be heard by members of other groups, participants may feel constrained from sharing and the sessions will likely be less

effective. Counselors should perform services in a confidential setting. (*See* "Scopes of Practice and Career Ladder for Substance Use Disorder Counseling," September 2011, pp 8-12, *at http://store.samhsa.gov/shin/content/PEP11-SCOPES/PEP11-SCOPES.pdf; See* "The American Counseling Association, 2014 ACA Code of Ethics," Section B.3.c. Page 7, at http://www.counseling.org/resources/aca-code-of-ethics.pdf). This amendment is necessary because the current practice fails to meet professionally recognized standards for substance use disorder counseling.

This amendment is also necessary because in some instances members of rival gangs have been included in different groups in the same room, which has created a safety risk to participants and facility staff.

Likewise, for individual counseling sessions to be effective, the sessions must also be conducted in a confidential setting. A beneficiary establishes a trusting relationship with their therapist or counselor that facilitates the sharing of personal information. If a beneficiary's comments can be overhead by others, the beneficiary may feel constrained from sharing and the session will likely be less effective. State and county PSPP reviewers and state investigators have observed individual counseling sessions conducted in non-confidential settings. This amendment is necessary because the current practice fails to meet professionally recognized standards for substance use disorder counseling. *(See* "Scopes of Practice and Career Ladder for Substance Use Disorder Counseling," September 2011, pp 8-12, at http://store.samhsa.gov/shin/content/PEP11-SCOPES/PEP11-SCOPES.pdf. (*See* "The American Counseling Association," 2014 ACA Code of Ethics," Section B.3.c. Page 7, at http://www.counseling.org/resources/aca-code-of-ethics.pdf).

Subsection (b) - Paragraph (11)

The existing regulations do not prevent minors from participating in group counseling sessions with adults. However, minors are at a different developmental stage than adults and lack the maturity, insight and life experience of adults. As a result, treatment approaches that are appropriate for adults may be inappropriate and ineffective for minors. Providers should utilize appropriate treatment approaches with minors, which are different than those for adults. (*See* "Age Appropriate Services for Youth" prepared by Elinore McCance-Katz MD, PhD) This amendment is necessary to ensure minors are not in group counseling sessions with adults. Such sessions may be ineffective for minors and fail to meet professionally recognized standards for substance use disorder counseling. Additionally, including minors and adults in the same counseling session creates an environment where minor participants could be taken advantage of by adult participants.

The exception for "students receiving treatment at a provider's certified school site" is necessary because some high school students receiving treatment are 18 years of age or older and the Department does not want to prevent them from receiving these services. Since these beneficiaries are still in high school, the treatment approaches used in the school based programs would be the most appropriate and effective for them.

Subsection (b) - Paragraph (11)(B)
This new paragraph is necessary to specify the number of participants allowable in group counseling for day care habilitative services. The existing regulations do not limit the number of participants. For a substance use disorder group counseling session to be effective there must be a limited number of participants. A study funded by the federal Substance Abuse and Mental Health Services Administration found that group sizes between eight and twelve are effective. (*See* Ingersoll, Wagner and Gharib (2002). P.54. "Motivational Groups for Community Substance Abuse Programs," Richmond, VA, Mid-Atlantic Addiction Technology Transfer Center*.)* In addition, Dr. Elinore McCance-Katz, MD, Chief Medical Officer, Substance Abuse and Mental Health Services Administration, also recommends a group size of eight to twelve. (*See* "Age Appropriate Services for Youth" prepared by Elinore McCance-Katz MD, PhD)

Other states have similar limitations on the number of participants in a session. Pennsylvania limits groups to no more than ten participants (55 Pa. Code Section 1223.2); Washington limits groups to no more than twelve participants (Washington Admin. Code 388-877B-0300 (c)); Ohio also limits groups to no more than twelve participants. (Ohio Admin. Code 3973:2-1-08 (O)).

Although it has been common practice for providers to give therapists and counselors discretion to determine the appropriate group size based on group dynamics, some providers have included up to forty participants in a counseling session. This amendment is necessary to prevent this practice, which falls below professionally recognized standards of care (as described above).

Based on the professional recommendations outlined above, the Department has determined that group counseling shall be conducted with no more than twelve participants. This amendment also requires a minimum of two participants in each counseling session to accommodate providers in rural counties that may only have two participants.

For outpatient drug free services and narcotic treatment programs, the number of participants allowed in group counseling sessions will continue to be four to ten as specified in Paragraph (11)(A); WIC Section 14021.6(d); Title 22, CCR Section 51516.1(a)(3)(A)3.; and Title 9, CCR Section 10345(b)(3)(B)).

Because these regulations apply to Medi-Cal beneficiaries, if even one participant in a group is a Medi-Cal beneficiary the size limit applies. The last clause, "only one of whom needs to be a Medi-Cal beneficiary" is necessary to make this clear. This provision is also consistent with Title 22, CCR Section 51516(a)(3)(A)3. and with WIC Section 14021.6(d).

Subsection (b) - Paragraph (12)
The sentence "Telephone contacts, home visits, and hospital visits shall not qualify as Medi-Cal reimbursable units of services" is removed because this information is included in the new definition of "face-to-face."

Subsection (b) - Paragraph (13)
The phrase “licensed to practice medicine in the state of California” is removed because it is no longer necessary since the definition of “physician” includes this requirement.

Subsection (b) - Paragraph (14)
The term “means” replaces the term “is” for consistency with the other definitions in Subsection (b).

Subsection (b) - Paragraph (21)
“Physician” is not defined in the existing regulations. This definition is necessary because only physicians licensed by the Medical Board of California or the Osteopathic Medical Board of California, are qualified to participate in the DMC program. This is consistent with the general Medi-Cal program practice that physicians be licensed with the Medical Board of California or the Osteopathic Medical Board of California.

Subsection (b) - Paragraph (22)
Amendments to the definition of “postpartum” are necessary to clarify that the term postpartum means a time period following the end of a beneficiary’s pregnancy rather than a class of eligible individuals. Deletion of the reference to Section 50262.3(a) is necessary because Sections 50260 and 50262.3 define the eligibility period differently and the definition in Section 50260 controls for purposes of this section.

Subsection (b) - Paragraph (24)
The term “legal” is removed for clarity.

Subsection (b) - Paragraph (25)
“Relapse” is not defined in the existing regulations. This definition is necessary to implement the requirements under Subsection (h)(6)(A) that a therapist or counselor complete a discharge plan for each beneficiary. This definition is based on the definition specified in the glossary of the Center for Substance Abuse Treatment. Addiction Counseling Competencies: “The Knowledge, Skills, and Attitudes of Professional Practice.” Technical Assistance Publication (TAP) Series 21, page 174. HHS Publication No. (SMA) 08-4171 at: http://store.samhsa.gov/shin/content//SMA12-4171/SMA12-4171.pdf.

Subsection (b) - Paragraph (26)
“Relapse trigger” is not defined in the existing regulations. This definition is necessary to implement the requirements under Subsection (h)(6)(A) that a therapist or counselor complete a discharge plan for each beneficiary.

Subsection (b) - Paragraph (28)
“Support plan” is not defined in the existing regulations. This definition is necessary to implement the requirements under Subsection (h)(6)(A) that a therapist or counselor complete a discharge plan for each beneficiary. This definition is added for clarity, is generally understood to have this meaning in the substance use disorder community and relates to sober social supports which assist individuals maintain sobriety both during and after formal treatment.

Subsection (b) - Paragraph (29)
"Therapist" is not defined in the existing regulations. Although the term is understood by the substance use disorder community, it is defined to specify which individuals can perform the role of a therapist, and is consistent with "SPA 12-005, Supplement 3 to Attachment 3.1-A, pages 5, 6 and Supplement 3 to Attachment 3.1-B, pages 3, 4."

Subsection (g)

Subsection (g) - Paragraphs (1), (1)(A) and (1)(B)
These amendments consolidate subsections (g) and (i), eliminate duplication and list all of the documents that providers must maintain in each beneficiary's individual patient record in one subsection. The documents are listed in Paragraphs (1)(A) and (1)(B) for clarity; Paragraph (1)(A) includes the requirements in existing Subsection (g)(1), with the exception of the addition of Paragraph (1)(A)(iii), which is discussed below. Paragraph (1)(B) lists required documentation related to treatment episodes, which were formerly in Subsections (g) and (i).

Paragraph (1) specifically replaces existing language "For purposes of this regulation,…..but not be limited to," with a more specific lead-in sentence to expanded Paragraphs (1)(A) and (1)(B), for purposes of clarity.

Subsection (g) - Paragraph (1)(A)(iii)
Providers may provide perinatal services, which are paid at higher rates, to pregnant women and women in their postpartum period. (*See* Subsections (c)(1) and (c)(2)) Some providers bill for perinatal services provided to women who are no longer eligible, which results in overpayments to the providers and unnecessary costs to the DMC program. Requiring providers to include documentation of each beneficiary's pregnancy and the last day of their pregnancy is necessary because it will allow the Department to audit claims for perinatal services to determine whether the services were provided during the beneficiary's postpartum period.

Subsection (g) - Paragraph (1)(B)(i)
This amendment is necessary to expressly specify that physical examination documentation shall be included in a beneficiary's individual patient record, when available.

Subsection (g) - Paragraph (1)(B)(iii)
This amendment is necessary to specify that documentation of minimum provider and beneficiary contact shall be included in a beneficiary's individual patient record. This provision was relocated from Subsection (i)(4).

Subsection (g) - Paragraph (1)(B)(ix)
This amendment is necessary to specify that a discharge plan shall be included in a beneficiary's individual patient record, to demonstrate that this service was provided.

Subsection (g) - Paragraph (1)(B)(xi)
This amendment is necessary to specify that documentation of compliance with Section 51490.1(b) shall be included in a beneficiary's individual patient record. This provision was relocated from Subsection (i)(9).

Subsection (g) - Paragraph (1)(B)(xiii)
This paragraph was relocated from Subsection (i)(7).

Subsection (g) - Paragraph (2) and (2)(A) – (E)
The purpose of the sign-in sheet provision is to require providers to document beneficiaries' attendance at group counseling sessions. Some providers have noted that the existing requirement is unclear. Additionally, Department auditors have received generic sign-in sheets from providers that do not clearly document beneficiary attendance at particular counseling sessions. These amendments are necessary to clarify the providers' obligations.

These additions are also necessary to ensure that the Department can verify that these sessions were conducted and billed for appropriately. The Department has found that some providers bill for more counseling sessions than a therapist and/or counselor could reasonably conduct in one day. Paragraphs (2)(A), (2)(B) and (2)(D) are necessary to enable the Department to determine whether a therapist or counselor conducted the number of sessions for which claims were submitted by tying the sign-in sheets to the counselors timesheets. The requirements under Paragraphs (2)(A) and (2)(E) to include a typed or legibly printed name, as well as the signature of the therapist or counselor and the beneficiaries, are necessary for identification and verification purposes.

Paragraph (2)(A) also indicates that the signature of the therapist and/or counselor on the sign-in sheet is a certification that the information included is accurate and complete. This provision is necessary to specify that the therapist and/or counselor is the party responsible for attesting to the information as provided on the sign-in sheet. This provision will also assist the Department in enforcing disallowances based on discrepancies in the records.

Some providers have participants sign the sign-in sheets in advance of the counseling session, which defeats the purpose of having the sign-in sheet as documentation of a beneficiary's actual attendance. The last sentence in Paragraph (E) is necessary to address this practice by requiring that participants sign in at the beginning of or during the counseling session. The provision that allows participants to sign in during the counseling session accommodates participants who may arrive late.

In addition, Paragraphs (2)(B), (2)(C) and (2)(E) are necessary to allow the Department to more effectively verify each beneficiary's attendance at counseling sessions by tying sign-in sheets to progress notes.

Subsection (h)

Subsection (h) - Paragraph (1)(A)
The phrase "the provider shall perform all of the following" is replaced with the phrase "each of the following requirements shall be met" for clarity because some of the listed requirements must be performed by a physician, rather than a "provider."

Subsection (h) - Paragraph (1)(A)(i)
This amendment adds a requirement that providers document their admission procedures. This is necessary so the Department can verify that the provider developed such procedures. This amendment also removes the requirement that providers develop admission criteria because it is not necessary since the regulations set forth the admission criteria.

Subsection (h) - Paragraph (1)(A)(ii)
The addition of the phrase "The provider shall" is necessary to clarify who is responsible for performing this function in light of the amendment to Paragraph (1)(A), removing reference to the provider.

Subsection (h) - Paragraph (1)(A)(iii)
This paragraph was revised and incorporates some provisions from the existing Paragraph (1)(A)(iii)(b). The existing Paragraph (1)(A)(iii)(b) does not require a physician to review a beneficiary's medical history and substance use history if the physician reviews documentation of a recent physical examination. This new paragraph requires a physician to review each beneficiary's personal, medical and substance use history regardless of whether the physician performs or reviews documentation of a beneficiary's physical examination. A physician must review these histories to determine whether a beneficiary has a substance use disorder and whether the services offered by the DMC program are appropriate for that beneficiary.

Subsection (h) - Paragraphs (1)(A)(iv), (1)(A)(iv)(a), (1)(A)(iv)(b) and (1)(A)(iv)(c)
Paragraph (1)(A)(iv) replaces Paragraph (1)(A)(iii)(a) and (b). The existing regulations require providers to perform a physical examination of each beneficiary or have the physician complete a waiver "specifying the basis for not requiring a physical examination," within thirty days of admission. This waiver option is being abused. Providers often do not perform physical examinations and provide no basis for the waiver, except for a general conclusion that the waiver is based on the physician's clinical judgment. In addition, stakeholders have advised the Department that it is cost prohibitive for many providers to perform physical examinations; many counties have too few qualified individuals to perform physical examinations of beneficiaries; and it often takes beneficiaries several months to obtain a physical examination, so the thirty day period is too short. In response to initial stakeholder input and because the waiver option was being abused, these provisions now eliminate the waiver option and have amended the physical examination requirement.

Paragraph (1)(A)(iv)(a) is added and Paragraph (1)(A)(iv)(b) is relocated from Subsection (h)(1)(A)(iii)(a) because ideally when a beneficiary is admitted to a

substance use disorder program a physician will either perform a physical examination of the beneficiary or review documentation of a recent physical examination. These assist physicians to determine whether a beneficiary has a health condition that puts the beneficiary at risk if put in a stressful situation, which might make a particular treatment modality inappropriate. Physical examinations also assist physicians to evaluate whether a beneficiary has a mental condition that will not allow the individual to benefit from treatment or indicate a different modality would be more appropriate. In addition, it is important for DMC program beneficiaries to receive a physical examination because many have significant untreated illnesses. (*See* "Prevalence, severity, and co-occurrence of chronic physical health problems of persons with serious mental illness." Psychiatr Serv. 2004 Nov; 55(11):1250-7, Abstract. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2759895/; and Han, B, Gfroerer, J, Rourke Batts, K, Colliver, J, "Co-occurrence of Selected Chronic Physical Conditions and Alcohol, Drug, or Mental Health Care Utilization among Persons Aged 18 to 64 in the United States." Center for Behavioral Health Statistics and Quality Data Review, March 2011. http://www.samhsa.gov/data/2k11/DR002ChronicConditions/ChronicConditions.pdf.)

However, as discussed above, some providers are unable to meet the existing requirements, so the physical examination at admission to the treatment program is optional.

Paragraph (1)(A)(iv)(a) provides that a physician shall review documentation of a beneficiary's physical examination if performed during the twelve month period prior to the beneficiary's admission to treatment date. This is necessary because physical examinations older than twelve months are significantly less helpful to a physician in assessing a beneficiary since the beneficiary's health condition can change during that time. The twelve month period is also consistent with the general practice of patients receiving annual physical examinations. The requirement that a physical examination be performed within thirty days in Paragraph (1)(A)(iv)(b) is in the existing regulations. The requirement that a provider describe in the beneficiary's individual patient record the efforts made to obtain documentation of the physical examination is necessary to enable the Department to enforce the documentation review requirement under this paragraph.

Paragraph (1)(A)(iv)(b) was relocated from Subsection (h)(1)(A)(iii)(a), and is an option in meeting the physical examination requirements specified under Paragraph (1)(A)(iv).

Paragraph (1)(A)(iv)(c) applies where a beneficiary has not had a physical examination in the prior twelve months or if a beneficiary has had a physical examination but the provider has not been able to obtain the documentation and the provider does not perform a physical examination during the intake process. By requiring a provider to include a goal of obtaining a physical examination in the beneficiary's treatment plan, this paragraph addresses stakeholder concerns regarding cost and timing while still requiring providers to attempt to have beneficiaries obtain a physical examination. In addition, once a beneficiary has obtained a physical examination, if the beneficiary has a significant untreated illness, obtaining treatment for that illness will become a treatment plan goal. (*See* Subsection (h)(2)(A)(i)(i)).

Subsection (h) - Paragraph (1)(A)(v)
This paragraph is re-worded and relocated from Subsection (h)(1)(D)(ii) for purposes of organizational clarity. The thirty day requirement is necessary to clarify that the physician must diagnose the beneficiary within thirty days of the beneficiary's admission to treatment date. The existing regulations require a physician to diagnose each beneficiary using a corresponding diagnostic code from the Diagnostic and Statistical Manual of Mental Disorders but do not expressly require the diagnosis be documented. Physicians often fail to adequately document the beneficiary's diagnosis. The last sentence was added to clarify and emphasize that the physician must document the basis for each beneficiary's diagnosis in the beneficiary's individual patient record. This provision is necessary so that the Department can audit provider compliance with the diagnosis requirement.

Subsection (h) - Paragraph (1)(A)(vi)
This paragraph combines the existing Subsections (h)(1)(A)(iii) and (h)(1)(D)(i). Subsection (h)(1)(D)(i) provides in part that the physician determine medical necessity based on "the physician's admission of each beneficiary pursuant to Subsection (h)(1)." Subsection (h)(1)(A)(iii) requires the assessment of each beneficiary's physical condition within thirty days of admission to treatment. This reorganization is necessary for clarity.

Subsection (h) - Paragraph (1)(B)
The phrase "for each beneficiary" is necessary for purposes of clarity and to specify that the provider or physician shall comply with all of the provisions under this paragraph for every beneficiary.

Subsection (h) - Paragraph (1)(B)(ii)
The term "the" is included for accurate grammar.

Subsection (h) - Paragraph (1)(B)(iii)
The term "the" is included for accurate grammar and for sentence flow due to the addition of the term "beneficiary."

Subsection (h) - Paragraphs (1)(D) and (1)(D)(i)
This paragraph is removed and the requirement that a physician establish medical necessity is added to Subsections (h)(1)(A)(vi), (h)(2)(A)(ii)(c), (h)(2)(A)(iii)(c) and (h)(5)(A)(ii). This is a clarifying, non-substantive change.

Subsection (h) - Paragraph (1)(D)(ii)
This paragraph is moved to Subsection (h)(1)(A)(v) and re-worded for purposes of organizational clarity. *See* Subsection (h)(1)(A)(v) for further discussion.

Subsection (h) - Paragraph (2)(A)
The term "each" is added to the first line and the term "initial" is added to the third line for consistency and clarity. The requirement that the provider attempt to engage each beneficiary to participate in preparation of the beneficiary's treatment plans is necessary because if a beneficiary participates their treatment will likely be more effective.

And, failure to attempt to engage beneficiaries is below professionally recognized standards in the substance use disorder community. (*See* Adams, Neal and Grieder, Diane M., "Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery," Chapter 2, pp. 20-22, 2005; and Elsevier Academic Press; "Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders, Improving the Quality of Health Care for Mental and Substance Use Conditions," Chapter 3, p. 78, 2006, The National Academies Press) Because some beneficiaries will refuse to participate, providers are only required to attempt to engage beneficiaries.

Subsection (h) - Paragraph (2)(A)(i)
The phrase "and updated treatment plans" is added to clarify that all of these components need to be included in updated treatment plans also. This change is necessary because some providers do not include all components in updated treatment plans.

Subsection (h) - Paragraph (2)(A)(i)(g)
The existing regulations require a physician to diagnose each beneficiary but do not expressly state the requirement that the diagnosis be documented. This provision is necessary so that the Department can audit provider compliance with the diagnosis requirement. The diagnosis is to be included in treatment plans. It is logical to include the diagnosis in the treatment plans because the treatment plans are partly based on the beneficiary's diagnosis.

Subsection (h) - Paragraph (2)(A)(i)(h)
This provision is necessary to implement the requirement in Paragraph (1)(A)(iv)(c). See discussion of Paragraph (1)(A)(iv) above for the necessity of this requirement.

Subsection (h) - Paragraph (2)(A)(i)(i)
Department personnel performing PSPP reviews have noted that in some instances beneficiaries have a significant untreated medical illness. Failure of beneficiaries to timely obtain treatment can lead to more significant medical conditions and more costly and avoidable treatments.

Subsection (h) - Paragraphs (2)(A)(ii)(a), (2)(A)(ii)(c), (2)(A)(iii)(a), (2)(A)(iii)(c), (3)(A), (3)(B) and (6)(A)(iii)
These paragraphs require beneficiaries, counselors, therapists and physicians to type or legibly print their name and date initial and updated treatment plans, progress notes and discharge plans. Department auditors and investigators have difficulty reading the signatures on provider records. As a result it is difficult to identify the person, such as a physician, who signed the document. In addition, provider records are often not dated. The illegible signatures and absence of a date make it more difficult for the Department to effectively audit providers. This amendment is necessary to address this problem.

Subsection (h) - Paragraph (2)(A)(ii)(a)
Some physicians sign blank treatment plans, which provider staff later fill out and date. The requirement that physicians sign and date treatment plans is necessary to deter providers and physicians from engaging in this practice.

Subsection (h) - Paragraphs (2)(A)(ii)(b) and (2)(A)(iii)(b)
Providers bill for individual counseling sessions to prepare treatment plans and updated treatment plans. Existing regulations do not require a beneficiary to approve and sign treatment plans. It is difficult for the Department to verify if a treatment planning counseling session was held. This addition is necessary because it provides the Department with an additional means of verifying that a treatment planning counseling session was held.

This addition is also necessary because it will assist the Department to audit providers for compliance with the requirement that they attempt to engage beneficiaries in preparation of their treatment plans.

The requirement that the provider document the reason for the beneficiary's refusal to sign a treatment plan is necessary because otherwise providers could routinely not attempt to engage beneficiaries in preparing their treatment plans and the Department would be unable to enforce the requirement.

A beneficiary's refusal to sign their treatment plan to indicate whether they participated in its preparation is an indication that the beneficiary does not agree with the treatment plan and may be less likely to fully participate in treatment. If a beneficiary is unwilling to fully participate, the treatment will likely be less effective. Requiring providers to devise a strategy to engage such beneficiaries is necessary to ensure that providers attempt to engage such beneficiaries to participate in their treatment.

Subsection (h) - Paragraphs (2)(A)(ii)(c) and (2)(A)(iii)(c)
This amendment is necessary to clarify that in approving initial treatment plans and updated treatment plans the physician is making a determination that the services are medically necessary for the beneficiary. This requirement is stated in Paragraph (1)(D)(i) in the existing regulations.

Additionally under Paragraph (2)(A)(iii)(c), the phrase "the physician shall review…..plans" is relocated to the beginning of this paragraph.

Subsection (h) - Paragraph (2)(A)(iii)(a)
The term "complete" is added for consistency with Paragraph (2)(A)(ii)(a).

Subsection (h) - Paragraph (2)(B)
This amendment is necessary to clarify that the requirements in Title 9, CCR Section 10305 apply to the initial and updated treatment plans.

Subsection (h) - Paragraph (3)(A)
The existing regulations do not specify when or how soon after a counseling session that a therapist or counselor must prepare progress notes or that the therapist or counselor who conducted the counseling session must prepare the progress note.

Department personnel have encountered providers who prepare generic progress notes in response to a request while the auditors are on site. These notes are often prepared

by someone other than the therapist or counselor who conducted the corresponding session and do not reflect the progress of the beneficiaries. Because of the omissions in the regulations, the Department could not sanction the providers for not timely preparing the notes or because the notes are inaccurate. In addition, the lack of progress notes for a counseling session makes it difficult for the Department to verify whether the corresponding counseling session occurred.

This amendment is necessary because it will allow auditors to enforce the requirement that the therapist or counselor who conducts a counseling session timely prepare a corresponding progress note. It will also assist the Department to determine whether the corresponding counseling session occurred. The Department considered requiring therapists and counselors to complete the progress notes on the same day as the corresponding session, but decided that seven days was a more reasonable timeframe.

Subsection (h) - Paragraph (3)(A)(i)
The requirement that progress notes indicate the topic of the corresponding counseling session is necessary to enable the Department to more readily verify that the counseling session occurred.

Subsection (h) - Paragraph (3)(A)(iii)
The requirement that therapists and counselors record the start and end times of counseling sessions as opposed to the duration in minutes of the sessions, in progress notes, is necessary to enable the Department to determine whether a therapist or counselor conducted the number of sessions for which claims were submitted, by tying the progress notes to the counselor timesheets.

The phrase “(month, day, year)” is removed for consistency throughout the regulations and because “date” is a commonly understood term.

The term “and” replaces the term “or” for clarity.

Subsection (h) - Paragraph (3)(B)
Existing regulations do not specify when therapists and counselors must prepare the weekly progress notes. Department personnel have encountered providers who prepare generic progress notes in response to a request while the auditors are on site. These notes are often prepared by someone other than the therapist or counselor who conducted the corresponding activities and do not reflect the progress of the beneficiary. Because of the omissions in the existing regulations, the Department could not sanction the providers for not timely preparing the notes or because the notes are inaccurate.

This amendment is necessary because it will allow auditors to enforce the requirement that therapists and counselors timely prepare a weekly progress note for each beneficiary. The Department decided to require the progress note be prepared by the end of the following week to give providers flexibility and to be consistent with the requirement for outpatient drug free progress notes (Paragraph (3)(A)).

Subsection (h) - Paragraph (3)(B)(i)
The contents of this paragraph are relocated and amended in Paragraph (3)(B) above.

Subsection (h) - Paragraph (3)(B)(ii)
The requirement that therapists and counselors record the start and end times of counseling sessions as opposed to the duration of the sessions, in progress notes, is necessary to enable the Department to determine whether a therapist or counselor conducted the number of sessions for which claims were submitted by tying the progress notes to the counselor timesheets.

The phrase "(month, day, year)" is removed for consistency throughout the regulations and because "date" is a commonly understood term.

Subsection (h) - Paragraph (4)(A)
This amendment replaces the term "provider" with the term "physician." This amendment is necessary to clarify that a physician, rather than the "provider," must determine whether fewer than two counseling sessions per thirty day period are clinically appropriate for a beneficiary. This amendment is also consistent with the "SPA 12-005, Supplement 3 to Attachment 3.1-A, Page 3. and Supplement 3 to Attachment 3.1-B, page 1," since the treatment plan, which includes the number of counseling sessions, shall be approved by the physician.

The phrase "either of the following apply" is added and the term "and" is removed. This amendment allows a beneficiary to receive fewer than two counseling sessions if either condition is met. This amendment is necessary because there may be instances when it is clinically appropriate for a beneficiary to receive fewer than two counseling sessions even when the beneficiary is not making progress in reaching his or her treatment plan goals. This amendment is also necessary since under the existing regulations, the provider may provide and bill for counseling sessions that are not medically necessary.

Subsection (h) - Paragraph (5)(A)(i)
These changes are non-substantive. The phrase "For each beneficiary" is added to clarify that this requirement applies to all beneficiaries. The addition of the term "after" following six months is to correct an apparent typographical mistake. The phrase "progress and eligibility of the beneficiary" was re-worded to "beneficiary's progress and eligibility" for consistency within the regulations. The addition of the requirement that the counselor or therapist make a recommendation of whether the beneficiary should continue to receive services is a clarifying amendment. It is currently understood by providers and can be inferred from existing Paragraph (5)(A)(ii).

Subsection (h) - Paragraph (5)(A)(ii)
Under the existing regulations, the physician only determines whether a beneficiary needs to continue treatment (based on medical necessity) if the beneficiary's therapist or counselor recommends further treatment. This amendment requires the physician to determine whether continued services are medically necessary regardless of the therapist or counselor's recommendation. This amendment is necessary because under the existing regulations when a therapist or counselor does not recommend a beneficiary continue to receive services the therapist or counselor is effectively

determining that continued services for that beneficiary are not medically necessary and they are not licensed to make that determination.

The timing of the physician's review of each beneficiary is added for clarity. The requirement that the physician determine whether continued services are medically necessary is moved from Paragraph (1)(D)(i).

The last sentence of Paragraph (5)(A)(ii) requires the physician to document their determination of medical necessity in each beneficiary's individual patient record. The necessity of this requirement is discussed in Paragraph (5)(A)(ii)(a) below.

Subsection (h) - Paragraphs (5)(A)(ii)(a), (5)(A)(ii)(b), (5)(A)(ii)(c), (5)(A)(ii)(d) and (5)(A)(ii)(e)

The existing regulations require physicians to document the justification for each beneficiary continuing to receive services. (*See* existing Subsection (i)(5)) In spite of this requirement, the Department has found that some beneficiary's individual patient records include a standard statement on a template that indicates the beneficiary meets the medical necessity requirement, but it contains no evidence that a physician actually assessed whether continued treatment is medically necessary for the beneficiary. The absence of documentation to justify medical necessity is particularly prevalent where a provider provides services pursuant to a court order that requires a set period of treatment, e.g. 18 months, and in school based programs that are for set periods, e.g. a school year. As a result many beneficiaries appear to have been receiving services for a period of time after the services were no longer necessary.

The express requirement that a physician document the determination of medical necessity and that provisions (a) - (e) have been considered, are necessary to enable the Department to enforce this requirement. This requirement should reduce the instances of beneficiaries receiving unnecessary services.

Under existing regulations a physician is required to consider the beneficiary's prognosis and the therapist's or counselor's recommendation in determining whether continued services are medically necessary for a beneficiary (*See* existing Subsections (h)(5)(A)(ii)(b), (h)(5)(A)(ii)(c) and (h)(1)(D)(i)). This amendment requires physicians to also consider provisions (a), (b) and (c). This amendment is necessary because a physician cannot make a determination that continued services are medically necessary without reviewing these records. The provisions (d) and (e) were relocated from former Paragraphs (5)(A)(ii)(c) and (b) respectively and re-worded for clarity and to be consistent with the revisions to Paragraph (h)(5)(A)(i).

Subsection (h) - Paragraph (5)(A)(iii)

This paragraph was re-worded for clarity.

Subsection (h) - Paragraph (6)(A)

Providers can bill for individual counseling sessions to prepare and plan for a beneficiary's discharge from treatment. But, the existing regulations do not require providers to prepare a discharge plan, only a discharge summary, and Department auditors have noted some providers bill for discharge planning sessions that did not

occur. In other instances, providers bill for individual discharge planning counseling sessions when the counseling session is in fact not for the purpose of discharge planning, but rather an unauthorized purpose. (Individual counseling is allowed for intake, crisis intervention, collateral services, treatment planning, and discharge planning only.) Because existing regulations do not require providers to prepare a discharge plan, Department auditors cannot verify that a provider conducted discharge planning counseling as billed. As a result, it is necessary to require providers to prepare a discharge plan for each beneficiary. In addition, preparation of discharge plans are a standard of care in the substance use disorder community for the reasons cited in Paragraph (6)(A)(ii), below.

Because it is common for providers to lose contact with a beneficiary prior to a planned discharge, providers are not required to prepare a discharge plan for those beneficiaries.

Subsection (h) - Paragraphs (6)(A)(i) and (6)(A)(i)(a) – (b)
The purpose of a discharge plan is to assist a beneficiary maintain sobriety. The purpose of Paragraph (6)(A)(i)(a) is to assist beneficiaries to avoid relapsing when faced with relapse triggers. The purpose of Paragraph (6)(A)(i)(b) is to plan in advance where the beneficiary will obtain support in avoiding a relapse. The contents are standard in the substance use disorder field and consistent with standards of care in the substance use disorder community. *(See* Baron. M., Erlenbusch, B., Moran, C., O'Connor, K., Rice, K., Rodriguez, J., "Best Practices Manual for Discharge Planning: Mental Health & Substance Abuse Facilities, Hospitals, Foster Care, Prisons and Jails," pgs. 14 and 16-18, August 2008)

Subsection (h) - Paragraphs (6)(A) and (6)(A)(ii)
This amendment is necessary to specify when providers are to prepare a beneficiary's discharge plan. A beneficiary should be prepared to be discharged during the thirty day period prior to the beneficiary's last treatment. The thirty day timeframe is established to allow for adequate time for the therapist or counselor to discuss the discharge plan with the beneficiary during a face-to-face session(s) and to coordinate outside resources, including family, to establish a support system. A carefully developed discharge plan, produced in collaboration with the beneficiary, will identify and match beneficiary needs with community resources, providing the beneficiary with the support needed to sustain the progress achieved during treatment. A discharge plan will also minimize the likelihood that the beneficiary will "relapse" or have to return to care post successful completion of treatment, prevent a vulnerable beneficiary from becoming homeless and/or criminalized, and assist a beneficiary with re-entry to the community. Lack of discharge planning can cause an interruption in the care of a beneficiary, which is one of the most significant obstacles to establishing a stable recovery. (*See* Baron. M., Erlenbusch, B., Moran, C., O'Connor, K., Rice, K., Rodriguez, J., "Best Practices Manual for Discharge Planning: Mental Health & Substance Abuse Facilities, Hospitals, Foster Care, Prisons and Jails," pgs. 14 and 18-20, August 2008)

Subsection (h) - Paragraph (6)(A)(iii)
The discharge plan should result from individual discharge planning counseling sessions and reflect input from the beneficiary. The requirement that the therapist or

counselor and beneficiary sign the discharge plan is necessary because it will assist Department auditors in verifying that a provider conducted discharge planning sessions, as billed. Additionally, a provider must give the beneficiary a copy of the discharge plan for review and reference.

Subsection (h) - Paragraph (6)(B)
The primary purpose of a discharge summary is to document that a beneficiary is no longer in treatment. It is not necessary for a provider to prepare a discharge summary for a beneficiary who has a discharge plan, since the discharge plan also indicates the beneficiary is no longer in treatment. This amendment is necessary to clarify that a provider is only required to prepare, for a beneficiary, either a discharge plan or a discharge summary.

Subsection (h) - Paragraph (6)(B)(i)
The addition of the term “providers” is a clarifying, non-substantive amendment.

Subsection (i)

Subsections (i) and (i)(1) – (9)
The amendments under Subsection (i) are necessary to specify that the requirements apply for each beneficiary. An amendment has also been included to clearly specify the parties that are involved in the face-to-face contact. The sentence “In addition…contact” was relocated from Subsection (i)(8), because the records it describes do not need to be in individual patient records.

As a non-substantive amendment, Subsection (i)(1) through (9) is moved/consolidated into Subsection (g). This consolidation also eliminates existing duplication between these two subsections and clearly lists all of the documents that providers must maintain in each beneficiary’s individual patient record in one convenient location. The paragraphs are relocated as specified below:

- Paragraph (1) is relocated to Subsection (g)(1)(B)(i);
- Paragraph (2) is relocated to Subsection (g)(1)(B)(ii);
- Paragraph (3) is relocated to Subsection (g)(1)(B)(iv);
- Paragraph (4) is relocated to Subsection (g)(1)(B)(iii);
- Paragraph (5) is relocated to Subsection (g)(1)(B)(v);
- Paragraph (6) is relocated to Subsection (g)(1)(B)(x);
- Paragraph (7) is relocated to Subsection (g)(1)(B)(xiii);
- Paragraph (8) is relocated to Subsection (i); and
- Paragraph (9) is relocated to Subsection (g)(1)(B)(xi).

Subsection (j)

Subsection (j)(4)
The phrase “either of” is added for purposes of clarity, to specify that either Paragraph (4)(A) or (4)(B) would apply.

Subsection (k)

Subsection (k)(2)
The phrase "published by the American Psychiatric Association" is added for consistency with other references to this manual throughout the regulations.

The cross reference to the area of the regulations related to medical necessity has been updated to the correct subsection (Subsection (h)(1)(A)(vi)).

Subsection (l)

This amendment specifies when records shall be accepted by the Department. In an effort to prevent fraud (fabrication of documents), the Department shall only accept records provided to Department personnel, while they are on the provider's premises during the review. Records will not be considered after the on-site inspection. The amendments also more clearly link this subsection to Subsections (k) and (m) related to PSPP reviews and recovery of payments.

Subsection (m)

Subsection (m)(1)(C)
This is a clarifying amendment that makes provider violations of requirements in subsections (b), (c), (d), (g), (h) and (i) a basis for the Department to recover overpayments.

- Addition of Subsections (b), (c) and (d): This amendment is necessary to clarify that the Department can recover overpayments for a provider's failure to comply with the requirements for Drug Medi-Cal substance use disorder services in these subsections.
- Addition of Subsection (g): This amendment is necessary to provide the Department with a means to enforce provider requirements. This amendment clarifies that a provider's failure to meet these requirements including the documentation requirement to substantiate a woman's pregnancy and note the last day of pregnancy and the new sign-in sheet requirements shall constitute a basis for the Department to recover overpayments.
- Addition of all of Subsection (h): Existing regulation provides that the Department shall recover overpayments if the provider fails to comply with portions of Subsection (h). Subsection (h) sets forth conditions for a provider to receive reimbursement from the DMC program. Therefore, failure to meet any of the provisions under Subsection (h) is a basis for the Department to recover overpayments. This amendment clarifies that discrepancy and the Department's authority to recover overpayments for violation of the requirements as proposed through this regulatory action.
- Addition of Subsection (i): This amendment is necessary to clarify that a provider's failure to maintain documentation as specified in Subsection (i) shall constitute a basis for the Department to recover overpayments.

Subsections (m)(2)(A) and (m)(2)(B)
Paragraph (2)(A) is removed because Subsection (m)(1)(C) now covers all requirements under Subsection (h). Paragraph (2)(B) also includes non-substantive grammatical and re-designation changes.

Subsections (m)(4), (m)(5), (m)(6) and (m)(7)
The phrase “The provider” is replaced with “For all providers who” for consistent use of this phrase throughout these paragraphs under Subsection (m).

Also under Paragraph (5) the phrase “as specified in” is included for consistent use of this phrase under this paragraph and under Paragraph (6).

Under Paragraphs (5) and (6), cross references are updated to coincide with other amendments. Additionally, the reference to “outpatient drug free treatment services” is included because this is another area related to group counseling that was missing from this paragraph.

Subsection (p)

Subsections (p) and (p)(1)
Non-substantive amendments include adding the terms “each” and “the,” changing the terms “beneficiaries” to “beneficiary”’ and “their” to “the,” and removing the term “all,” for consistent use of the term “beneficiary” throughout the regulations.

Subsection (q)

Subsections (q) and (q)(1)(A)(ii)
The references to the appeals being “handled pursuant to Section 51015” and the initial appeal letter being “submitted in accordance with Section 51015” are removed because they are not applicable. Title 22, CCR Section 51015 sets forth an appeals process that is to be conducted by a fiscal intermediary. DMC program claims are processed by the Short-Doyle claiming system, which is run by the Department, not a fiscal intermediary. There is no fiscal intermediary in regard to DMC program claims.

Inclusion of this reference could result in a provider having no second level appeal because there is no fiscal intermediary and based on the reference, the Office of Administrative Hearings and Appeals could be determined to lack jurisdiction over the appeal. The lack of a second level appeal could indirectly interfere with the Department’s enforcement efforts.

51341.1 Repeating Non-substantive changes

Capitalization, grammar and punctuation amendments are included throughout the section for clarity and to incorporate proposed amendments.

Paragraphs were re-designated where appropriate to incorporate proposed amendments.

The phrase "of this regulation" is removed for consistency throughout the regulations and because it is not necessary since the subsections referenced are clearly under Section 51341.1.

Phrases such as "all of the following," "all of…," "meets all of the following conditions," "do all of the following," and "shall include all of the following" are added throughout the regulations to clarify that all of the conditions listed in each paragraph must be met.

The phrase "Therapist or" has been added throughout the regulations wherever "counselor" appears, to specify that either a counselor or a therapist can provide the service.

The term "beneficiaries" is replaced with the term "beneficiary" for consistency throughout the regulations.

The cross references to section 51490.1(d) have been corrected to 51490.1(b).

DOCUMENTS RELIED UPON

1. "DHCS Tightens Oversight of Drug Medi-Cal Centers," News Release, July 18, 2013, available at: http://www.dhcs.ca.gov/formsandpubs/publications/opa/Documents/2013/13-07DHCS-DMC7-18-13.pdf.
2. "Drug Medi-Cal Program Limited Scope Review," November 2013, available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/DMCLtdScopeRvw.pdf.
3. "Implementation Plan for Drug Medi-Cal Program Limited Scope Review," available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/ImpPlanforAuditRecom.pdf.
4. California State Plan Amendment (SPA 12-005), available at http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Recent%20State%20Plan%20Amendment%2012-005.pdf.
    - Supplement 3 to Attachment 3.1-A, pages 3, 3a
    - Supplement 3 to Attachment 3.1-A, pages 5, 6
    - Supplement 3 to Attachment 3.1-B, pages 1, 1a
    - Supplement 3 to Attachment 3.1-B, pages 3, 4
5. California State Plan Amendment (SPA 11-037b) http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Recent%20Amendment%20SPA%2011-037b.pdf.
6. "Scopes of Practice & Career Ladder for Substance Use Disorder Counseling," September 2011, pp 8-12, available at: http://store.samhsa.gov/shin/content/PEP11-SCOPES/PEP11-SCOPES.pdf.

7. "The American Counseling Association, 2014 ACA Code of Ethics," Section B.3.c, page 7, at http://www.counseling.org/resources/aca-code-of-ethics.pdf.
8. Elinore McCance-Katz, MD, Ph.d., Chief Medical Officer, Substance Abuse and Mental Health Services Administration, "Age Appropriate Services for Youth."
9. Ingersoll, Wagner and Gharib (2002). P.54. "Motivational Groups for Community Substance Abuse Programs," Richmond, VA, Mid-Atlantic Addiction Technology Transfer Center. http://people.uncw.edu/ogler/MI%20Groups%20for%20Com%20SA%20Prog.pdf.
10. Center for Substance Abuse Treatment. "Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice." Technical Assistance Publication (TAP) Series 21, page 174. HHS Publication No. (SMA) 08-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006. http://store.samhsa.gov/shin/content//SMA12-4171/SMA12-4171.pdf.
11. Adams, Neal and Grieder, Diane M., "Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery," Chapter 2, pp. 20-22, 2005.
12. Elsevier Academic Press; Institute of Medicine Committee on Crossing the Quality Chasm: "Adaptation to Mental Health and Addictive Disorders, Improving the Quality of Health Care for Mental and Substance Use Conditions," Chapter 3, p. 78, 2006, The National Academies Press.
13. Baron. M, Erlenbusch, B, Moran, C, O'Connor, K, Rice, K, Rodriguez, J, "Best Practices Manual for Discharge Planning: Mental Health & Substance Abuse Facilities, Hospitals, Foster Care, Prisons and Jails," pages 14 and 16-20, August 2008.
14. Danson R. Jones, Ph.D.; Cathaleene Macias, Ph.D.; Paul J. Barreira, M.D.; William H. Fisher, Ph.D.; William A. Hargreaves, Ph.D.; Courtenay M. Harding, Ph.D., "Prevalence, severity, and co-occurrence of chronic physical health problems of persons with serious mental illness." Psychiatr Serv. 2004 Nov; 55(11):1250-7, Abstract. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2759895/.
15. Han, B, Gfroerer, J, Rourke Batts, K, Colliver, J, "Co-occurrence of Selected Chronic Physical Conditions and Alcohol, Drug, or Mental Health Care Utilization among Persons Aged 18 to 64 in the United States." Center for Behavioral Health Statistics and Quality Data Review, March 2011. http://www.samhsa.gov/data/2k11/DR002ChronicConditions/ChronicConditions.pdf.
16. Summary of Initial Stakeholder Comments to the Department (March 2014).

STATEMENTS OF DETERMINATION

ALTERNATIVES CONSIDERED

The Department has determined that no reasonable alternative considered by the Department or that has otherwise been identified and brought to the attention of the Department would be more effective in carrying out the purpose for which this regulatory action was taken, would be as effective and less burdensome to affected private persons than the regulatory action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

Existing regulations related to the DMC program (substance use disorder services) are located in Section 51341.1. Using this regulatory proposal to make amendments to existing requirements and standards of the DMC program is the most effective and convenient way to provide (current/updated) information directly to those impacted (providers, physicians, beneficiaries).

This regulatory action is necessary pursuant to WIC Section 14124.26, which requires the Department to adopt emergency regulations. This action also implements WIC Section 14124.24, which requires the Department administer delivery of specified substance use disorder services. Additionally, this action is necessary to implement WIC Section 14043.75, by taking steps to prevent fraud and abuse related to substance use disorder services, under the Medi-Cal program. Specifically, this regulatory action will address abusive and fraudulent practices as identified in the targeted field reviews and PSPP reviews conducted by the Department, and will remove ambiguities from the existing regulations that have inhibited Department enforcement efforts in the past.

LOCAL MANDATE DETERMINATION

The Department has determined that the proposed regulations would not impose a mandate on local agencies or school districts, nor are there any costs for which reimbursement is required by Part 7 (commencing with Section 17500) of Division 4 of the Government Code.

County participation in the DMC program is voluntary, and currently not all counties offer the five DMC services: day care habilitative therapy, residential-based therapy, narcotic treatment therapy, and counseling in both an individual and group setting. The proposed amendments limit the number of participants allowed in a group counseling session for day care habilitative service, to twelve. No county-operated provider has billed in excess of the proposed group size of 12, so the proposed amendments will not have an economic impact on counties.

ECONOMIC IMPACT ANALYSIS/ASSESSMENT

The Department has made the determination that the regulations would not have a significant statewide adverse economic impact directly affecting businesses, including the ability of California businesses to compete with businesses in other states.

The Department has determined that the regulations would not significantly affect the following:

- The creation or elimination of jobs within the State of California.
- The creation of new businesses or the elimination of existing businesses within the State of California.
- The expansion of businesses currently doing business within the State of California.

Impact on Jobs and Businesses

This regulatory action will impact providers who choose to participate in the DMC program, providing substance use disorder services to Medi-Cal beneficiaries.

The Department has made the determination that the requirements related to group size for the day care habilitative service as proposed to be amended through these regulations will impact providers. In Fiscal Year 2011-2012, 79 providers billed for day care habilitative services. Of these 79, only 9 report a group size that exceeds the proposed limit of 12.

These 9 providers are likely to hire additional counselors to satisfy the new requirement and on average would have to absorb approximately $36,037 per year to continue offering day care habilitative services at the same capacity as before the reduction in group size. However, these additional costs are not anticipated to have a significant impact on the creation or elimination of jobs, the creation of new businesses, the elimination of existing businesses or the expansion of businesses in California.

County participation in the DMC program is voluntary, and currently not all counties offer the five DMC services: day care habilitative therapy, residential-based therapy, narcotic treatment therapy, and counseling in both an individual and group setting. Of the 79 providers of day care habilitative services, only 3 are county operated: Fresno, Humboldt, and Shasta. None of these counties have billed for group counseling services with more than 12 participants, so the proposed regulatory amendments will not have an economic impact on counties.

Benefits of the Proposed Regulation

The Department has determined that the regulations will not specifically affect worker safety or the state's environment. However, the regulations will benefit DMC providers through the provision of clear and comprehensive requirements for participation. This in turn will benefit the health and welfare of California residents by providing Medi-Cal beneficiaries the delivery of medically necessary and effective substance use disorder services that are provided under enhanced physician oversight. This regulatory

proposal ensures the proper and efficient administration of the Medi-Cal program, in accordance with federal and state laws. This is accomplished by improvements in the fiscal integrity of the DMC program through enhanced provider accountability and the Department's ability to enforce specific regulatory requirements.

EFFECT ON SMALL BUSINESSES

The Department has determined that the regulations would only affect small businesses that choose to provide substance use disorder services to Medi-Cal beneficiaries.

HOUSING COSTS DETERMINATION

The Department has made the determination that the regulations would have no impact on housing costs.