MID-POINT ASSESSMENT

Drug Medi-Cal Organized Delivery System
Part of the California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration Waiver

Prepared for the California Department of Health Care Services
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Table of Contents

General Background Information

The Drug Medi-Cal Organized Delivery System 1115 demonstration Project (DMC-ODS) was created by the California Department of Health Care Services (DHCS) to provide a continuum of care for substance use disorder (SUD) treatment services, more local control and accountability, greater administrative oversight, utilization controls to improve care and efficient use of resources, implementation of evidence-based treatment practices, and coordination with other systems of care (DHCS, 2024a). Prior to DMC-ODS, the system was comprised of fragmented services which created gaps that undermined client access and quality of care. The continuum of substance use disorder services was also uncoordinated, making it difficult for clients to navigate care before DMC-ODS (and currently outside of DMC-ODS counties). SUD treatment providers indicated that many important services they provided or wished to provide for clients were not billable. Further, the services were only reimbursable if delivered by a limited number of provider types, or they were too limited to provide proper care to clients. Additionally, providers were not required to deliver evidence-based practices in line with current research, and counties lacked the authority to fully ensure the quality and accountability of their local providers. As of November 2024, 39 of California's 58 counties had gone live with services under DMC-ODS, while the remainder maintained their status quo under the existing California Medicaid State Plan (Drug Medi-Cal State plan).

DMC-ODS was created to test the impact of organizing SUD services to improve care for Medicaid-eligible individuals with SUDs. The goal was to demonstrate that organized SUD care improves quality, access, coordination, and integration of treatment for beneficiaries while decreasing other health care system costs. Under DMC-ODS, care is organized according to the American Society of Addiction Medicine (ASAM) Criteria for SUD services. The ASAM Criteria are a set of guidelines developed to set a standard for assessment, placement, and treatment planning of clients with SUD and co-occurring disorders, as well as to a set standard for the provision of SUD treatment. DMC-ODS also supports a continuum of SUD care for beneficiaries, supports local control of the SUD care continuum, and creates requirements for accountability, and greater administrative oversight.

The DMC-ODS demonstration project was originally approved by the Centers for Medicare and Medicaid Services (CMS) in August 2015 as an amendment to California's

Bridge To Reform Demonstration, later became part of California's Medi-Cal 2020 waiver, and is now part of California Advancing and Innovating Medi-Cal (CalAIM), which is being implemented through a combination of 1115 and 1915b waivers starting January 1, 2022, and continuing through December 31, 2026. Most services that were part of the original DMC-ODS program are now covered in the Drug Medi-Cal State Plan, which makes these benefits available to all counties statewide. The present evaluation regards DMC-ODS counties under CalAIM as an extension of the DMC-ODS demonstration under Medi-Cal 2020 and thus will continue to evaluate the impact of DMC-ODS since its inception, including all services that were subsequently added to the DMC State Plan.

The population of focus for the ongoing DMC-ODS is Medicaid-eligible individuals with SUDs. As described in the CalAIM DMC-ODS Special Terms and Conditions (STCs) (CMS, 2021a), beneficiaries must meet the medical necessity criteria and reside in a DMC-ODS participating county to receive DMC-ODS services. Currently, the DMC-ODS program is implemented in 39 counties that cover 96.1 percent1 of California's population. As non-participating counties continue to opt in to DMC-ODS during the CalAIM demonstration, they will also become part of the DMC-ODS population for evaluation purposes.

To address the rapid rise in stimulant overdoses, DMC-ODS also covers Contingency Management (CM) under a new pilot program known as the Recovery Incentives Program: California's Contingency Management Benefit, which was implemented in March 2023. Stimulant-related overdose death rates in California are 7.2 times higher than they were ten years ago, putting stimulants on par with opioids in terms of total overdose-related deaths (California Overdose Surveillance Dashboard, 2024). Methamphetamine use is also associated with hypertension, myocardial infarction, stroke, aortic dissection, and heart failure (Manja et al., 2023). Currently, no Food and Drug Administration (FDA) approved medications exist for the treatment of Stimulant Use Disorders (StimUD), but studies have repeatedly supported the use of CM as a highly effective evidence-based practice in the treatment of StimUD, particularly in reducing drug use (De Crescenzo et al., 2018; Farrell et al., 2019; AshaRani et al., 2020; Brown & DeFulio, 2020; Ronsley et al., 2020). County participation in the Recovery Incentives Program is optional for DMC-ODS counties.

[1] Based on projections prepared by California Department of Finance (2024)

CMS approved the previous DMC-ODS evaluation plan on June 20, 2016. The subsequent evaluation documented DMC-ODS implementation and found that DMC-ODS has improved access to treatment, treatment quality, and coordination of care, and has also met the initial goals of DMC-ODS (Urada et al., 2016, 2017, 2018, 2019, 2021, 2022a). However, health disparities were identified in treatment placement. For example, disparities in timely linkage to care have been detected for youth, older adult, Black, and Hispanic Medi-Cal enrollees (Padwa et al., 2022). Also, once admitted, treatment engagement increased among younger clients but decreased among older ones.

Under the new DMC-ODS program, DMC-ODS remains mostly intact (with the noteworthy addition of Recovery Incentives Program), and changes to clarify or streamline billing, benefit rules, and facilitate Health IT. This assessment is therefore primarily focused on confirming maintenance of the measured improvements found during the initial program, identifying emerging trends, determining opportunities to facilitate further progress, and evaluating health equity.

The implementation period analyzed for this assessment varies by data source, but the overall assessment covers the first half of the demonstration approval period, from January 1, 2022, through June 30, 2024.

CMS approved Traditional Health Care Practices on October 16, 2024,2 which will be implemented initially only in DMC-ODS in California, with the potential to expand in the future to other services. This initiative will provide Medi-Cal coverage for traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations, or facilities operated by urban Indian organizations. An evaluation design is currently under development to address this new benefit.

Milestones

Consistent with State Medicaid Director 17-003 RE: Strategies to Address the Opioid Epidemic (CMS, 2017), as well as California's Special Terms and Conditions (CMS, 2021a), the milestones for DMC-ODS are:

[2] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Traditional-Health-Care-Practices-Approval.pdf

1. Access to critical levels of care for opioid use disorder (OUD) and other SUDs
2. Widespread use of evidence-based, SUD-specific patient placement criteria
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications
4. Sufficient provider capacity at each level of care
5. Implementation of comprehensive treatment and prevention strategies to address opioid use and OUD
6. Improved care coordination and transitions between levels of care.

CMS previously concluded that California had met these milestones under the previous Medi-Cal 2020 program (CMS/DHCS CalAIM 1115 STCs Working Session, December 15, 2021). The goal of this assessment will therefore be to assess maintenance of these achievements.

Methodology

Data Sources

Monitoring Metrics

CMS has identified the following SUD Metrics for assessing progress on demonstration's milestones. These metrics consist of (1) established quality measures endorsed by the National Quality Forum or included in other Medicaid Quality Measures measure sets, and (2) CMS-constructed implementation performance metrics to track 1115 waiver goals and milestones (CMS, 2024). The following metrics are being reported by DHCS to CMS:

Quarterly Metrics:

1. Metric #3 - Medicaid Beneficiaries with SUD Diagnosis (monthly)
2. Metric #6 - Any SUD Treatment
3. Metric #7 – Early Intervention
4. Metric #8 – Outpatient Services
5. Metric #9 – Intensive Outpatient and Partial Hospitalization
6. Metric #10 – Residential and Inpatient Services
7. Metric #11 - Withdrawal Management
8. Metric #12 - Medication Assisted Treatment (MAT)
9. Metric #23 - Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
10. Metric #24 - Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries

Annual Metrics:

1. Metric #4 - Medicaid Beneficiaries with SUD Diagnosis (annually)
2. Metric #5 - Medicaid Beneficiaries Treated in an IMD for SUD
3. Metric #13 - SUD Provider Availability
4. Metric #14 - SUD Provider Availability – MAT
5. Metric #15 – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

6. Metric #17 – Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
7. Metric #18 – Use of Opioids at High Dosage in Persons Without Cancer
8. Metric #21 – Concurrent Use of Opioids and Benzodiazepines
9. Metric #22 – Continuity of Pharmacotherapy for Opioid Use Disorder
10. Metric #25 - Readmissions Among Beneficiaries with SUD
11. Metric #26 - Overdose Deaths (count)
12. Metric #27 - Overdose Deaths (rate)
13. Metric #36 - Average Length of Stay in IMDs
14. SUD Health IT metric Q1
15. SUD Health IT metric Q2
16. SUD Health IT metric Q3

Quarterly monitoring metrics were generated by DHCS from calendar year 2022 Quarter 1 (January 1, 2022-March 31, 2022) through calendar year 2023 Quarter 4 (October 1, 2023-December 31, 2023). Annual metrics were generated for calendar year 2022 (January 1, 2022-December 31, 2022) and calendar year 2023 (January 1, 2023-December 31, 2023).

DHCS reported that 2022 Quarter 2 data was initially submitted to CMS in May 2023. However, due to claim lag and county submission timelines, CMS adjusted the SUD report submission timeline to ensure data accuracy. As a result, and to address the potential for incomplete data in Quarter 2 2022, CMS had DHCS resubmit the data in August 2023.

DMC-ODS predated the CMS requirement for monitoring metric reporting, and as a result, these metrics were not generated prior to the beginning of the CalAIM waiver in 2022.

Administrative Data Sources

ASAM Level of Care (LOC) Placement Data

Given that The ASAM Criteria are a defining feature of the DMC-ODS program, a large effort was initiated across DMC-ODS counties to collect data on the use of ASAM Criteria-based LOC brief initial screenings, initial assessments, reassessments, and

services delivered. This endeavor has been a collaborative effort between UCLA, DHCS, and counties to collect these data. DHCS Information Notice 17-035, which describes the requirements and procedures to collect ASAM Criteria-based LOC data, was released in September 2017 and then superseded by Information Notice 18-046 on October 1, 2018. These data include the date of screening or assessment, type (brief initial screen, initial assessment, follow-up assessment), indicated LOCs (per screener or assessment result), actual placement decision(s), the reason for the difference between indicated and actual LOCs (if any), and the reason for delays in placement (if any). Data on three types of screenings or assessments are possible, defined as follows on the data collection instrument:

- Brief Initial Screen: a brief initial screening that preliminarily determines an LOC placement until a full assessment can be performed
- Initial Assessment: a longer comprehensive assessment meant to determine the LOC recommendation and establish medical necessity
- Follow-up Assessment: following an initial assessment, any re-assessment of the client occurring during the same treatment episode

Up to three indicated and actual levels of care could be recorded. Indicated and actual levels of care are defined as:

- Indicated LOC. This is the initially recommended LOC according to the screening/assessment instrument prior to taking client preference into account. For example, this would be listed under "Final Level of Care Recommendations" if using CONTINUUM™ software
- Actual LOC/Withdrawal Management placement decision. This is the actual LOC decided upon after client input and the LOC where the client is referred

The options for LOC, as worded in the LOC reporting template, are listed below. These include broad To Be Determined (TBD) options. TBD options allow for the results of brief initial screenings that may indicate a general treatment modality the client should report to for further assessment (e.g., outpatient) without specifying the exact LOC to be received there (e.g., 1-outpatient or 2.1-intensive outpatient). The list also includes Withdrawal Management (WM) levels of treatment, which can be combined with other levels of care.

Level of Care

None
Outpatient/Intensive Outpatient (OP/IOP), exact level TBD
Residential, exact level TBD
Withdrawal Management (WM), exact level TBD
Ambulatory WM, exact level TBD
Residential/Inpatient WM, exact level TBD
Narcotic Treatment program/Opiate Treatment program (NTP/OTP)
0.5 Early Intervention
1.0 OP
2.1 IOP
2.5 Partial Hospitalization
3.1 Clinically Managed Low-Intensity Residential
3.3 Clinically Managed Population-Specific High-Intensity Residential
3.5 Clinically Managed High-Intensity Residential Services
3.7 Medically Monitored Intensive Inpatient Services
4.0 Medically Managed Intensive Inpatient Services
1-WM Ambulatory WM without Extended Onsite Monitoring
2-WM Ambulatory WM with Extended Onsite Monitoring
3.2-WM Clinically Managed Residential WM
3.7-WM Medically Monitored Inpatient WM
4-WM Medically Managed Intensive Inpatient WM

If at least one of the indicated and actual levels of care do not match, providers are asked to select the reason for the difference. The options are:

Reason for difference

Not applicable - no difference
Clinical judgment
Lack of insurance/payment source
Legal issues
Level of care not available
Managed care refusal
Client preference
Geographic accessibility
Family responsibility

Language
Used two residential stays in a year already.
Other (please explain)

California Outcome Measurement System, Treatment (CalOMS-Tx)

CalOMS-Tx is California's data collection and reporting system for all clients in publicly funded SUD treatment services. Treatment providers collect information from clients at admission and discharge, then send this data to DHCS each month. CalOMS-Tx provides California's contribution to the Treatment Episode Dataset (TEDS), maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA) and includes National Outcome Measures (NOMs). More information on CalOMS-Tx can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx

Drug Medi-Cal Claims (DMC Claims)

In California, Medicaid-funded SUD treatment is paid for through DMC claims. DMC is a carve-out for specialty care SUD treatment. For this evaluation, data from DMC claims provides patient demographics, access to treatment, types of services provided, and costs.

UCLA Evaluation Data Collection Activities

County Administrator Survey

UCLA developed an online county administrator survey to obtain information and insights from behavioral health administrators from counties participating in DMC-ODS. UCLA last collected data from May 1, 2024, through June 30, 2024. The survey addresses the following topics: access to care, screening and placement practices, services and training, quality of care, (collaboration, coordination, and integration of services), and DMC-ODS implementation status, among others. Additionally, UCLA has incorporated new high interest areas such as perceptions on the Recovery Incentives Program and CalAIM. Responses were received from all 38 counties that had joined DMC-ODS at the time of the survey (100 percent response rate, including partial survey responses). Responses to these questions were compiled and are summarized in this report. The 2024 County Administrator Survey can be found in Attachment B.

Treatment Perceptions Survey (TPS)

TPS for adults was developed by UCLA, based on San Francisco County's Treatment Satisfaction Survey. TPS for youth was based on Los Angeles County's Treatment Perceptions Survey (Youth). Both survey questionnaires include items from the Mental Health Statistics Improvement Program, MHSIP. Input on the survey development was solicited from and provided by: DHCS, the Substance Abuse Prevention Treatment+ Committee (SAPT+) of the County Behavioral Health Director's Association (CBHDA) of California, the DMC-ODS External Quality Review Organization (EQRO) Clinical Committee, Behavioral Health Concepts (BHC), the Youth System of Care Evaluation Team at Azusa Pacific University, and other stakeholders. TPS was designed to serve multiple purposes. The first is to fulfill counties' EQRO requirement that a patient satisfaction survey is conducted at least annually using a validated tool. TPS also addresses the data collection needs for the CMS required evaluation of DMC-ODS. Lastly, TPS supports DMC-ODS quality improvement efforts and provides key information on the impact of the program.

TPS is administered annually as part of a major statewide undertaking by UCLA, counties, and providers during a specified five-day survey period. The survey for adults currently includes 16 statements addressing patient perceptions of access, quality, care coordination, outcome, and general satisfaction. The survey for youth currently includes 19 statements and the same five domains as the adult survey plus an additional domain: therapeutic alliance. As providers continued to use telehealth to deliver services to patients, the telehealth items for both adult and youth surveys included two questions. There is a final section where comments may be written. Items were also better aligned with domains. Survey respondents indicate the extent to which they disagree or agree with statements using a 5-point Likert scale (1= Strongly Disagree and 5= Strongly Agree). The survey also collects demographic information (i.e., gender, age, race/ethnicity, and length of time receiving services at the treatment program).

The administration of TPS occurs annually during a specified five-day survey period determined by UCLA and in agreement with DHCS. TPS had been strictly paper-based (one-page and large-print versions) during the first three survey periods in calendar years (CYs) 2017, 2018, and 2019. In CY 2020, UCLA added an online version to facilitate data collection and expedite analysis as much as possible.

Both paper-based and online surveys are available in English and 12 threshold languages (Spanish, Chinese, Tagalog, Farsi, Arabic, Russian, Hmong, Korean, Eastern Armenian, Western Armenian, Vietnamese, and Cambodian) for both adults and youth.

The annual collection periods occur in the Fall of each calendar year. Responses to the 2023 TPS are summarized in this report. The 2023 survey period occurred October 16-20, in 38 DMC-ODS counties. During this period, 693 adult programs and 131 youth programs with unique provider IDs participated in the data collection. A total of 18,174 TPS forms from both adults and youth were received from 31 participating counties and seven PHC counties. Adults accounted for 95.3 percent of forms (N = 17,327), and youth accounted for 4.7 percent (N = 847). This CY collection cycle was the seventh administration of the annual survey. Over the course of these survey administrations, changes in satisfaction scores have remained relatively small, and the ratings for all domains have remained high across time for both adults and youth (scores on average over 4.0 on a scale from 1.0 to 5.0). The 2023 TPS Survey can be found in Attachment B.

Analytic Methods

Analysis of Required Data

Monitoring Metrics

For descriptive purposes, differences were calculated from the first available set of metrics to the last using the following formulas, consistent with CMS's Mid-Point Assessment Technical Assistance document (CMS, 2021b):

- Absolute Change = Value of metric at mid-point - Value of metric at baseline
- Percent Change = (Value of metric at mid-point - Value of metric at baseline)/Value of metric at baseline

Provider Availability Assessment Data

In California, network adequacy has been analyzed by the state's EQRO for DHCS. DHCS has then produced a DMC-ODS annual network certification corrective action plan report (DHCS, 2023c). UCLA reviewed and summarized findings from this report.

Other Data Sources

Analysis of Quantitative Survey Data

County administrator and client surveys included Likert rating scales and binary measures (e.g., yes/no). Descriptive statistics, including mean and standard deviation for continuous outcomes as well as frequency and percentage for binary outcomes, were calculated for all survey samples. These analyses were also conducted by demographic groups to look for differences in access and outcomes by race, ethnicity, gender, and age. More complex analyses are planned in the future, consistent with the CMS-approved evaluation plan.

Analysis of Qualitative Survey Data

The research team identified salient themes in the data through conventional content analysis (Hsieh & Shannon, 2005) on comments that patients left in response to open-ended survey questions.

Analysis of Administrative Data

In a previous DMC-ODS evaluation report, a causal link between DMC-ODS implementation and treatment access during the Medi-Cal 2020 waiver was established (Bass et al, 2022). For this Midpoint Assessment, these analyses were expanded to include additional years of data to assess the persistence and robustness of this effect during the current CalAIM waiver.

Specifically, event study (ES) and difference-in-difference (DD) designs were used to analyze whether the introduction of DMC-ODS causally affected the unique number of clients receiving services based on DMC claims data. Given the staggered introduction of DMC-ODS across counties in California over time, exploiting this variation within the ES and DD designs allowed us to estimate a causal effect of DMC-ODS. Specifically, the DD design compared the posttreatment (e.g., post-DMC-ODS implementation) difference in the outcomes of interest between DMC-ODS and State Plan counties to the pretreatment (e.g., pre-DMC-ODS implementation) difference in the outcomes of interest between DMC-ODS and State Plan counties. The ES design is similar to the DD design but allows the effect of DMC-ODS to vary from 12 months or more prior to introduction to 12 months or more after the introduction. All ES and DD models used

data from DMC claims at the county-month-year-level for the calendar years 2016-2023 (unless otherwise noted), and controlled for time-invariant county effects, county-invariant time effects, and client-level demographics. All regressions were weighted by the county population, and standard errors are clustered at the county level.

Accounting for the COVID-19 Public Health Emergency

The 2022 baseline period of DMC-ODS under CalAIM was the last full year of the COVID-19 Public Health Emergency. California's COVID-19 State of Emergency ended February 28, 2023, and was followed soon after by the end of the federal Public Health Emergency on May 11, 2023 (California Health and Human Services, 2023). The effect of COVID-19 on DMC-ODS was documented in an evaluation report (Bass et al., 2022) and caused SUD treatment admissions to fall. Therefore, there is a risk that metrics comparing 2022 and 2023 may show apparent improvements (e.g., increases in access) in part due to a receding COVID-19 effect. To address this, ES and DD graphs are presented to illustrate the effect of DMC-ODS on access starting well before the start of the COVID-19 Public Health Emergency, during the emergency, and in the aftermath (2016-2023).

Assessment of Overall Risk of Not Meeting Milestones

The overall risk of not meeting each demonstration milestone was rated as low, medium, or high based on progress toward critical monitoring metrics. As suggested by CMS (2021b), the following definitions were used:

- Low risk: For all or nearly all of the critical metrics associated with the milestone (75 percent or more of metrics moving in the direction expected), the state is moving in the direction expected according to its annual goals and overall demonstration targets.
- Medium risk: For most of the critical metrics associated with the milestone (between 25 and 75 percent), the state is moving in the direction expected according to its annual goals and overall demonstration targets.
- High risk: For few of the critical metrics associated with the milestone (less than 25 percent), the state is moving in the direction expected according to its annual goals and overall demonstration targets.

There is an expectation of consistency (maintenance) for most metrics, reflected as no change or improvement, since the beginning of the CalAIM waiver represented the seventh year for the DMC-ODS demonstration and CMS previously concluded that California had met these milestones under the previous Medi-Cal 2020 waiver (CMS/DHCS CalAIM 1115 STCs Working Session, 2021). For this assessment, consistency is defined as a change of less than 10% or progress in a positive direction (e.g. increased access to critical levels of care). Exceptions include Metrics 23 (Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries), 24 (Overdose deaths – count), 25 (Overdose deaths – rate), and 36 (average length of stay in IMDs). For these metrics, the expected direction is no change to a decrease.

In addition to the metrics, administrative data analyses, provider availability assessment data, and state policies were reviewed wherever these were relevant to the milestone and available. Where stakeholder positive/negative ratings relevant to the individual milestones were available, this feedback was used along with assessment purposes. Otherwise, qualitative stakeholder feedback was primarily used to add context to data interpretations and recommendations.

For Milestones 2 and 3 there are no monitoring metrics, so the other data sources described above became the basis for assessment ratings.

Although implementation plan action items are often also considered in the mid-point assessments of 1115 waivers, DMC-ODS was largely implemented during the prior Medi-Cal 2020 waiver and therefore did not have a new implementation plan for the CalAIM demonstration.

Methodological Limitations

UCLA relies on monitoring metrics calculated and reported by DHCS in this report. DHCS reported that they have identified data quality and reporting issues that may affect the accuracy of some reporting and will recalculate and report affected metrics if needed.

The California Administrative data sets (CalOMS-Tx, DMC claims, ASAM LOC) used to produce the findings in this report have many of the same shortcomings as other administrative data sets, particularly related to missing data, inconsistent reporting, and delays in data reporting. UCLA relied on DHCS for the calculation of all monitoring

metrics. DHCS has been very responsive to questions about these calculations. In some cases, however, mid-point metrics were not available in time for this report due to data availability (e.g., overdose deaths generated by the Department of Public Health). At other times it was difficult to determine whether changes in the metrics were due to real trends in service provision or data-related challenges. In particular, the implementation of payment reform in 2023 may have affected metrics based on claims by causing reductions or delays in claim submissions as providers adjusted to new billing requirements.

Our survey data are reliant on the responses of participants, which may be biased by a desire to provide answers that the respondent feels will put them in a positive light. Monitoring metrics are produced by DHCS and shared in report form, which limits our ability to analyze or check the data in detail.

Wherever possible, different types of data were examined in parallel to mitigate the limitations of each data source and converge on conclusions (e.g. monitoring metrics, administrative data analysis, and client surveys).

Additionally, to address issues of data completeness in the administrative data, imputation was sometimes required to create estimates (e.g., ASAM LOC placement data).

Findings

Progress Towards Demonstration Milestones

Milestone 1: Access to critical levels of care for OUD and other SUDs.

Monitoring Metrics

Table 1. Monitoring metrics for access to critical levels of care for OUD and other SUDs.*

Metric Number	Metric Name	Count/ Rate at baseline	Count/ Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
6	Any SUD Treatment	125,199.3	130,682.0	5,482.7	4.4%	Consistent	Consistent	**Y**
7	Early Intervention	488.3	2,747.3	2,259.0	462.6%	Consistent or Increase	Increase	**Y**
8	Outpatient Services	70,717.3	66,277.0	-4,440.3	-6.3%	Consistent	Consistent	**Y**
9	Intensive Outpatient and Partial Hospitalization Services	2,473.3	749.3	-1,724.0	-69.7%	Consistent	Decrease	**N**
10	Residential Services	8,052.0	8,668.7	616.7	7.7%	Consistent or Increase	Consistent	**Y**
11	Withdrawal Management	1,512.7	1,684.3	171.7	11.3%	Consistent	Increase	**Y**

Metric Number	Metric Name	Count/ Rate at baseline	Count/ Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
12	Medication Assisted Treatment	49,267.7	54,412.7	5,145.0	10.4%	Consistent	Increase	**Y**
22	Continuity of Pharmaco-therapy for Opioid Use Disorder	14.9%	13.7%	-1.2%	-8.1%	Consistent	Consistent	**Y**

** These counts are the total number of Medi-Cal beneficiaries in DMC-ODS statewide with at least one claim for the respective service*

As shown in Table 1, seven of the eight metrics (87.5%) moved in the intended direction, indicating either consistency or a move in the direction of increased access. Most metrics indicated increases of 4.4 percent -11.3 percent, but the results for Early Intervention (+462.6 percent) and Intensive Outpatient and Partial Hospitalization Services (-69.7 percent) results were outliers. These deviations were further investigated to understand the underlying reasons, and possible explanations are discussed below.

Early Intervention

The monthly count of beneficiaries receiving early intervention services increased steadily since April 2023. The reasons for this are unclear. The leader of a large treatment organization suggested it may be related to the ability to provide treatment pre-diagnosis that historically was not possible. DHCS suggested:

"With the implementation of Payment Reform, it is allowable to bill [Screening, Brief Intervention and Referral to Treatment] and other assessment services (CPT Codes) on the same day. This allowed providers to bill for services that may have previously been unbilled. That is likely the cause of the increase."

(DHCS, email to UCLA, November 13, 2024)

In 2025, UCLA will continue to monitor this and will collect data from county administrators to try to clarify the underlying reasons for this increase. However, this appears to be a positive development resulting either from increased delivery of these services or claims for services that have previously been unreimbursed.

Intensive Outpatient Treatment and Partial Hospitalization

The number of claims meeting the metric specifications for monthly beneficiaries receiving intensive outpatient/partial hospitalization services fell by 69.7 percent since January 2022.

In response, DHCS reported that starting July 1, 2023, the healthcare common procedure coding system (HCPCS) Code H0015 previously used for intensive outpatient was no longer a valid code for Drug Medi-Cal billing, and that new CPT codes are being used replacement of the HCPCS code, but that these are not included in the CMS specifications for this metric. UCLA was able to independently confirm four pieces of evidence that are consistent with this explanation:

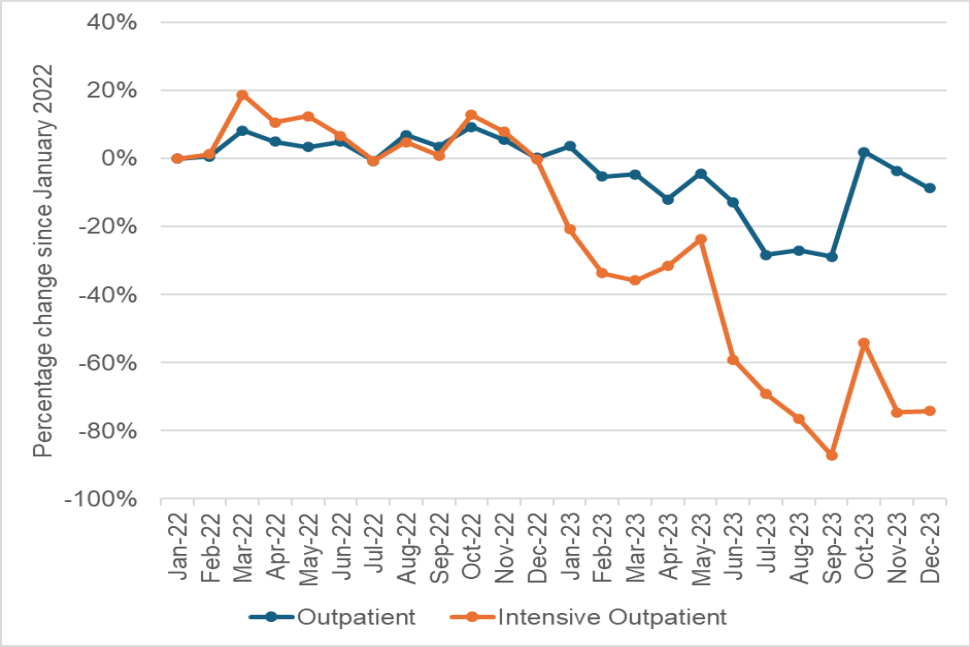
- Large decreases did not occur in outpatient treatment over the same time period even though outpatient treatment is typically delivered by the same providers as intensive outpatient treatment (see Figure 1). Overall, the dip in intensive outpatient treatment is also a clear outlier from the broader treatment trends, as the number of beneficiaries receiving treatment is up 4.4 percent overall.

- H0015 appeared in the Drug Medi-Cal billing manual in 2022 but was removed in 2023 (DHCS, 2022; DHCS, 2023a)
- The sharpest portion of the decrease occurred from June through September 2023, a pattern consistent with a system transitioning to new codes.

UCLA reached out to large treatment providers who anecdotally could not confirm any real decrease in intensive outpatient.

Taken together, these suggest the apparent decrease in the intensive outpatient is due to a change in billing codes rather than a reduction in services, and that this result is likely to persist in future monitoring metrics as long as a mismatch between the newer codes and the codes specified by this metric persists.

Figure 1. Monthly beneficiaries receiving outpatient and intensive outpatient/partial hospitalization services.

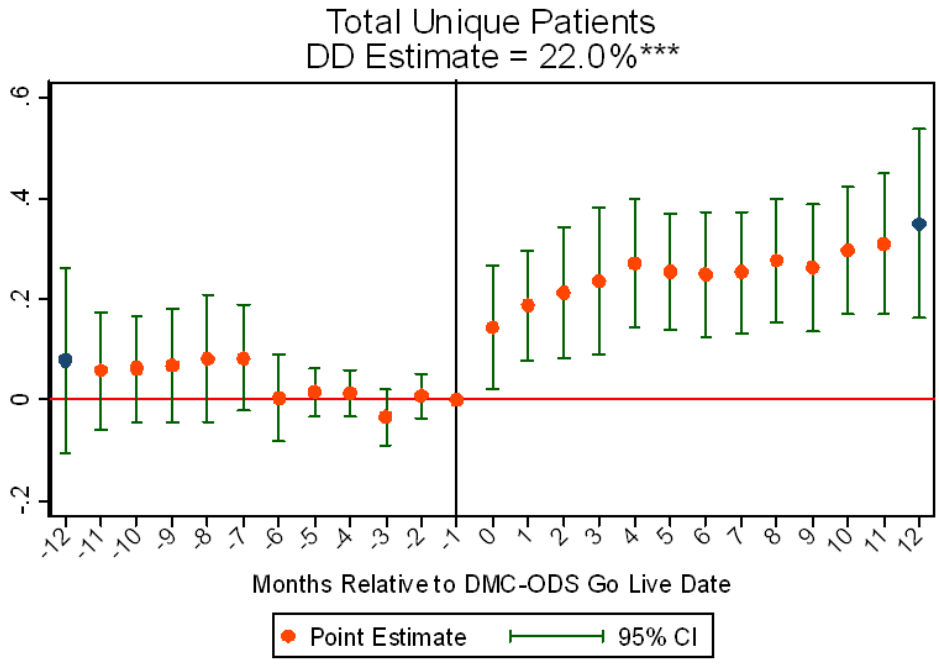


Administrative Data: Event Study and Difference-in-Differences Estimates

Next, to empirically assess the impact of DMC-ODS on the number of patients receiving services, we estimated event study and DD models. Specifically, the DD models compare the posttreatment (e.g., post-DMC-ODS implementation) difference in the outcomes of interest between DMC-ODS and State Plan counties to the pretreatment (e.g., pre-DMC-ODS implementation) difference in the outcomes of interest between DMC-ODS and

State Plan counties. The ES models are similar to the DD models but allow the effect of DMC-ODS to vary from 12 months or more prior to introduction to 12 months or more after the introduction.

Figure 2: Event study estimates of the effect of DMC-ODS on unique number of patients receiving services.

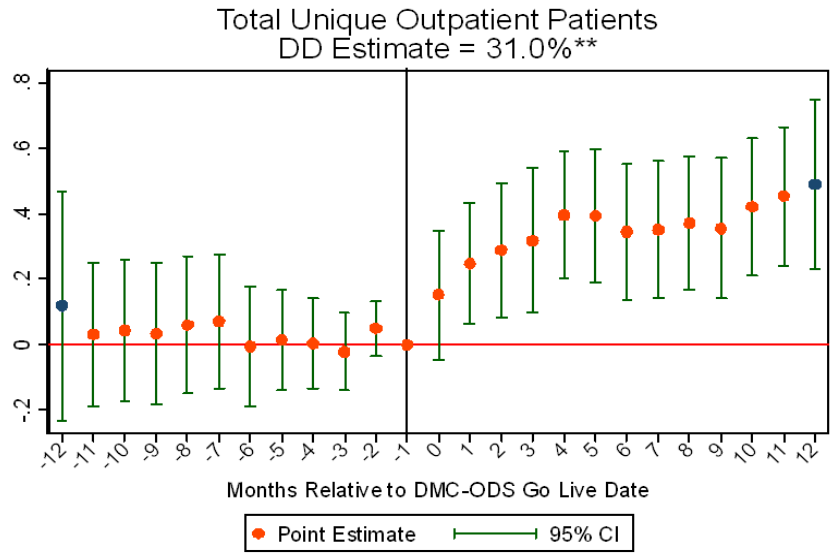


*Event study estimates (orange dots) and 95 percent confidence intervals (green bars) of the effect of DMC-ODS on the log of the unique number of patients receiving services are shown. Data are from DMC Claims for CY 2016 – CY 2023. All estimates are relative to the year prior to the "Go Live" date on which each county-initiated DMC-ODS implementation. The difference-in-difference estimate is also presented. *** indicates significance at the one percent level.*

Figure 2 presents the ES estimates and the overall DD estimate of the effect of DMC-ODS introduction, using DMC Claims data, on the natural log of the unique number of patients receiving services. The natural log of the unique number of patients receiving services is taken to reduce the skewness of the outcome, and for ease of interpretation of the coefficients. The figure indicates a sharp increase in the unique number of patients receiving services after the introduction of DMC-ODS. The DD coefficient suggests that, compared to State Plan counties, the introduction of DMC-ODS significantly increased the unique number of patients receiving DMC-funded services in DMC-ODS counties by 22 percent.

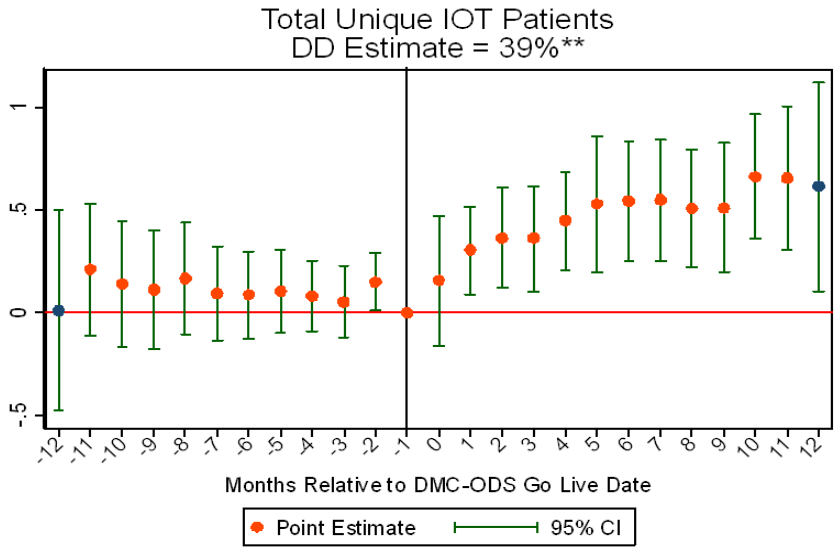
To determine if the introduction of DMC-ODS affected the number of patients receiving services by modality, separate ES and DD models were estimated for outpatient services, intensive outpatient (IOT) services, NTP/OTP services, and residential services. Figure 3 panels (a)-(d) present the ES estimates and DD estimates by modality, respectively. Figure 3 suggests that the introduction of DMC-ODS had a positive impact on the unique number of patients receiving DMC-funded services across all modalities, though the estimated effect for NTP/OTP is not significant. DMC-ODS significantly increased the number of unique outpatient patients in participating counties by 31 percent, intensive outpatient patients in participating counties by 39 percent, and residential patients in participating counties by 368 percent, compared to State Plan counties.

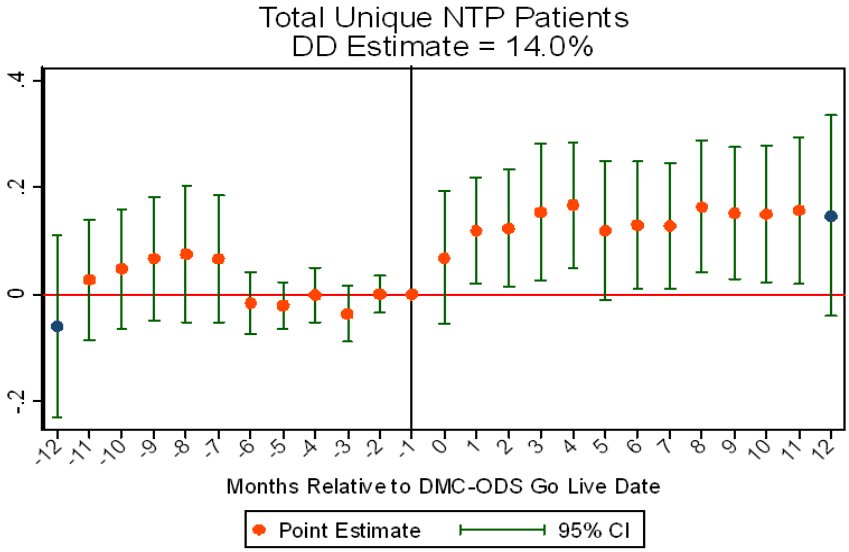
Figure 3 (Panels a – d): Event study estimates of the effect of DMC-ODS on unique number of patients receiving services, by modality.

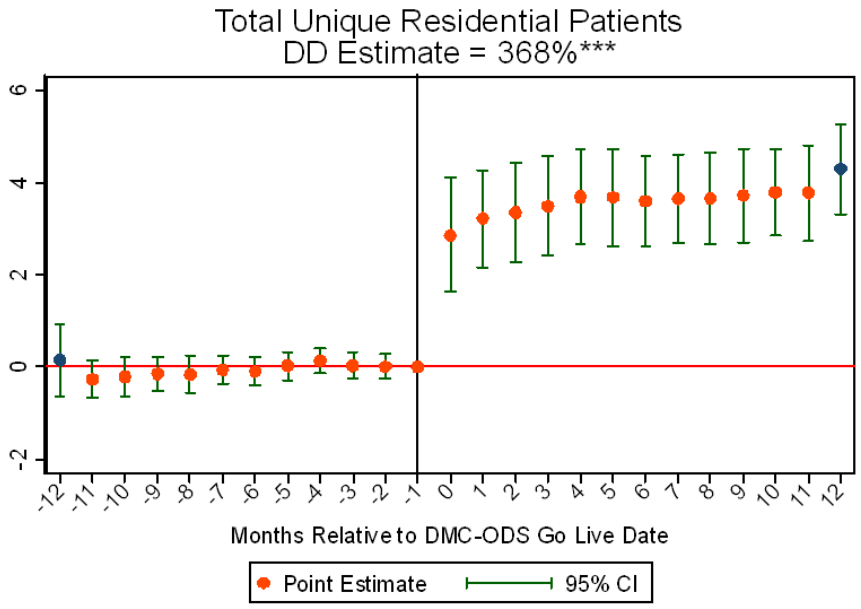


Event study estimates (orange dots) and 95 percent confidence intervals (green bars) of the effect of DMC-ODS on the log of the unique number of patients receiving services are shown. Panel (a) is outpatient, panel (b) is IOT, panel (c) is NTP/OTP, and panel (d) is residential.

(Panel b)


Total Unique IOT Patients
DD Estimate = 39%**
-.5
0
.5
1
-12 -11 -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7 8 9 10 11 12
Months Relative to DMC-ODS Go Live Date
Point Estimate
95% CI


Total Unique NTP Patients
DD Estimate = 14.0%
-.2
0
.2
.4
-12 -11 -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7 8 9 10 11 12
Months Relative to DMC-ODS Go Live Date
Point Estimate
95% CI



*Data are from DMC Claims for CY 2016 – CY 2023. All estimates are relative to the year prior to the Go Live date. The difference-in-difference estimate is also presented. *** indicates significance at the 1 percent level, and ** indicates significance at the 5 percent level.*

Stakeholder Feedback: Clients

Stakeholder feedback was collected from clients through a client Treatment Perceptions Survey (TPS) conducted annually during a one-week period among all clients in treatment in all DMC-ODS counties.

Table 2. Percentage of clients agreeing with individual TPS Access questions.

Adults	**2021**	**2022**	**2023**
The location was convenient (public transportation, distance, parking, etc.)	85.3%	85.5%	86.0%
Services were available when I needed them	89.1%	88.8%	88.8%
Youth	**2021**	**2022**	**2023**
The location of services was convenient for me	84.3%	80.5%	84.7%
Services were available at times that were convenient for me	84.7%	84.2%	87.0%
I had a good experience enrolling in treatment	84.5%	83.4%	86.9%

These ratings were consistent across and stable across modalities and years, suggesting client perceptions of access in DMC-ODS have been maintained from the Medi-Cal 2020 waiver baseline (2021) into the CalAIM waiver.

Table 3. TPS average client ratings across Access domain questions by modality

Adults	**2021**	**2022**	**2023**
Outpatient / Intensive Outpatient Treatment	4.4	4.4	4.4
Residential Treatment	4.3	4.2	4.3
Opioid Treatment Programs	4.3	4.3	4.4
Withdrawal Management	4.4	4.3	4.3
Youth	**2021**	**2022**	**2023**
Outpatient / Intensive Outpatient Treatment	4.3	4.2	4.3

(1=Strongly Disagree, 5=Strongly Agree).

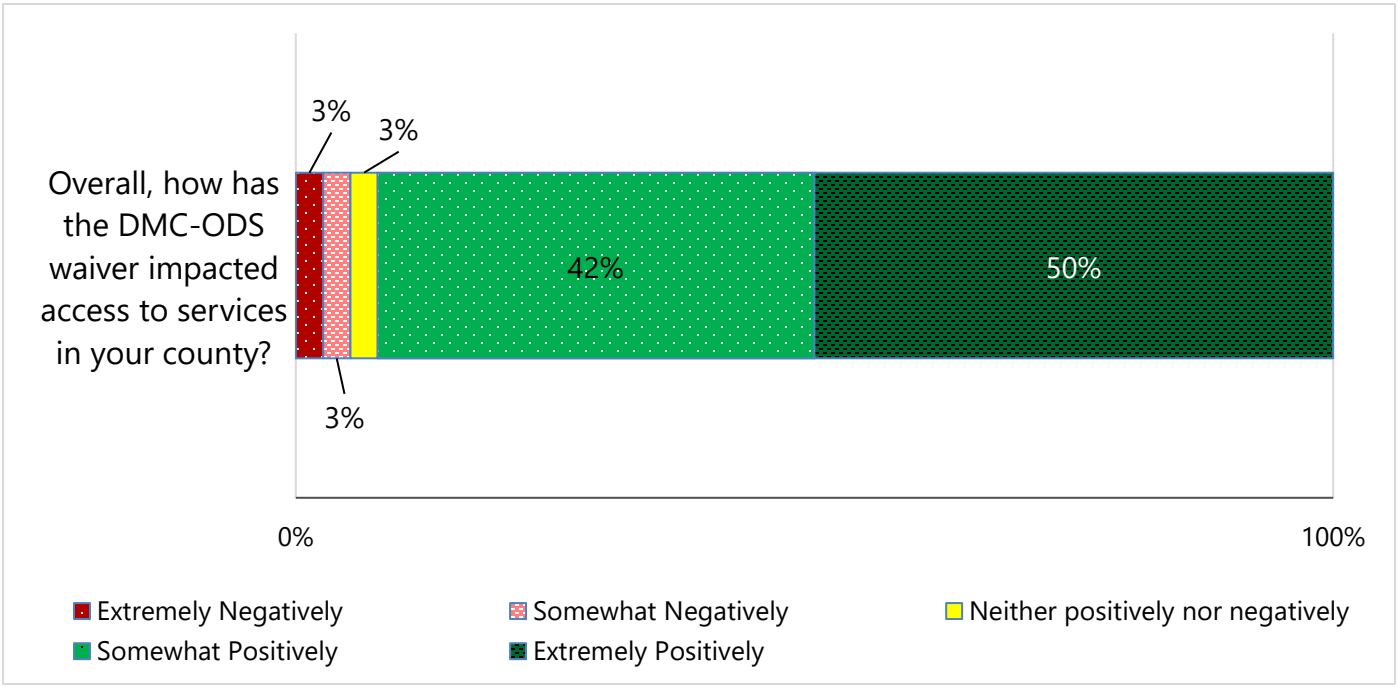
Numbers for other youth modalities were suppressed due to the small number of respondents.

Stakeholder Feedback: County Administrators

Stakeholder feedback on the impact of DMC-ODS on access was also collected from the administrators who oversee the SUD treatment system in each of the participating DMC-ODS counties.

As shown in Figure 4, 92 percent of county administrators reported that DMC-ODS positively impacted access to SUD services in their county (somewhat [42 percent] and extremely [50 percent]). Two counties reported that DMC-ODS negatively impacted access to care and one county reported neither a positive nor negative response. Administrators from these counties noted long wait times, integration challenges, and managing ASAM authorization requirements as persistent barriers to access services in their counties.

Figure 4. County administrator responses on the overall impact of DMC-ODS on access to services in their county. 2024 County Administrator Survey



However, when asked to share additional comments regarding access to SUD treatment under DMC-ODS, county administrators acknowledged successes with the overall improved structure of the service delivery system, highlighting better screening and assessment processes as well as expanded LOC.

One county administrator remarked that "access has significantly improved with the CalAIM Behavioral Health Initiative changes." Another administrator reported that "DMC-ODS has provided a structured approach to service delivery…ensuring members receive appropriate levels of care."

County administrators also offered suggestions for what could be done to further improve access to SUD services. These are summarized below.

- **Increase Financial Support**: One suggestion emphasizes the need to increase reimbursement rates to cover the cost of care and sustain providers. There was a specific emphasis on the rates for residential services. Some county administrators reported an increased demand for residential treatment, but one noted that "*current rates (in their county) for residential treatment do not support increasing bed capacity*."

- **Evaluate Funding Disparities**: Particularly from smaller counties, several county administrators reported receiving "*significantly less DMC-ODS funds for services (particularly for residential services)" compared to neighboring DMC-ODS counties, making it "challenging to afford out-of-county rates*." One county indicated that" a *neighboring county is paid anywhere from 50 percent to 75 percent more and we have to make up that cost in other funds if we use those services.*" This suggests the need to consider offering funding support to help smaller counties cover the costs of out-of-county providers without experiencing financial hardship.

- **Streamline Eligibility Processes**: County administrators also elevated the need to review the intercounty transfer processes to improve the Medi-Cal application registration process. County administrators highlighted that eligibility issues, often stemming from homelessness, frequent relocations, and jail releases, complicate the process administratively. These complications lead to delays in accessing essential services, like withdrawal management. One county administrator noted that "*in spite of DHCS attempt to ensure clients can access care, if they have not started an intercounty transfer or need to start their M/C app, it takes time to register in the system.*"

- **Support Provider Staffing and Address Provider Burnout/Fatigue**: County administrators overwhelmingly suggested the need to provide additional resources and support to alleviate the burden on existing staff and attract new professionals to the field. Overall, county administrators reported a critical need

for more treatment providers and noted the frustration and fatigue among existing providers, which leads to high provider turnover and vacancies and ultimately access delays and reduced service capacity. One county administrator reported that the "*rapid and ever-changing rules with CalAIM have made our contracted providers angry, frustrated, and feel taken advantage of.*" Another administrator stated that "a*lthough access to treatment is better, it doesn't mean anything when less staff have to do 2-3 people's jobs*." Another reported that residential programs may "*temporarily reduce their census to make sure they have adequate staffing within the program*." Suggested strategies included offering competitive salaries and professional development opportunities.

- **Enhance Transportation and Housing Options**: "*Transportation is a barrier to treatment as well as a lack of recovery residences*" noted one county administrator. Increasing access to Medi-Cal transportation services and development of more recovery residences could help. Another administrator commented that "*[when their clients] are released [from detox or residential treatment], they have no other options to live in a safe environment but return to the environment that they used substances in before they left for treatment*."

- **Improve Referral Processes**: One county administrator observed that a substantial gap remains between the number of individuals in need and those who are offered and accept referrals for treatment. They reported that despite "*having staff available (in an Emergency Department) seven days a week from 7am to 10pm, only 10-15 percent of individuals accept referrals,*" The literature suggests barriers to successful referrals commonly include beliefs about the need for and process of treatment, lack of transportation, fear of negative consequences (e.g. incarceration, inconvenience, withdrawal, custody of children or loss of parental rights), and personal traits including motivation (Farhoudian et al, 2022; Raven et al, 2010). A combination of education, transportation assistance, motivational interviewing, and warm handoffs may help address these issues

- **Streamline Regulatory Requirements**: Another suggestion centered on improving the ASAM review and authorization requirements as an area to expedite treatment initiation. One administrator reported that *"DMC-ODS has introduced barriers to treatment in that ASAMs must be reviewed by LPHAs and that Levels 3.1, 3.3, and 3.5 must be authorized prior to treatment."* Another stated

that while *"CalAIM changes makes it easier to help people access care faster…the ASAM paperwork is cumbersome in comparison to mental health assessment and can be a barrier."* One county suggested the state *"reduce reliance on LPHAs and entrust Certified SUD Counselors to complete ASAM assessments."* DHCS has implemented Behavioral Health Documentation Redesign to streamline documentation requirements for SUD services and anticipates revisiting assessment and authorization policies again in conjunction with implementing ASAM's 4th Edition Criteria.

- **Expand Youth Treatment Options**: Multiple county administrators commented on the limited number of youth residential treatment providers across the state. One added, "*given the extensive reporting requirements, the few providers that have adolescent residential treatment do not want to contract with counties for DMC-ODS services*."

- **Provide Transition Support for Providers**: One county administrator commented that "It would have been great to have support for providers to make the transition to DMC-ODS. Definitely [technical assistance] (TA) and maybe even some financial assistance to make the transition." Administrators also emphasized the need for additional support for adolescent residential programs. Another administrator commented on the difficulty in securing contracts for higher levels of care (3.7 and 4 LOC), stating that they "do not see in the near future a solid plan for the higher LOC."

- **Monitor and Improve Access**: Overall, county administrators suggested to continue to leverage the structured approach provided by DMC-ODS and note the improved processes to "track and ensure clients are assessed and accessing the right level of care within the required timeline."

Milestone 2: Use of evidence-based SUD-specific patient placement criteria

Table 4. Monitoring Metrics for evidence-based SUD-specific patient placement criteria

Metric Number	Metric Name	Count/Rate at baseline	Count/Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
5	Medicaid beneficiaries treated in an IMD for SUD	684.0	882.0	198.0	29.0%	Consistent or Increase	Increase	**Y**
36	Average length of stay in IMDs	30.7	25.2	-5.4	-17.7%	Decrease	Decrease	**Y**

As shown in Table 4 above, the number of Medicaid beneficiaries in an IMD for SUD increased from baseline to the midpoint. Although this did not align with the targeted direction of change listed in the state's monitoring protocol, UCLA assesses that DMC-ODS has produced change in the intended direction and recommends the direction of the target in the monitoring protocol be revisited with CMS. This applies to both metrics 5 and 10. Expansion of access to residential treatment in IMDs to stabilize individuals with severe SUD as part of an organized delivery system is a core component of DMC-ODS. Successful implementation therefore requires an increase or consistency in this metric, not a decrease. Coupled with the state's progress on the use of evidence-based placement criteria and a reduction in the average length of stay in IMDs (Metric 36), these suggest appropriate expansion treatment in IMDs.

Administrative Data: ASAM Level of Care Placement Data

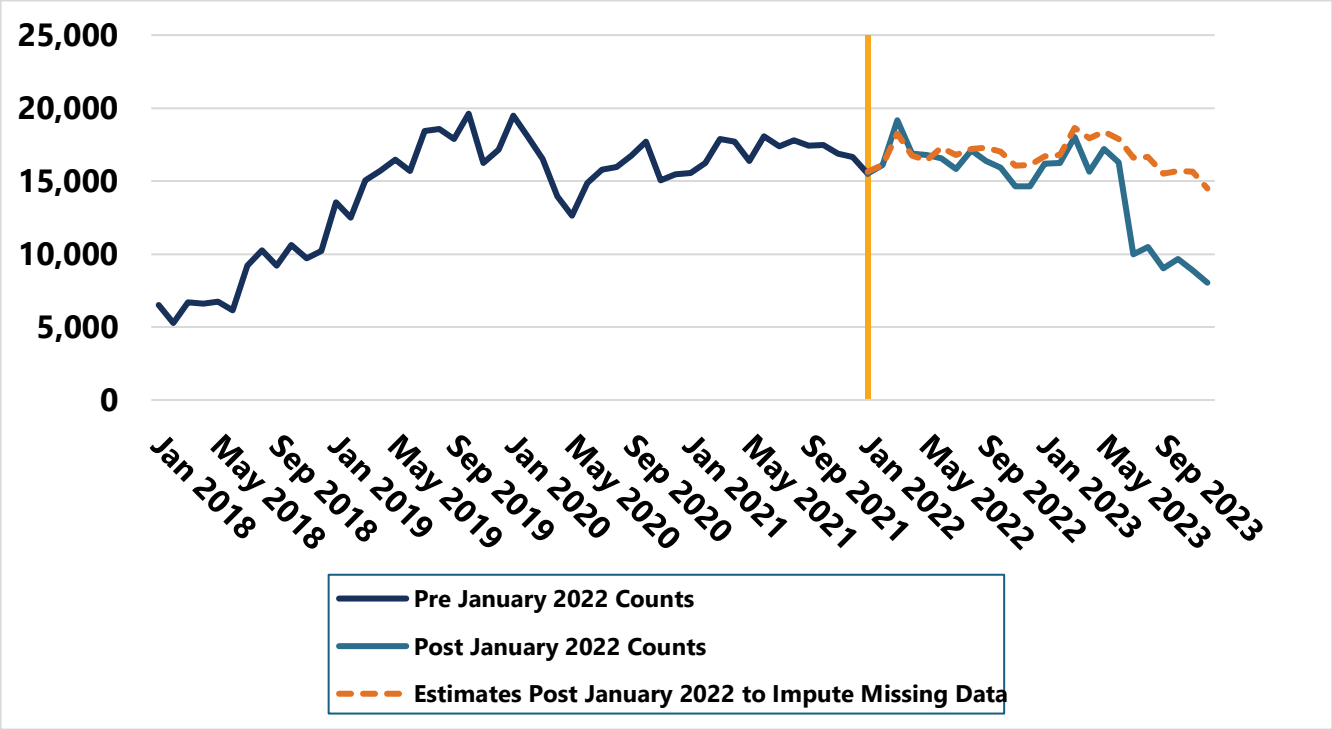
As described by DHCS (2023b), a full ASAM Criteria Assessment is required to determine placement into the appropriate level of care for all DMC-ODS clients within 30 days of their first visit with a licensed practitioner of the healing arts, or within 60 days for adults experiencing homelessness. For prevention and early intervention services, a brief screening may be used. Each time an assessment or brief screening was conducted, the results were recorded in the state's ASAM LOC Placement dataset. Between January 2022 and June 2024, a total of 395,220 screenings and assessments were recorded, covering a total of 145,255 Medi-Cal beneficiaries. During that time, 74.3 percent of ASAM screenings and assessments resulted in a recommended LOC that matched the placement decision of the client's LOC. As detailed previously (Urada et al., 2022), the most common reasons for mismatches were patient preference followed by clinical judgment. Based on the rates previously reported for each reason, the match rate excluding mismatches due to patient preference would be 81.2%, while excluding both patient preference and clinical judgment generates a match rate of 86.2%.

Not all counties have complete data through the end of 2023 due to incomplete submissions. Where data was incomplete, we used monthly county data of covariates received from CalOMS-Tx to create monthly predictive estimates for the total number of ASAM Criteria Assessments and screenings that should have been received statewide from 2022 through 2023. Estimates were predicted by the county via an elastic net, also known as a penalty regression, with k-fold cross-validation over 20 folds due to uncertainty on the correlation many of the covariates may have with ASAM assessment

monthly counts. Furthermore, a few counties missed a month in the middle of their ASAM reporting data. Such cases were imputed with the mean of the prior and following month before being included in the training model.

Figure 5 shows estimated values in red. Based on these estimates, use of ASAM Criteria Assessments and brief screenings has been maintained during the CalAIM portion of DMC-ODS

Figure 5. ASAM Criteria Assessment State Totals. ASAM Level of Care Placement data



Stakeholder Feedback: County Administrators

When asked what would be helpful for DHCS to know about the implementation of the ASAM Criteria Assessment tools, County administrators suggested:

- **Ensure Compatibility with Electronic Health Records (EHRs)**: The most frequently mentioned issue by county administrators was the challenge to integrate ASAM Assessment tools with their EHR systems. Several administrators commented on how "*difficult [it is] to put into EHRs due to licensing requirements*," and how time consuming it is to "*build the form into their EHR*." The administrators also noted that, *"requiring counties to accept certain tools - rather than considering to review/approve the tool embedded into our EHR -*

makes it challenging to report data to DHCS as it has to be manually entered (the embedded assessment tool automatically captures the required elements for reporting)." Another remarked that "*the time to develop a NEW/validated tool embedded into an EHR is a significant project that will take time.*" One administrator also highlighted that the cost of implementing ASAM tools is a barrier, with electronic versions being expensive and paper versions inadequate for data tracking in EHR systems. These comments appear to refer to DHCS guidance in BHIN 23-068 aimed at standardizing DMC-ODS assessment, and specifically to guidance that counties use either the free ASAM Criteria Assessment Interview Guide or ASAM CONTINUUM software. The objective of this guidance is to replace the historically used county-specific assessments with a standardized set of ASAM-approved assessments. The state and ASAM could explore working together to facilitate integration of these assessments, particularly the free ASAM Criteria Assessment Interview Guide, with commonly used EHR platforms.

- **Simplify and Shorten Assessments**: Administrators acknowledged the benefits of a "*shared mandated tool*," but commonly remarked that the current tools are often seen as "*unnecessarily long" and "onerous*," making them "*difficult to administer and less valuable as clinical tools*." One county remarked that their "*providers frequently complain about the size and time it takes to complete the Interview Guide*." Another county suggested "*having a brief ASAM for follow-ups while in treatment would be more efficient*." To help providers with assessment requirements, DHCS has released BHIN 23-068 which eliminates the 30-/60-day assessment timeframe. This change aligns with CalAIM's Behavioral Health Administrative Integration goals and promotes consistency between SMHS and DMC/DMC-ODS, while also reducing administrative burden.

- **Develop Validated Tools for Youth**: County administrators elevated the need for a validated tool for youth and adolescent assessments. One county administrator indicated, "*having an Adult guide with an Adolescent guide still forthcoming has been a complaint.*"

- **Provide Adequate Training and Implementation Time for ASAM Criteria 4th Edition Adaptation:** Several administrators commented about the substantial undertaking ahead to adapt county and provider systems to the new ASAM 4th Edition. One indicated that their "*entire network will require training on ASAM 4th*

Edition. Counties will need time to implement the change." Another administrator elevated the "*need [for] ample time to not only build the form into our EHR, but also to update everything else that it touches, including the level of care data reporting requirements and any potential changes to codes and modifiers*." Another county remarked on the time needed to "*adapt to the new tools and validate data prior to submission*."

- **Enhance Technical Assistance on Data Reporting:** Based on county administrator comments, some have experienced frustration with DHCS support about the ASAM LOC reporting process. One administrator noted that they "*have been requesting TA from DHCS in submitting the ASAM LOC data for 2 years"* without resolution, "*which has been very challenging and frustrating*". Another administrator reported the need to "*clarify the [ASAM LOC report] template [with] clear instructions on how to populate each column accurately*." Another administrator suggested "*developing a streamlined approach for counties to report to the state at defined intervals, through a singular portal*."

- **Clarify and Differentiate between Tools:** Terminology around screening and assessment can be confusing, including terms like "brief" and "full." While brief ASAM screener is "helpful," one asked to "*differentiate between the ASAM LOC Screening (entry) and the full ASAM assessment*."

Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities

There are no CMS monitoring metrics for Milestone 3.

California enacted Senate Bill 823 in 2018, which required DHCS to adopt the ASAM criteria, or an equivalent evidence-based standard, as a minimum standard of care for all licensed adult SUD treatment facilities. Residential facilities are now required to either obtain an ASAM LOC Certification from the partnership between ASAM and the Commission on Accreditation of Rehabilitation Facilities International, or a DHCS LOC Designation (DHCS, 2021a, 2021b). These certifications are meant to ensure facilities are capable of delivering care consistent with the ASAM criteria. The DHCS LOC designation program applies to the following LOC.

- Level 3.1 – Clinically Managed Low-Intensity Residential Services,
- Level 3.2 – Clinically Managed Residential Withdrawal Management (WM)
- Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services
- Level 3.5 – Clinically Managed High-Intensity Residential Services.

Residential facilities may apply for and receive more than one LOC designation. The process for obtaining a DHCS LOC Designation includes a DHCS LOC Designation Application with supporting documentation and an on-site or virtual compliance review of the facility.

These policies were implemented during the Medi-Cal 2020 demonstration and have been maintained during the CalAIM demonstration (DHCS 2021a, DHCS 2021b).

As of November 15, 2024, 994 facilities have received an ASAM LOC (DHCS, 2024).

Milestone 4: Sufficient provider capacity at each level of care

Monitoring Metrics

Table 5. Metrics for milestone 4.*

Metric Number	Metric Name	Count/ Rate at baseline	Count/ Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
13	SUD Provider Availability	4,609.0	12,392.0	7,783.0	168.9%	Consistent or Increase	Increase	**Y**
14	SUD Provider Availability - MAT	3,853.0	11,626.0	7,773.0	201.7%	Consistent or Increase	Increase	**Y**

** Number of providers who were enrolled in Medicaid and qualified to deliver SUD services*

Provider capacity increased according to these metrics. However, DHCS cautioned in its report that for both measures, "some or all of this increase" may be attributable to changes in the way MAT prescribers were identified. DHCS explained, "In January 2023, the Drug Enforcement Administration (DEA) eliminated the DATA-Waiver Program, also known as the X-Waiver. As a result, all prescriptions for buprenorphine only required a standard DEA registration number. The previously used DATA-Waiver registration numbers were no longer needed for any prescription. This meant that any practitioner with a current DEA registration that includes Schedule III authority was allowed to prescribe buprenorphine for Opioid Use Disorder (OUD) in their practice." (DHCS, 2024)

Due to the changes described above, conclusions on the actual expansion of provider availability cannot be drawn from these metrics at this time.

Provider Availability Assessment (network adequacy)

DHCS reviews each DMC-ODS county's compliance in the following areas:

1. Time or Distance Standards – Geographic Access Mapping
2. Network Capacity and Composition – Availability of Services
3. Language Capacity; and,
4. Mandatory Provider Type - American Indian Health Facility (AIHF).

In its 2022 Annual Network Certification DMC-ODS Corrective Action Plan report (DHCS, 2023b), the state reported that as of June 2023 there were 31 DMC-ODS Plans that required an annual network adequacy certification (30 counties and Partnership HealthPlan of California), and among these, ten were non-compliant. These plans and the reasons for non-compliance are summarized in Table 5. The plans that were out of compliance most failed to meet capacity and composition standards for adult outpatient as well as children/youth (0-17) residential programs (five plans each). These plans struggled with time and distance standards most often for children/youth opioid treatment programs.

Table 6. Standards not met by ten DMC-ODS plans out of compliance in June 2023.

	Service type and Age group							
Plan	**OP 18+**	**IOT 18+**	**Res 18+**	**OTP 18+**	**OP 0 17**	**IOT 0 17**	**Res 0 17**	**OTP 0 17**
Contra Costa							CC	
Merced			CC					
Monterey	CC	CC	CC	CC	CC	CC	CC	CC
Partnership				TD & CC	TD		TD	
Sacramento			CC				CC	TD & CC
San Bernardino	CC				CC			
San Mateo	CC			CC			CC	TD
Santa Cruz	CC				CC			TD & CC
Tulare							CC	TD
Yolo					TD			
CC Totals	**5**	1	3	3	3	1	**5**	3
TD Totals	0	0	0	1	2	0	1	**4**

Abbreviations: IOT: Intensive Outpatient Treatment. OP: Outpatient treatment. Res: Residential treatment. OTP: Opioid Treatment Program. CC: Capacity and Composition Standard. TD: Time or Distance Standard

This table only provides a snapshot as of June 2023. Some or all of these counties may now be in compliance. A new network certification report is expected to be released in 2025 and will be examined for the DMC-ODS Interim Evaluation Report.

For context, the number of plans out of compliance in May 2021 was six out of 30 plans (DHCS, 2021), followed by two out of 31 plans in June 2022 (DHCS 2022b). There were ten plans out of compliance in June 2023, which represents an increase relative to previous years. Notably, however, nine of these ten plans had been fully in compliance in both 2021 and 2022. It is unclear whether the 2023 increase in non-compliance was due to actual changes in provider capacity or other factors, such as shortcomings in documentation.

Stakeholder Feedback: County Administrators

According to the 2021 California Behavioral Health Workforce Assessment Report, many Californians are unable to access the services they need. Often, these barriers are related to a gap between high service demand and low workforce supply (Center for Applied Research Solutions [CARS] & DHCS, 2022). When asked about workforce challenges and what is needed to address these issues, county administrators overwhelmingly reported the need for higher rates and increased wages to retain well-qualified staff and attract new providers (CARS & DHCS, 2022).

County administrators indicated that "*workforce shortages have been ongoing for years*." Several commented that "*higher billable rates are essential to be able to cover staff salaries… [and that] current rates are too low and not sustainable.*" One county administrator indicated the need for more attention on SUD counselors, who are "*often overlooked in broader behavioral health workforce initiatives.*" Overall, there is a pressing need for structured internships, professional development courses, and clear career progression pathways for these counselors.

Administrators offered several suggestions to DHCS including the development of initiatives to attract more professionals into the SUD field, providing grants or other financial resources to support the hiring of additional staff or to compensate for overtime work due to staff shortages, offering stipends for licenses and certifications, renewals, and trainings, and establishing a program and funding similar to MHSA for a workforce tuition and loan repayment programs in exchange for two years of service in a public behavioral health agency. They also mentioned that additional investment in telehealth and other technological solutions can extend the reach of the current workforce, making services more accessible.

> Administrators in rural counties highlighted that their unique challenges regarding their rates and staff shortages were due to population size, which they indicated "*require a deeper understanding and tailored support from DHCS*." One county administrator from a rural county elevated the need for "*DHCS County Analysts/Auditors to have a better understanding of [their] struggles*" that larger counties do not face.

Additionally, excessive administrative burdens, including extensive compliance reporting and continuous policy changes, contribute to workforce retention issues. One county elaborated, "*Many agencies report workforce retention issues related to excessive*

administrative burdens required of Medi-Cal programs. Although some CalAIM Initiatives are geared toward this, it would be helpful if DHCS would reduce administrative requirements, such as the extent of compliance reporting/monitoring and continuous policy changes, which then result in the need to update contracts, policies and procedures, monitoring tools, practice guidelines, and develop provider staff training."

County administrators indicated that streamlining these processes and reducing redundancy could alleviate some of these pressures.

In summary, county administrators offered the following suggestions to address workforce challenges.

- **Increase Compensation**: Ensure competitive salaries and financial incentives to attract and retain qualified staff.
- **Focus on SUD Workforce**: Develop targeted initiatives for SUD counselors, including professional development and career progression opportunities.
- **Address Rural Challenges**: Provide additional support and understanding for rural counties facing unique challenges.
- **Reduce Administrative Burden**: Streamline administrative processes and reduce redundancy to improve workforce retention.
- **Enhance Training Programs**: Offer specialized and introductory training programs to enhance workforce skills and support new counselors.
- **Provide Financial Assistance**: Offer grants, stipends, and incentive programs to support workforce development.
- **Leverage Technology**: Invest in telehealth and other technological solutions to maximize workforce efficiency and reach.

Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.

Monitoring Metrics

Table 7. Opioid metrics for milestone 5.

Metric Number	Metric Name	Count/Rate at baseline	Count/Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
18	Use of Opioids at High Dosage in Persons Without Cancer	2.6%	2.5%	-0.1%	-3.8%	Consistent or Decrease	Consistent	**Y**
21	Concurrent Use of Opioids and Benzodiazepines	8.1%	7.3%	-0.8%	-9.9%	Consistent	Consistent	**Y**
23	ED visits for SUD per 1,000 beneficiaries	2.1	1.9	-0.2	-8.4%	Consistent or Decrease	Consistent	**Y**
27	Overdose Death rate per 100,000 Beneficiaries	42.8	NA	NA	NA	Consistent or Decrease		

Table 7 shows the opioid metrics for Milestone 5. Metrics 18, 21, and 23 have remained consistent. Directionally, they have all made progress toward decreased use of opioids and ED visits for SUD since baseline. Metric 27 only had data for the baseline rate and were therefore unable to calculate if the state was trending the desired direction. DHCS reported to UCLA that California received an extension from CMS for Metrics 26 and 27, that the next planned submission for these metrics is due June 2026, and that DHCS is in the process of requesting Metric 26 and 27 baseline data be resubmitted to CMS.

Administrative Data: CalOMS-Tx

Based on analysis of CalOMS-Tx data, use of MAT among people with OUD statewide has been relatively stable over the course of DMC-ODS. However, the composition of the medications used is changing. While methadone delivered through OTPs represents most of these medications, methadone's share is slowly decreasing over time while use of buprenorphine is becoming more common. Outside of the DMC-ODS specialty care treatment system, rates of buprenorphine prescriptions per 1,000 residents have increased from 18.6 in calendar year 2021 to 21.74 in 2023, representing an increase of 16.8 percent in just two years (California Overdose Surveillance Dashboard, 2024). This is also consistent with the finding that overall, MAT claims have increased (see Milestone 1, Metric 12). A recent impact analysis report on California's combined efforts including Medi-Cal and grant programs suggests MAT expansion together with naloxone distribution contributed to a recent reduction in the number of opioid overdoses in the state (Khurana et al., 2024). DMC-ODS delivery of MAT services is therefore part of a larger comprehensive treatment strategy to address opioid abuse and OUD.

Stakeholder Feedback: County Administrators

When asked to describe about how DHCS could help counties address challenges associated with fentanyl with free text responses, county administrators had the following suggestions:

- **Continue and Enhance the Naloxone Distribution Program:** County administrators reported that California's Naloxone Distribution Program has been helpful in enhancing harm reduction and overdose prevention services, and that further support to ensure the sustainability of these efforts is important. Some administrators also suggested expanding the range of products offered through the Naloxone Distribution Program to include higher-

dose medications and medication disposal systems.

- **Increased Public Education and Stigma Reduction**: Several county administrators reported that harm reduction services designed to address the fentanyl crisis *"operate against a wave of opposition from community members with uninformed stigma towards harm reduction."* Administrators suggested that increasing funding and support for community education about fentanyl and harm reduction in the form of media/social media campaigns, community events, and billboards could help shift public attitudes around these issues. Some administrators also suggested focusing efforts on educating local policymakers and Boards of Supervisors in order to enhance political support for harm reduction efforts.

- **Enhance Services in Residential Levels of Care:** County administrators suggested several ways that services at residential levels of care could be leveraged to help address the fentanyl and overdose crisis. These included: (1) allowing longer lengths of stay for clients who use fentanyl and/or are experiencing homelessness; (2) encouraging utilization of residential treatment with incidental medical services by increasing rates to adequately cover the costs of medical service delivery; and (3) allow for payment of MAT and withdrawal management services delivered in outpatient settings on the same day that residential services are delivered, since many residential programs do not have the capacity to prescribe medications.

- **Improve Treatment Utilization Through Low-Barrier and Mobile SUD Services:** County administrators suggested several ways that current barriers to SUD treatment access and utilization can be mitigated to better meet the needs of individuals who are not currently engaged in care. First, they suggested removing abstinence requirements for treatment by *"adding regulatory/statutory] language that make(s) it clear that people using substances can be treated continuously regardless of status of substance use."* They also suggested that creating mechanisms to enhance Behavioral Health Plan and Medi-Cal Managed Care Plan reimbursement for low-barrier SUD services, could *"increase the likelihood"* that individuals with SUD who are still actively using substances can be identified and connected to care. They also suggested that by encouraging counties to launch mobile methadone and buprenorphine programs, the State could potentially engage many unserved individuals in care.

Milestone 6: Improved care coordination and transition between levels of care

Monitoring Metrics

Table 8. Metrics for care coordination and transitions in care.

Metric Number	Metric Name	Count/ Rate at baseline	Count/ Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
15	Initiation of AOD Treatment - Alcohol abuse or dependence	19.4%	20.2%	0.8%	4.1%	Consistent or Increase	Consistent	**Y**
15	Initiation of AOD Treatment - Opioid abuse or dependence	21.9%	31.8%	9.9%	45.2%	Consistent or Increase	Increase	**Y**
15	Initiation of AOD Treatment - Other drug abuse or dependence	19.1%	19.2%	0.1%	0.5%	Consistent or Increase	Consistent	**Y**
15	Initiation of AOD Treatment - Total AOD abuse or dependence	19.6%	21.2%	1.6%	8.2%	Consistent or Increase	Consistent	**Y**

Metric Number	Metric Name	Count/ Rate at baseline	Count/ Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
15	Engagement of AOD Treatment - Alcohol abuse or dependence	5.6%	5.8%	0.2%	3.6%	Consistent or Increase	Consistent	**Y**
15	Engagement of AOD Treatment - Opioid abuse or dependence	8.0%	9.6%	1.6%	20.0%	Consistent or Increase	Increase	**Y**
15	Engagement of AOD Treatment - Other drug abuse or dependence	5.9%	5.9%	0.0%	0.0%	Consistent or Increase	Consistent	**Y**
15	Engagement of AOD Treatment - Total AOD abuse or dependence	6.0%	6.3%	0.3%	5.0%	Consistent or Increase	Consistent	**Y**

Table 8, continued.

Metric Number	Metric Name	Count/Rate at baseline	Count/Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
17.1	Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit	31.1%	27.7%	-3.4%	-10.9%	Consistent or Increase	Decrease	**N**
17.1	Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit	21.4%	18.8%	-2.6%	-12.0%	Consistent or Increase	Decrease	**N**
25	Readmission Among Beneficiaries with SUD	15.4%	16.1%	0.7%	4.5%	Consistent or Decrease	Consistent	**Y**

Metrics 15 and 25 are moving in the expected direction. However, metric 17.1 is not moving in the expected direction. DHCS also reports metric 17.2 on emergency department visits for mental illness, but this metric has been excluded in this report since mental illness is not the primary focus of DMC-ODS.

The metric 17.1 results are somewhat surprising because California is home to an extensive California Bridge program that focuses on bridging patients with opioid, stimulant, or alcohol use disorders from emergency departments into treatment. This program scaled up quickly from 2019 through 2023 (Samuels et al., 2024). Most sites were active as of the baseline year of 2022, however, which may have lessened its effect when comparing 2022 to 2023.

The results are also surprising because treatment initiation increased 45.2% among patients with OUD more generally (Metric 15), but appeared to decrease in referrals from EDs (Metric 17.1).

One explanation may be challenges in computing this metric. DHCS is in the process of validating previously reported mid-point results for metric 17.1.

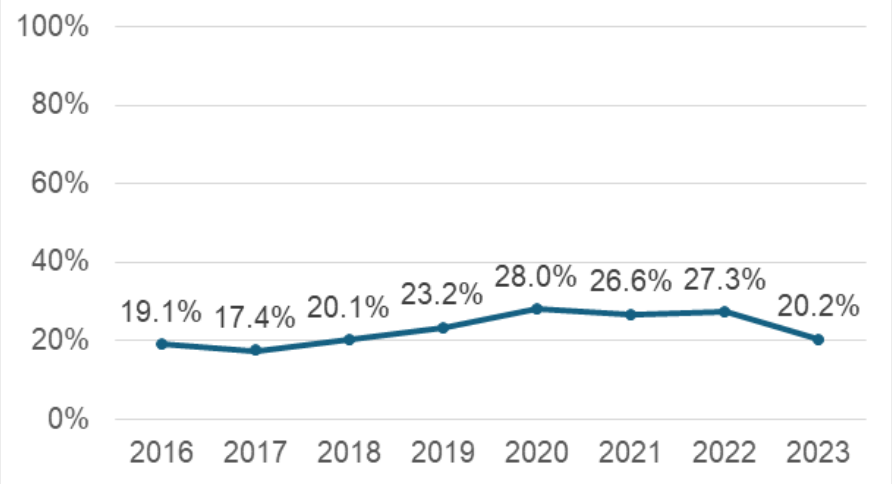
Stakeholder Feedback: California Bridge

UCLA reached out to CA Bridge researchers and leaders to get feedback on why rates might have fallen on Metric 17.1. They expressed concerns over the current accuracy of the diagnostic coding used in ED billing, and speculated that the patient population could be becoming more difficult to refer successfully, which may have led to reduced follow-up rates. UCLA cannot confirm this with the data available. The total number of ED visits with SUD diagnoses was similar between the two years (98,328 in 2022, 96,445 in 2023, with data reporting lag possibly reducing the 2023 number). This suggests the population of ED patients with SUD did not grow dramatically, but UCLA also cannot rule out the stakeholder's hypothesized shift to a more difficult population with the available data.

Administrative Data: CalOMS-Tx

As shown in Figure 6 below, transitions from residential treatment were stable from 2021 to 2022 after rising during the earlier years of DMC-ODS. The rate fell in 2023, but it is unclear whether this may be due to data reporting lag. UCLA will continue to monitor this trend and will recalculate transitions using Drug Medi-Cal claims for the 2025 interim evaluation report.

Figure 6. Transition rate from residential treatment to any treatment within 14 days of discharge (%, Medi-Cal beneficiaries, 2016-2023, CalOMS-Tx)



Stakeholder Feedback: Clients

From 2021 through 2023, adult and youth TPS respondents agreed to Care Coordination questions at a high rate, as shown in Table 9 (Gilbert et al., 2022, Gilbert et al., 2023, Gilbert et al., 2024). Relative to the other items on the TPS survey, however, care coordination items are the lowest rated, suggesting there may be room for improvement even if perceptions are generally positive.

Table 9. Percentage of clients agreeing with individual TPS Care Coordination questions.

Adult	2021	2022	2023
Staff here work with my physical health care providers to support my wellness	84.3%	84.7%	82.7%
Staff here work with my mental health care providers to support my wellness	83.9%	83.7%	81.8%
Staff here helped me to connect with other services as needed (social services, housing, etc.)	N/A	N/A	80.9%

Youth	2021	2022	2023
Staff here make sure that my health and emotional health needs are being met (physical exams, depressed mood, etc.)	89.2%	88.3%	87.6%
Staff here helped me with other issues and concerns I had related to legal/probation, family, and educational systems	85.5%	79.8%	83.4%

Table 10. Client Treatment Perceptions Survey average ratings across Care Coordination domain questions by modality

Adult	2021	2022	2023
Outpatient / Intensive Outpatient Treatment	4.4	4.4	4.3
Residential Treatment	4.3	4.2	4.1
Opioid Treatment Programs	4.2	4.3	4.3
Withdrawal Management	4.3	4.2	4.2
Youth	**2021**	**2022**	**2023**
Outpatient / Intensive Outpatient Treatment	4.3	4.2	4.3

(1=Strongly Disagree, 5=Strongly Agree)
Numbers for other youth modalities suppressed due to the small number of respondents.

A set of 15 interviews with DMC-ODS clients in three residential treatment programs was previously conducted specifically to ask about transitions to different LOC (Antonini et al., 2020). These clients reported that care coordination, peer support services, family counseling, recovery support services, and recovery residences were important to support successful transitions in care. They also suggested graduating residential clients be provided with visits to outpatient locations for an orientation, or that an outpatient counselor visit them before they graduate to provide an easier transition.

Stakeholder Feedback: County Administrators

As part of the county administrator survey, administrators were asked if and how they have seen care coordination evolve since the implementation of DMC-ODS. Overall, the free text responses were consistently positive, noting "*gradual increases in care coordination*" since implementation of DMC-ODS, "*but still not enough*." All responses indicate that care coordination is a "*crucial service for each level of care*" and administrators have seen improvement "*at all critical points*" (admission, transition, and

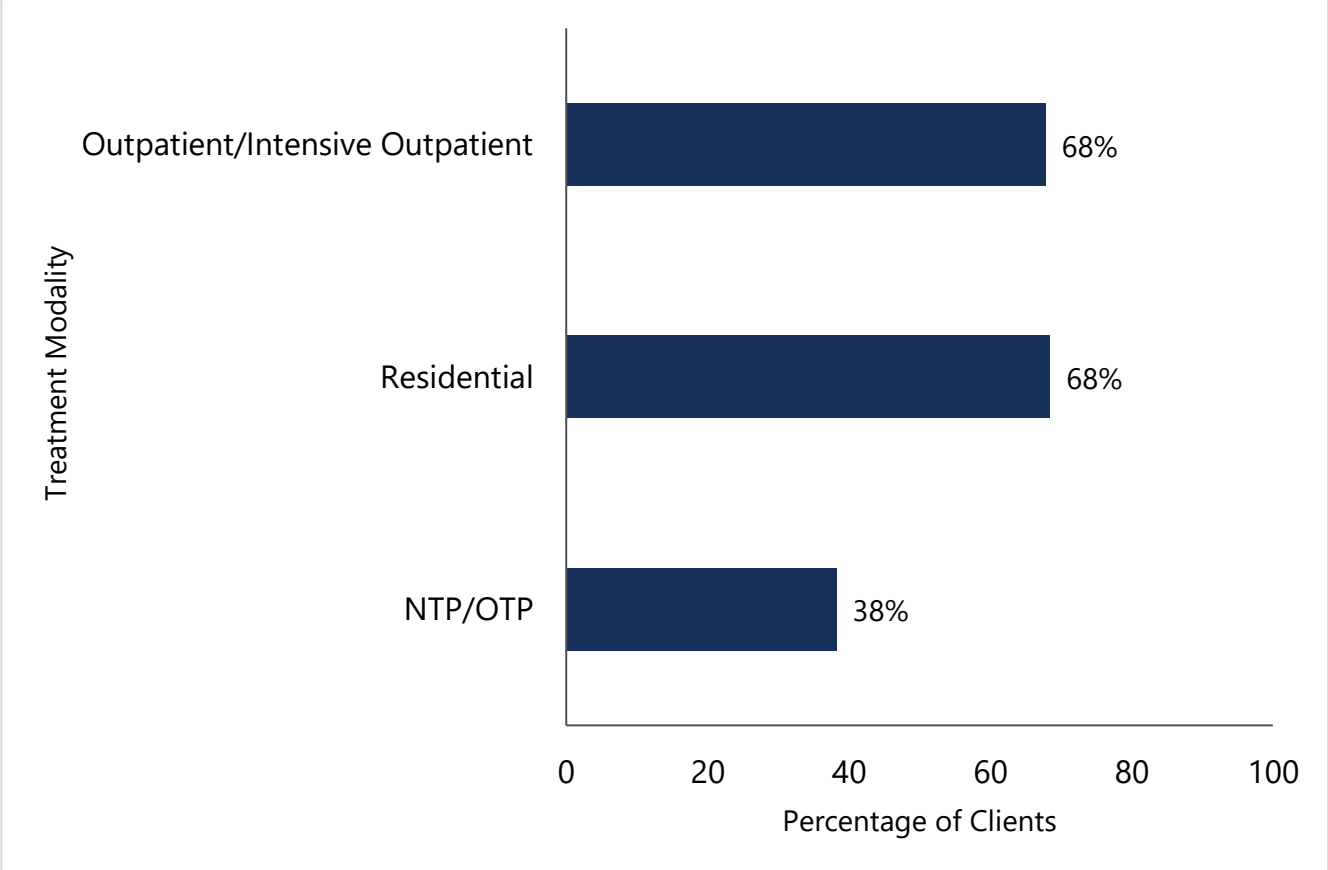
during treatment), yet more is needed. Administrators highlighted various strategies that have worked to enhance care coordination for their beneficiaries. One administrator indicated that through DMC-ODS, *"we've been able to add [care coordination] to all LOC [levels of care] which has been successful*." Another remarked on their county's success after "*work[ing] with their providers to develop pathways to improve care coordination during admissions and transition*." Another administrator mentioned placing "*SUD Liaisons in each clinic that assist with care coordination and linkage*."

The most common contributing factors to improved care coordination included:

- Improved utilization of the care coordination benefit,
- Enhanced structure and reimbursable roles for peers and recovery coaches, and
- Increased communication and collaboration among providers.

Earlier DMC-ODS evaluation reports document the implementation challenges associated with care coordination benefits (previously known as case management), noting struggles with documentation requirements and uncertainty around billing practices. However, utilization has increased over time. In 2020, county administrators from active DMC-ODS counties at that time estimated an average of 28.6 percent of their beneficiaries received care coordination services (Urada et al., 2021). In 2021 this increased to 53.1 percent (Urada et al., 2022a), and in 2024 administrators estimated 68.0 percent of their beneficiaries in outpatient, intensive outpatient, or residential treatment received care coordination services (see Figure 7). However, while overall use of care coordination is increasing, utilization in NTP/OTP settings remains low (38 percent). A provider previously attributed this to the cost-reimbursement structure for NTPs/OTPs (Urada et al., 2021). CalAIM Behavioral Health Payment Reform implemented on July 1, 2023, transitioned counties from cost-based reimbursement to fee-for-service reimbursement, and UCLA will monitor whether use of care coordination changes over time in CalAIM following this transition.

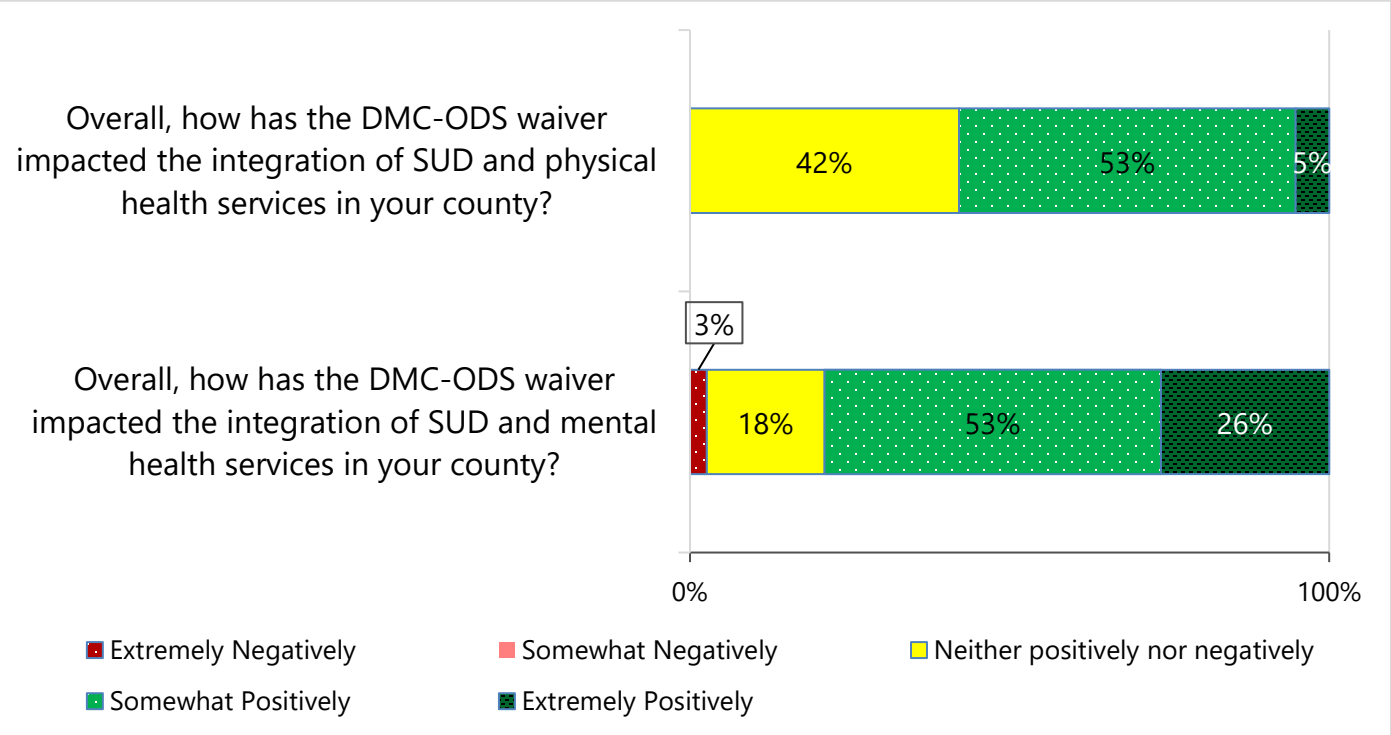
Figure 7: County administrator estimations of percentage of clients receiving care coordination (case management) services in their county by Treatment modality. 2024 County Administrator Survey.



Another contributing factor reported by county administrators for the increasing care coordination observed in their counties was the use of peers as part of this service. In 2022, DHCS launched the Medi-Cal Peer Support Services benefit establishing Medi-Cal Peer Specialists as a provider type and to provide specific support services. As part of this endeavor, DHCS established the Medi-Cal Peer Support Specialist Certification (PSSC) program to support this opportunity. While many have reported challenges with the certification process and about half of county administrators indicated a need for more clarification about this benefit, administrators consistently support the expanded role and "*promotional pathway(s) for peers,*" noting that peers are a *"wonderful contribution"* to service delivery teams. In particular, county administrators reported that peers have been effective in providing outreach and engagement services with *"good connection with clients due to lived experience",* expanding the reach of the provider to improve care delivery and linkage.

While care coordination has gradually improved within the SUD levels of care in DMC-ODS participating counties, county administrators reported varying progress integrating SUD services with the mental health and physical health systems. As shown in Figure 8 below, county administrators reported a more positive impact from DMC-ODS on the integration of SUD and mental health (SUD/MH) services than with physical health services (SUD/PH), 79 percent SUD/MH as compared with 58 percent SUD/PH, with a higher percentage reporting an extremely positive impact with SUD/MH integration. County administrators also reported a more neutral impact with SUD/PH integration as well.

Figure 8: County administrator responses to the impact of DMC-ODS on integration of SUD services with MH and PH services. 2024 County Administrator Survey.



As the client responses discussed above (Stakeholder Feedback – Clients) suggest, clients do not perceive a large deficiency in service coordination. More than 80 percent of respondents perceived coordination between their SUD providers and mental health and physical health providers. Overall, as one administrator summed up, the "*DMC-ODS has allowed for a more broad/whole person approach to looking at a person's needs which has brought to light [mental health] and physical health needs*."

Despite these successes, county administrators reported that challenges in delivering care coordination services persist. The most common reported challenges are primarily with billing, documentation, and staffing issues. Providers have historically provided care coordination but have not billed for it. As one administrator stated, "s*ome providers still don't document care coordination as often as they say they provide it*." Another administrator commented that it is best if care coordination services are provided by the county, because "c*ontracted providers have limited capacity."* Another administrator remarked that vacant positions impact the capacity of SUD counselors who are *"doing the best they can."*

Based on free text responses about integration of care and care coordination, county administrators reported the following suggestions:

- **Increase Resource Allocation**. One of the primary recommendations among county administrators was to ensure that the SUD system receives adequate attention and resources. This includes not only funding but also a dedicated focus on problem-solving efforts. As one administrator noted, "*It's unrealistic to starve a system of resources and then expect it to integrate with systems that receive much more attention and resources over the course of decades*." Another administrator commented that "*The changes under CalAIM has been helpful in some ways, but the volume of changes has also been a detriment*." "*System resources are more focused on implementation of MH requirements in my county – much less about DMC requirements.*" This imbalance needs to be addressed to ensure counties and providers receive the necessary support.
- **Address regulatory and knowledge barriers with both Managed Care Plans (MCPs) and Mental Health Plans (MHPs)**. Currently, MCPs are slower to integrate with DMC-ODS, yet both continue to have challenges due to "*perceptions of CFR 42 Part 2 restrictions, lack of knowledge of SUD services/interventions, and challenges with change management.*" One county commented on the disproportionate pressure put on MHPs to integrate compared to MCPs, stating that "*DHCS does not put the same level of pressure on the MCPs, and they should*."

- **Simplify the certification processes for MH providers to become ODS certified**. The perceived burden of requirements has deterred many providers from seeking certification. As one provider mentioned, "*Many MH providers actively avoid becoming ODS certified because 'word on the street' is that there are way too many requirements to becoming and remaining ODS certified*."

- **Continue to address stigma within the broader healthcare system**. Despite efforts to integrate and coordinate care, SUD services still face substantial stigma. "*It seems like SUD is still fighting for recognition and stigma reduction*," one administrator observed.

- **Strengthen Coordination with Physical Health Care**: Focus on better coordination with primary care providers and hospitals, addressing overloaded caseloads and differing treatment paradigms. One administrator commented that some of their "m*edical providers subscribe to alternative [and older SUD] treatment paradigms/approaches that are not always congruent with DMC-ODS accepted practices*."

- **Address staffing issues to support care coordination.** Providing care coordination and documenting these services takes time. "*The SUD counselors are spread thin, due to not being able to fill vacant positions. So, they do the best that they can*."

- **Provide technical assistance on the Peer Support Specialist Certification process and the utilization of the benefit.** The implementation of a structured pathway to build peer support as a billable service in the SUD system is highly underutilized with reported challenges. As knowledgeable and valuable components in the recovery process, peers can be a critical tool to improve care coordination and "*help clients stay in treatment by assisting with various needs*."

- **Provide technical assistance on defining Recovery Services and the utilization of the benefit.** County administrators acknowledged the impact recovery coaching has in care coordination, yet it is the most underutilized benefit. Counties and providers would benefit from clarification on the differences between recovery services and a recovery service LOC, how recovery services are different than similar benefits such as individual counseling, group counseling, patient education, etc., and when to use recovery services.

- **Provide technical assistance on billing for care coordination.** Offer detailed training on how to bill for care coordination, including what codes to use and when/where to use them. Ensure that billing guidelines are clear and accessible to all providers.

Monitoring Metrics Subgroups

Monitoring metrics were also reported by three age subgroups, as well as among dual-eligible (Medicaid and Medicare) and pregnant beneficiaries (see Table 11). The under-18 age group had more positive progress in access from baseline to mid-point compared to other age groups, while metrics suggested dual-eligibles services increased while services for pregnant beneficiaries remained mostly consistent.

Table 11. Monitoring metrics by subgroup.
Table 11a. Age subgroups

Metric Number	Metric Name	Age Subgroup	At baseline	At midpoint	Absolute change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
3	Medicaid bene-ficiaries with SUD diagnoses	<18	15,741.0	22,062.3	6,321.3	40.2%	Consistent	Increase	Y
		18-64	430,522.0	451,681.3	21,159.3	4.9%		Consistent	Y
		65+	26,875.0	36,796.3	9,921.3	36.9%		Increase	Y
6	Any SUD treatment	<18	2,929.3	4,300.3	1,371.0	46.8%	Consistent	Increase	Y
		18-64	115,897.7	117,816.3	1,918.6	1.7%		Consistent	Y
		65+	6,372.3	8,565.3	2,193.0	34.4%		Increase	Y
7	Early Inter-vention	<18	6.3	343.3	337.0	5323.4%	Consistent or Increase	Increase	Y
		18-64	463.3	2,342.0	1,878.7	405.5%		Increase	Y
		65+	18.7	62.0	43.3	231.6%		Increase	Y

Metric Number	Metric Name	Age Subgroup	At baseline	At midpoint	Absolute change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
8	Outpatient Services	<18	1,865.7	2,466.0	600.3	32.2%	Consistent	Increase	Y
		18-64	64,197.0	59,023.0	-5,174.0	-8.1%		Consistent	N
		65+	3,934.7	4,788.0	853.3	21.7%		Increase	Y
9	Intensive Outpatient and Partial Hospital-ization Services	<18	61.7	24.0	-37.7	-61.1%	Consistent	Decrease	N
		18-64	2,390.0	705.0	-1,685.0	-70.5%		Decrease	N
		65+	21.1	20.3	-0.8	-3.8%		Consistent	Y
10	Residential Services	<18	96.3	216.0	119.7	124.3%	Consistent or decrease	Increase	Y
		18-64	7,834.3	8,427.3	593.0	7.6%		Consistent	Y
		65+	121.3	178.3	57.0	47.0%		Increase	Y

Table 11a, continued.

Metric Number	Metric Name	Age Subgroup	At baseline	At midpoint	Absolute change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
11	Withdrawal Manage-ment	<18	4.0	0.0	-4.0	-100.0%	Consistent	Decrease	N
		18-64	1,480.0	1,640.3	160.3	10.8%		Increase	Y
		65+	28.7	44.0	15.3	53.3%		Increase	Y
12	Medication Assisted Treatment	<18	252.7	581.3	328.6	130.0%	Consistent	Increase	Y
		18-64	48,429.0	52,960.7	4,531.7	9.4%		Increase	Y
		65+	586.0	837.3	251.3	42.9%		Increase	Y
23	ED visits for SUD per 1,000 bene-ficiaries	<18	0.12	0.13	0.01	8.3%	Consistent or Decrease	Consistent	N
		18-64	3.64	3.21	-0.43	-11.8%		Decrease	Y
		65+	0.99	0.99	0.00	0.0%		Consistent	Y
24	Inpatient stays per 1,000 bene-ficiaries	<18	0.06	0.07	0.01	16.7%	Consistent or Decrease	Increase	N
		18-64	1.80	1.80	0.00	0.0%		Consistent	Y
		65+	1.23	1.66	0.43	35.0%		Increase	N

Table 11b. Dual-Eligibility Subgroup

Metric Number	Metric Name	Count/ Rate at baseline	Count/ Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
3	Medicaid beneficiaries with SUD diagnoses	48,278.0	62,536.0	14,258.0	29.5%	Consistent	Increase	**Y**
6	Any SUD treatment	11,495.0	14,276.0	2,781.0	24.2%	Consistent	Increase	**Y**
7	Early Intervention	25.0	117.3	92.3	369.2%	Consistent or Increase	Increase	**Y**
8	Outpatient Services	7,606.0	8,495.0	889.0	11.7%	Consistent	Increase	**Y**
9	Intensive Outpatient and Partial Hospitalization Services	132.7	89.3	-43.4	-32.7%	Consistent	Decrease	**N**
10	Residential Services	362.3	403.3	41.0	11.3%	Consistent or Decrease	Increase	**Y**
11	Withdrawal Management	86.3	108.0	21.7	25.1%	Consistent	Increase	**Y**
12	Medication Assisted Treatment	528.3	1,414.3	886.0	167.7%	Consistent	Increase	**Y**

Table 11c. Pregnant Subgroup

Metric Number	Metric Name	Count/ Rate at baseline	Count/ Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
3	Medicaid beneficiaries with SUD diagnoses	20,756.7	17,650.7	-3,106.0	-15.0%	Consistent	Decrease	**N**
6	Any SUD treatment	2,019.7	2,032.7	13.0	0.6%	Consistent	Consistent	**Y**
7	Early Intervention	7.7	66.0	58.3	757.1%	Consistent or Increase	Increase	**Y**
8	Outpatient Services	1,106.0	1,074.3	-31.7	-2.9%	Consistent	Consistent	**N**
9	Intensive Outpatient and Partial Hospitalization Services	76.0	18.0	-58.0	-76.3%	Consistent	Decrease	**N**
10	Residential Services	197.0	192.7	-4.3	-2.2%	Consistent or Decrease	Consistent	**N**
11	Withdrawal Management	27.7	25.7	-2.0	-7.2%	Consistent	Consistent	**N**
12	Medication Assisted Treatment	630.0	739.0	109.0	17.3%	Consistent	Increase	**Y**

Other Monitoring Metrics

The following monitoring metrics were also reported by DHCS (see Table 12) but were not specifically associated with one of the milestones listed above.

Table 12. Other Monitoring Metrics

Metric Number	Metric Name	Count/ Rate at Baseline	Count/ Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
3	Medicaid beneficiaries with SUD diagnoses	473,138	510,540	37,402	7.9%	Consistent	Consistent	**Y**
4	Medicaid beneficiaries with SUD diagnoses (annually)	732,176	761,215	29,039	4.0%	Consistent	Consistent	**Y**
24	Inpatient stays per 1,000 beneficiaries	1.1	1.2	0.1	7.0%	Consistent or Decrease	Consistent	**N**
26	Overdose Deaths	6,284	NA	NA	NA	Consistent or Decrease		
SUD Health IT Q1	Number of Checks	9,121,368	98,159,799	89,038,431	976.2%	Consistent or Increase	Increase	**Y**

Metric Number	Metric Name	Count/ Rate at baseline	Count/ Rate at midpoint	Absolute Change	Percent Change	Demonstration Target	Directionality of Change	Progress (Y/N)
SUD Health IT Q2	Number of web updates	23.0	10.0	13.0	56.5%	Consistent or Increase	Increase	**Y**
SUD Health IT Q3	Number of corrections live	3.0	3.0	0.0	0.0%	Consistent or Increase	Consistent	**Y**

These metrics paint a consistent picture of a system that is increasing or maintaining DMC-ODS progress in the expected direction. Midpoint overdose death metrics are not expected to be available until Summer 2025.

Budget Neutrality

Although an independent cost analysis has not been conducted, DHCS reports being on track for budget neutrality requirements at this time, as evidenced by DHCS's quarterly budget neutrality workbook submissions to CMS.

Assessment of Overall Risk of Not Meeting Milestones

Summary of overall risk of not achieving demonstration milestones

Milestone 1: Access to critical levels of care for OUD and other SUDs.

Goals for this milestone were met for 7/8 (87.5%) of the metrics. Furthermore, ES and DD estimates suggested access is being maintained. Also, the client and county administrator survey feedback were positive. Together, these findings consistently suggest a low risk of not achieving Access demonstration milestones. The monitoring metrics did suggest the number of beneficiaries receiving intensive outpatient treatment declined sharply, which is likely due to a change in billing codes but merits further monitoring.

Risk level: Low

Milestone 2: Use of evidence-based SUD-specific patient placement criteria

California tracks use of ASAM screenings and assessments through ASAM LOC Placements data. After generating data-driven estimates to correct for missing data submissions, it is clear that the use of these screenings and assessments has continued at a high level and has been consistent with previous years.

Expansion of access to treatment in IMDs within an organized delivery system is a core component of DMC-ODS, and the number of beneficiaries treated in IMDs for SUD has risen accordingly since 2022 (Metric 5). As new counties join DMC-ODS, the numbers will likely continue to increase or remain consistent. UCLA recommends the current target direction of this metric (decrease) be revisited with CMS.

Risk level: Low

Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities

There are no CMS monitoring metrics for Milestone 3. Standards for provider qualification designations for residential treatment were established and implemented during the previous Medi-Cal 2020 waiver. These policies have been maintained in the current CalAIM waiver. As of November 15, 2024, 994 facilities have received an ASAM LOC designation.

Risk level: Low

Milestone 4: Sufficient provider capacity at each level of care

Monitoring Metrics were inconclusive due to changes in how providers were identified. However, in the most recent available Annual Network Certification DMC-ODS Corrective Action Plan report, 11 out of 31 plans were non-compliant as of June 2023 (35.4 percent). This report and comments from stakeholders converge upon a need for more youth residential treatment specifically, though other metrics point to possible challenges outpatient treatment (see Milestone 1). Stakeholders also provided feedback on workforce challenges to provider capacity and provided suggestions to address them.

Risk level: Medium

Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.

Although the overdose deaths metric was not available for 2023, the three available monitoring metrics (75%) were in the targeted direction. Administrative data suggest mostly level or slightly decreased use of MAT within DMC-ODS providers, but with a strong increase in use of MAT overall. County stakeholders offered suggestions on how to continue expanding opioid treatment and prevention strategies.

Risk level: Low

Milestone 6: Improved care coordination and transition between levels of care

All Metrics 15 (initiation and engagement) and 25 (readmissions) suggested progress. but Metric 17.1 (follow-up after ED visit) did not. Transitions from residential treatment were stable in 2022. They appeared to decrease slightly in 2023, but reporting lag could play a role. Stakeholder feedback from clients was positive and stable but there is room for improvement. Stakeholder feedback from county administrators suggested a positive impact of DMC-ODS and improving use of care coordination, but administrators also cited additional challenges that remain. Taken together, these mixed results suggest a medium risk.

Risk level: Medium

Recommendations

The following are recommendations focused on the two milestones rated medium risk, milestone 4 and 6.

Milestone 4: Sufficient provider capacity at each level of care

- Explore and address reasons for the apparent decrease in intensive outpatient treatment to determine the underlying reasons in this decrease in claim submission, whether it is due to billing processes or an actual decline in services. Investigate Network Adequacy in collaboration with the EQRO. In particular, it would be helpful to gain an understanding of the degree to which plans are out of compliance and what the underlying causes are. For example, failing a time standard due to provider shortages requires a different solution than missing documentation.

- Explore ways to create additional capacity in adult outpatient as well as children/youth residential programs in geographic areas with insufficient capacity. The need for youth residential treatment was particularly highlighted by stakeholders. This can be addressed in part by prioritizing these types of capacity in BHCIP funding. Consistent with this, on December 7, 2022, DHCS announced $480.5 million in grants for 54 projects aimed at constructing new facilities and expanding existing facilities that serve youth with substance use and/or mental health disorder (Jacques, 2022). In 2024, California voters approved Proposition 1, an initiative that includes up to $6.4 billion to expand the capacity of behavioral health care facilities (DHCS, 2024). This effort, referred to during implementation as the Behavioral Health Transformation, should support expansion of treatment where network adequacy has historically fallen short.

- Address workforce challenges by leveraging investments like the BH-CONNECT Workforce Initiative and Behavioral Health Services Act (SB 326) funding, including:

    - Addressing burnout/fatigue
    - Increasing compensation
    - Providing professional training and development
    - Providing support for rural counties
    - Reducing the administrative burden on staff
    - Investing in training community-based providers

- Providing financial assistance, including scholarships, and loan repayment
- Supporting recruitment and retention efforts
- Increasing slots for specific residency or fellowship programs
- Investing in telehealth to maximize workforce efficiency and reach
- Provide Support for providers joining DMC-ODS

Milestone 6: Improved care coordination and transition between levels of care

- Explore why follow-up care after an emergency room visit metric (Metric 17.1) has decreased. This could include gathering additional information from Bridge sites, leveraging ongoing CA Bridge reporting required under State Opioid Response grant requirements, as well working with the EQRO to gather information on the accuracy of the metric from the multiple performance improvement projects currently underway that focus on this metric (Behavioral Health Concepts, 2024).

  If the monitoring metric is not found to indicate a true decline in the effectiveness of CA Bridge referrals, support efforts to add California Bridge Navigators to increase coordination between EDs and DMC-ODS treatment and encourage follow-up by connecting patients to doctors outside of DMC-ODS who can prescribe buprenorphine for OUD. In a recent study of California Bridge sites, 15.9 percent of patients without navigators engaged in outpatient treatment within 30 days of ED discharge, but the rate was more than three times as high (50.4 percent) among patients with a navigator (Anderson et al., 2023).

- Address challenges in referring patients to prescribers, including prescribers outside of the DMC-ODS system. Commonly used treatment finder websites like SAMHSA's findtreatment.gov and their buprenorphine practitioner locator (SAMHSA, 2024) currently cite their source of information as the list of practitioners "who previously held a DATA-2000 waiver to prescribe buprenorphine." However, the DATA-2000 requirement was eliminated by the Consolidated Appropriations Act of 2023, and SAMHSA warns, "this list is not inclusive of all practitioners able to provide buprenorphine." Over time this list is

becoming increasingly inaccurate, which stakeholders have anecdotally reported is undermining referral efforts. DHCS-supported TreatmentAtlas.org lists California specialty SUD treatment centers but does not list individual buprenorphine prescribers covered by the broader health care system, e.g. individual practitioners covered by Medi-Cal MCPs or through facilities like federally qualified health centers. DHCS should consider rebuilding a more reliable list of currently active California prescribers, starting by leveraging existing DHCS-funded projects with active prescribers like the California Hub and Spoke System, prescribers participating in Opioid and Stimulant Implementation Support Training and Technical Assistance (OASIS-TTA), and referral networks used by CA Bridge.

- Address regulatory and knowledge barriers with both MCPs and MHPs. Stakeholders cited "*perceptions of CFR 42 Part 2 restrictions, lack of knowledge of SUD services/interventions, and challenges with change management,*" as a barrier.

- Draw from lessons learned during the CalAIM Authorization to Share Confidential Medi-Cal Information (ASCMI) Form and consent management services and the Universal Release of Information pilot. (DHCS, 2024e).

- Strengthen Coordination with Physical Health Care: Focus on better coordination with primary care providers and hospitals, addressing overloaded caseloads and differing treatment paradigms. One administrator commented that some of their "*medical providers subscribe to alternative [and older SUD] treatment paradigms/approaches that are not always congruent with DMC-ODS accepted practices*."

- Provide technical assistance on billing for care coordination. Stakeholders suggested detailed training on how to bill for care coordination, including what codes to use and when/where to use them.

- Work with the EQRO to highlight and disseminate lessons learned and successes from performance improvement projects focused on transitions and referrals, including Riverside County's use of regional Care Coordination Teams (Urada et al., 2019), and results from counties with projects focusing on the Follow-Up After Emergency Department Visit metric (Behavioral Health Concepts, 2024).

- Encourage use of care coordination, peer support services, family counseling, recovery support services, and recovery residences specifically to support successful transitions between LOC. Encourage or incentivize implementation of warm handoffs from residential programs, including providing graduating residential clients with visits to outpatient locations or having an outpatient counselor visit them before they graduate.
- Conduct additional analyses to determine the most common reasons for all-cause readmissions among beneficiaries with SUD.

Determination of factors likely to affect future performance

DHCS established the Behavioral Health Continuum Infrastructure Program (BHCIP) to award $2.2 Billion to expand behavioral health through construction, acquisition and expansion of properties, and investments in mobile crisis infrastructure. In March 2024, California voters passed Proposition 1, which included $6.38 billion in bond funding to develop an array of behavioral health treatment (California Health and Human Services, 2024). These efforts are expected to substantially increase SUD treatment provider capacity, and through the funding that has been released, 432 new and expanded facilities are being supported, with the final round of funding closing in October.

Assessment of the state's capacity to provide SUD services

Adequacy of state's capacity at the mid-point

As described in the discussion of milestone 4, most plans are compliant with network adequacy standards, but several are encountering challenges, particularly with adult outpatient treatment as well as children/youth residential programs.

Changes in the state's capacity

As described in the discussion of milestone 1, data sources suggest treatment access is successfully being maintained.

Identified needs for additional capacity

As discussed in the sections on milestones 1 and 4, stakeholders identified additional youth residential capacity as a specific need. Consistent with this, shortages of youth residential treatment were also the most common reason for plan non-compliance in the most recent available Annual Network Certification.

Next Steps

As described above, challenges include capacity in adult outpatient and children/youth residential programs, as well as successful referrals from the larger system of care, and within DMC-ODS LOC. These suggest a medium risk of not meeting milestones 4 and 6. However, the state also has meaningful strengths, including substantial funding to enhance treatment capacity, which could potentially address both milestones. DHCS provided feedback on the assessment findings, recommendations, and provided the following next steps to strengthen progress on these milestones.

Milestone 4: Sufficient provider capacity at each level of care

DHCS agrees with UCLA-ISAP's recommendations and will use them to guide future SUD service implementation to achieve improvements of this milestone. DHCS will coordinate with its partners to both explore any potential decrease in real service utilization and any potential correlation to provider availability, accessibility, and timely delivery of services. With its internal and external partners, DHCS will explore policy changes and any other mechanisms available to the Department to address additional capacity for SUD services and expand services across geographic areas identified with insufficient capacity, with special attention to youth residential services.

Milestone 4 Recommendation Bullet Point 1: Intensive Outpatient Treatment: Explore and address reasons for the apparent decrease in intensive outpatient treatment to determine the underlying reasons in this decrease in claim submission, whether it is due to billing processes or an actual decline in services.

DHCS Response to Bullet Point 1: Intensive Outpatient Treatment: As outlined in Milestone #1, DHCS believes that the apparent decline of intensive outpatient treatment is not necessarily due to an actual decline in treatment but could be due to a change in

billing codes. However, DHCS will continue to analyze data trends to determine if the apparent decrease in intensive outpatient treatment is due to other factors. If the data shows a significant decrease in intensive outpatient treatment, DHCS will reach out to the DMC-ODS counties with low intensive outpatient treatment claims to determine if there are other causes outside of the change in billing codes. Once the outreach is complete and the root cause(s) of the decrease has been determined, DHCS will provide necessary technical assistance to address any concerns. DHCS aims to complete the data analysis, conduct outreach and provide technical assistance to counties by the end of 2026.

Milestone 4 Recommendation Bullet Point 2: Network Adequacy: Investigate Network Adequacy in collaboration with the EQRO. It would be helpful to gain an understanding of the degree to which plans are out of compliance and what the underlying causes are. For example, failing a time standard due to provider shortages requires a different solution than missing documentation.

DHCS Response to Bullet Point 2: Network Adequacy: As required by 42 CFR 438.364, DHCS contracts with Health Services Advisory Group (HSAG) to prepare an annual, independent, technical report that summarizes findings on the quality, timeliness, and accessibility of SMHS and SUD services, including opportunities for quality improvement. HSAG conducts the network adequacy validation (NAV), validating the systems and processes, data sources, methods, and results, according to the *CMS EQR Protocol 4. Validation of Network Adequacy*.

DHCS will utilize the 2024-25 External Quality Review (EQR) Technical Report, Protocol 4 activities to gain an understanding of Plans that are out of compliance on network adequacy standards and the underlying causes. Below is the estimated timeline:

- **November 2025:** DHCS to review and approve SMHS and DMC-ODS Plan EQR Tech Report Volume 4.
- **December 2025:** DHCS to utilize the EQR Tech Report Volume 4 and identify any trending patterns based on HSAG's results.
- **January 2026 - December 2026:** DHCS to work with appropriate programs within the Department, external stakeholders, and Plans to explore opportunities to develop new methodologies and policies and conduct monitoring calls to address the identified issues.

- **January 2027 – August 2027:** DHCS to work on publishing updated guidance via Behavioral Health Information Notice (BHIN).

DHCS would like to note that HSAG conducted the NAV only for Timely Access in the 2024-25 EQR Technical Report. DHCS will collaborate with HSAG to include additional network adequacy standards (i.e. Time or Distance, Capacity and Composition, etc.) in future NAV activities.

Milestone 4 Recommendation Bullet Point 3: SUD Program Capacity: Explore ways to create additional capacity in adult outpatient as well as children/youth residential programs in geographic areas with insufficient capacity. The need for youth residential treatment was particularly highlighted by stakeholders. This can be addressed in part by prioritizing these types of capacity in BHCIP funding. Consistent with this, on December 7, 2022, DHCS announced $480.5 million in grants for 54 projects aimed at constructing new facilities and expanding existing facilities that serve youth with substance use and/or mental health disorder (Jacques, 2022). In 2024, California voters approved Proposition 1, an initiative that includes up to $6.4 billion to expand the capacity of behavioral health care facilities (DHCS, 2024). This effort, referred to during implementation as the Behavioral Health Transformation, should support expansion of treatment where network adequacy has historically fallen short.

DHCS Response to Bullet Point 3: SUD Program Capacity: DHCS was authorized through 2021 legislation to establish the Behavioral Health Continuum Infrastructure Program (BHCIP) and award $2.2 billion to construct, acquire, and expand properties and invest in mobile crisis infrastructure related to behavioral health. In March 2024, California voters passed Proposition 1, a two-bill package including the Behavioral Health Services Act (BHSA) and the Behavioral Health Infrastructure Bond Act (BHIBA) of 2024. This effort, referred to during implementation as the Behavioral Health Transformation, will support the statewide expansion of treatment in the areas of greatest need where network adequacy has historically fallen short. Entities receiving BHCIP and BHIBA grant funds are required to operate services in the financed facility for the intended purposes for a minimum of 30 years. Facilities must also provide behavioral health Medi-Cal services and have a contract with their county. DHCS was authorized to award up to $4.4 billion in BHIBA funds for BHCIP competitive grants. The first round of awards under Proposition 1 were announced in May 2025 and included adult outpatient as well as children/youth residential programs. The application window for the second round of funding is closing in October 2025.

Milestone 4 Recommendation Bullet Point 4: Workforce Challenges: Address workforce challenges by leveraging investments like the BH-CONNECT Workforce Initiative and Behavioral Health Services Act (SB 326) funding, including:

    - Addressing burnout/fatigue
    - Increasing compensation
    - Providing professional training and development
    - Providing support for rural counties
    - Reducing the administrative burden on staff
- Investing in training community-based providers
- Providing financial assistance, including scholarships, and loan repayment
- Supporting recruitment and retention efforts
- Increasing slots for specific residency or fellowship programs
- Investing in telehealth to maximize workforce efficiency and reach

DHCS Response to Bullet Point 4: Workforce Challenges: DHCS is actively addressing workforce challenges through initiatives like the Workforce Initiative authorized through the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration. The Workforce Initiative will support the training, recruitment and retention of behavioral health practitioners to provide Medi-Cal behavioral health services across the continuum of care. Individual recipients of workforce funding will complete a 2-4 year service commitment in one or more Medi-Cal behavioral health settings. The Workforce Initiative includes five workforce programs administered in partnership with the Department of Healthcare Access and Information (HCAI) over the 5-year demonstration period (2025-2029):

- Medi-Cal Behavioral Health Student Loan Repayment Program (to reduce educational debt for behavioral health professionals who commit to serving Medi-Cal members and underserved communities).
- Medi-Cal Behavioral Health Scholarship Program (to support scholarships for individuals pursuing behavioral health degrees or certifications to serve the Medi-Cal population).
- Medi-Cal Behavioral Health Recruitment and Retention Program (to provide recruitment and retention bonuses, supervision support for pre-licensure and pre-certification practitioners, and certification/licensure and training supports with the aim of recruiting and retaining behavioral health practitioners to serve the Medi-Cal population).

- Medi-Cal Behavioral Health Community-Based Provider Training Program (to build up the workforce of Alcohol or Other Drug Counselors, Community Health Workers/Promotors'/Representatives and Peer Support Specialists by funding training and education to create a healthcare workforce pipeline to address community-based workforce shortages throughout the state).
- Medi-Cal Behavioral Health Residency Training Program (to increase the availability of General Psychiatrists, Child and Adolescent Psychiatrists, Addiction Psychiatrists and Addiction Medicine Physicians that are trained and serve in Medi-Cal safety net settings.

Further, in DHCS' efforts to provide "Health Care for All," the Department has updated its telehealth guidance and permits telehealth for Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment through Medi-Cal, following specific guidelines for provider enrollment, service delivery, and documentation. To ensure quality of care, providers must be enrolled with DHCS and meet the same standards of care as in-person services. Medi-Cal members may also always choose to request services from an in-person provider. DHCS' efforts to comprehensively update telehealth policies are intended to help ensure that all Californians, particularly those living in rural communities with the most acute shortages of certain licensed professionals, are able to receive appropriate health care services.

DHCS has also focused on documentation reform as a means to reduce the administrative burden on county BHPs. As a component of CalAIM, the Department's documentation reform updates include streamlining documentation for Specialty Mental Health Services and Substance Use Disorder treatment. DHCS continues to provide technical assistance for BHPs and providers to support implementation of these updated requirements, and recently released updated and additional training modules through a free online platform.

In addition, CalAIM Behavioral Health Payment Reform was implemented beginning July 1, 2023, shifting counties away from cost-based reimbursement, which has historically been administratively burdensome for the State, counties, and subcontracted behavioral health providers. In addition to reducing administrative burden associated with cost reporting, the transition to a fee-for-service payment methodology is intended to be an incremental step toward enabling new value-based payments and alternative payment models at the plan and provider levels.

Milestone 6: Improved care coordination and transition between levels of care

DHCS agrees with UCLA-ISAP's recommendations and will use them to guide future SUD service implementation to achieve improvements of this milestone. To date, DHCS has embarked on a few initiatives aimed at addressing some of the challenges identified in this report, as described below.

DHCS is also in the process of validating previously reported mid-point results for Metric 17.1 and will recalculate the measure if appropriate. For example, the observed decline in follow-up care after emergency room discharge for SUD may reflect an alignment to new billing guidance under the CalAIM Behavioral Health Payment Reform implemented in July 2023, rather than a true decrease in service provision, given measure calculation needs to follow national specifications (for Metric 17.1) which may not reflect new billing codes. The DHCS responses to Milestone 6 recommendations are based on the assumption that there is a true rate decrease.

Milestone 6 Recommendation Bullet Point 1: Follow-up Care: Explore why follow-up care after an emergency room visit metric (Metric 17.1) has decreased. This could include gathering additional information from Bridge sites, leveraging ongoing CA Bridge reporting required under State Opioid Response grant requirements, as well working with the EQRO to gather information on the accuracy of the metric from the multiple performance improvement projects currently underway that focus on this metric (Behavioral Health Concepts, 2024).

DHCS Response to Bullet Point 1: DHCS recognizes the decline in the FUA measure and is taking a coordinated, multi-pronged approach to understand and address its underlying causes. While the overall trend is concerning, it remains unclear which populations or service pathways are driving the decline, in part because current reporting does not disaggregate follow-up rates by substance type or specific SUD diagnosis.

To investigate and respond effectively, DHCS will pursue disaggregation of FUA data by various criteria, such as geography, diagnosis, and procedure codes. This approach is essential to determine whether specific populations are being systematically missed by existing outreach and navigation supports, including those provided through the Bridge model and Community Health Workers (CHWs). It will also help clarify whether

disparities exist by region, provider type, or health plan, or if care gaps are related to differences in diagnosis practices, service availability, or coordination workflows. This disaggregated analysis will serve as a critical investigative strategy to identify where care breakdowns are occurring and why, ultimately informing more targeted and effective interventions.

In parallel, DHCS will reassess its previous efforts related to the Behavioral Health Quality Improvement Program (BH-QIP) and reinforced by the BH-CONNECT Incentive Program to ensure that actionable steps supporting care coordination are fully realized. These steps include:

- Enabling bidirectional data sharing by implementing real-time data exchange between DMC-ODS plans and MCPs through direct APIs or Health Information Exchanges (HIEs), to ensure timely communication of critical events such as admissions, discharges, and referrals.
- Deploying active FHIR APIs to provide authorized providers and care coordinators with real-time access to patient records, appointments, and care plans to support timely and coordinated follow-up.

These data modernization and coordination efforts are essential preconditions for improving FUA performance and closing gaps in care. Additionally, 19 DMC-ODS plans have committed to studying their own data and improving FUA performance as part of their 2024 to 2025 Performance Improvement Projects through the External Quality Review Organization process. This broad participation demonstrates strong alignment with statewide priorities and reflects a shared commitment to strengthening care transitions, follow-up, and outcomes for individuals with substance use disorders.

Finally, starting in 2024, several dyad teams comprised of MCP and County Behavioral Health staff (inclusive of SMHS and DMC-ODS) have been working together in a quality improvement collaborative facilitated by DHCS and the Institute for Healthcare Improvement (IHI) to improve FUA and FUM performance. Participating teams are implementing multi-pronged quality improvement approaches with a focus on data sharing and care coordination across delivery systems.

Milestone 6 Recommendation Bullet Point 2: Follow-up Care and Monitoring Metrics: If the monitoring metric is not found to indicate a true decline in the effectiveness of CA Bridge referrals, support efforts to add California Bridge Navigators to increase

coordination between EDs and DMC-ODS treatment and encourage follow-up by connecting patients to doctors outside of DMC-ODS who can prescribe buprenorphine for OUD. In a recent study of California Bridge sites, 15.9 percent of patients without navigators engaged in outpatient treatment within 30 days of ED discharge, but the rate was more than three times as high (50.4 percent) among patients with a navigator (Anderson et al., 2023).

DHCS Response to Bullet Point 2: Follow-up Care and Monitoring Metrics: DHCS agrees it is surprising to see a decrease in overall performance on the FUA measure, particularly in light of recent efforts to launch, expand, and sustain the CA Bridge navigation model. Bridge clinics have appeared to be remarkably successful in filling critical gaps in the system of care and increasing access to MAT, with follow-up rates as high as 92 percent for patients that were served by a navigator. CA Bridge quarterly reports show that in 2023, access to outpatient addiction treatment remained the most significant challenge the emergency room programs faced. DHCS will continue to engage CA Bridge leaders and review data to better understand the finding specific to emergency room referrals, while simultaneously working to sustain the Bridge model statewide and pursuing additional strategies to improve care coordination and access to MAT.

DHCS has taken decisive steps to sustain and expand the Bridge model beyond the limitations of grant-funded pilots by clarifying how ED navigation services can be covered in Medi-Cal. Specifically, DHCS has issued guidance directing MCPs to establish clear billing pathways for substance use navigator services provided by Community Health Workers in Emergency Departments, and communicate these payment policies to their contracted hospitals. This approach is meant to ensure that navigator services, including Community Health Workers, are financially sustainable and fully integrated into routine care delivery, thereby maintaining essential linkage and navigation supports for individuals with substance use disorders.

DHCS also recognizes that while emergency rooms have become increasingly accessible entry points for addiction care, clinics have not achieved the same level of accessibility. Patients face multiple barriers when trying to establish ongoing care: evaluators have observed that there were not enough clinics available, and those that existed often maintained high-threshold requirements for entry. The process of getting into a clinic involves numerous steps and obstacles that many patients struggle to navigate, even with support. As described in DHCS' response to Bullet Point 3 (below), under the Behavioral Health Services Act DHCS is advancing new requirements for counties to

promote low-barrier access to MAT, including telehealth models, drop-in clinics, and mobile NPTs. These interventions, when combined with improvements in data sharing and care coordination as described throughout this report, should support improved rates of follow-up for individuals who visit emergency departments for SUD.

Milestone 6 Recommendation Bullet Point 3: Referring Patients: Address challenges in referring patients to prescribers, including prescribers outside of the DMC-ODS system. Commonly used treatment finder websites like SAMHSA's findtreatment.gov and their buprenorphine practitioner locator (SAMHSA, 2024) currently cite their source of information as the list of practitioners "who previously held a DATA-2000 waiver to prescribe buprenorphine." However, the DATA-2000 requirement was eliminated by the Consolidated Appropriations Act of 2023, and SAMHSA warns, "this list is not inclusive of all practitioners able to provide buprenorphine." Over time this list is becoming increasingly inaccurate, which stakeholders have anecdotally reported is undermining referral efforts. DHCS-supported TreatmentAtlas.org lists California specialty SUD treatment centers but does not list individual buprenorphine prescribers covered by the broader health care system, e.g. individual practitioners covered by Medi-Cal MCPs or through facilities like federally qualified health centers. DHCS should consider rebuilding a more reliable list of currently active California prescribers, starting by leveraging existing DHCS-funded projects with active prescribers like the California Hub and Spoke System, prescribers participating in Opioid and Stimulant Implementation Support Training and Technical Assistance (OASIS-TTA), and referral networks used by CA Bridge.

DHCS Response to Bullet Point 3: Referring Patients: To address challenges in referring patients to prescribers, including prescribers outside of the DMC-ODS system, DHCS currently maintains BH navigator prescriber lists through the CA Bridge program and is exploring opportunities to further develop this information through California's CA Bridge contract with the Public Health Institute. The CA Bridge Connect platform is in the beginning stages of development and intends to provide real-time crisis care for opioid addiction set to launch in six pilot counties in October 2025 and continue rollout in 2026. The CA Bridge platform will include a list of searchable navigators throughout California and aims to close the gap in overcoming the challenge of connecting patients for follow-up care after MAT through 24-7 immediate call, text, and chat which is referred to a BH navigator and an initial visit is set to prescribe low-barrier MAT.

In addition to the CA Bridge Connect platform, under the Behavioral Health Services Act (BHSA) counties are required to invest in assertive, field-based initiation of SUD

treatment and specifically low-barrier MAT access points. DHCS recognizes that more proactive strategies are needed to engage, prevent overdose, and improve access to MAT for most individuals living with SUD who remain unengaged in care, beyond traditional treatment settings and approaches, which only reach a small percentage of people living with SUDs. Pursuant to the BHSA counties will be required to deploy assertive field-based initiation programs that proactively engage individuals living with SUD and offer low barrier access to MAT.

Assertive field-based initiation promotes a proactive "no-wrong door" approach to connect more individuals living with SUD to MAT on a voluntary basis, similar to assertive, field-based models that promote proactive engagement and treatment of individuals living with Serious Mental Illness (SMI). Assertive field-based initiation is focused on providing rapid access to MAT and connection to services for individuals at the highest risk of overdose. Counties are encouraged to identify these populations, including those who are unhoused/housing insecure, justice-involved and/or those with co-occurring mental health needs. Assertive field-based initiation requires counties to conduct ongoing, targeted outreach to engage and initiate individuals living with SUD into MAT in any community based and low barrier setting. Community based low barrier settings include the street, shelters, homeless encampments, consumer-operated wellness centers, drop-in centers, syringe service programs, medication and mobile Narcotic Treatment Programs (NTPs), and other easily accessible locations that aim to reach people where they are.

Milestone 6 Recommendation Bullet Point 4: Knowledge Barriers: Address regulatory and knowledge barriers with both MCPs and MHPs. In particular, stakeholders cited "*perceptions of CFR 42 Part 2 restrictions, lack of knowledge of SUD services/interventions, and challenges with change management,*" as a barrier.

DHCS Response to Bullet Point 4: Knowledge Barriers: DHCS recognizes that effective care coordination for members receiving substance use disorder (SUD) services can be impeded by regulatory uncertainty, provider knowledge gaps, and local-level change management challenges. In response, DHCS has implemented a range of policies, tools, and technical assistance strategies—and continues to build upon these efforts—to support integrated, person-centered care across the Medi-Cal delivery system.

Key guidance and tools include:

- Updated Data Sharing Guidance for DMC-ODS plans (to be published in 2025):

DHCS is working to enable consistent, real time sharing of member information among Medi-Cal partners to support seamless point-of-care decision-making and improve health outcomes. To facilitate this, DHCS is preparing to publish consolidated behavioral health data sharing guidance through a BHIN and All Plan Letter (APL). The goal of these policy bulletins is to both clarify existing requirements and add additional procedural data-sharing requirements between county Behavioral Health Programs (BHPs), Drug Medi-Cal (DMC) Programs, and Medi-Cal Managed Care Plans (MCPs). DHCS will clarify requirements for critical member data to be shared bidirectionally and in real time, in accordance with federal and state data sharing and privacy regulations, including federal interoperability standards.

- CalAIM Data Sharing Authorization Guidance (Published March 2022): This document offers comprehensive guidance to support data sharing among Managed Care Plans (MCPs), healthcare providers, community-based organizations, local health jurisdictions, counties, and other public agencies involved in CalAIM implementation. It aims to clarify how entities can legally and effectively exchange data to support integrated care.

- ASCMI Form (Published July 2025): This standardized form allows providers and care partners to obtain individual consent for real-time data sharing, including with MCPs and other service providers. The ASCMI Form has been updated to enhance clarity, usability, and compliance with federal and state laws, incorporating extensive stakeholder feedback on its language, structure, and formatting.

- Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (Updated June 2025): These standardized tools are designed to determine and guide referrals to adult and youth members to the appropriate Medi-Cal mental health delivery system (either a Managed Care Plan or County Behavioral Health Plan) that is expected to best support each member. MHPs and BHPs are required to use The Adult and Youth Screening Tools for Medi-Cal Mental Health Services (Screening Tools) for members seeking mental health services for the first time. The goal of this initiative is to ensure timely, coordinated care for members requiring transition between delivery systems to improve health outcomes for members. The Screening Tools include questions related to substance use disorder (SUD) that require a referral for an SUD assessment if an individual responds affirmatively.

- MOU Requirements: BHIN 23-057 requires a Memorandum of Understanding (MOU) between DMC-ODS counties and MCPs to ensure member care is coordinated. The DMC-ODS/MCP MOUs must include provisions for data sharing and confidentiality requirements. The MOUs will further describe the data and information that can be exchanged to improve care coordination and referral processes.

- DMC-ODS counties and MCPs are required to meet quarterly to discuss care coordination and referral concerns. Additionally, DMC-ODS counties must compile an annual report for DHCS, summarizing the key points from these quarterly meetings, including updates on care coordination and referral concerns discussed. DHCS will leverage this report to identify any concerns with coordination of care and provide necessary technical assistance to counties.

- DMC-ODS Technical Assistance: The Department maintains a robust and comprehensive array of training and technical assistance resources to support substance use treatment providers within its DMC-ODS program. DHCS is actively expanding provider education and training through a multifaceted approach that includes webinars, regional learning collaboratives, and regularly updated clinical guidance. These efforts are undertaken in close partnership with the UCLA ISAP, ensuring that providers have access to the latest best practices and clinical innovations.

- Evidence-Based Practices: DHCS is also broadening the menu of evidence-based practices to include comprehensive models of care that emphasize integration of substance use disorder treatment with broader behavioral health services. This includes innovative approaches such as Assertive Community Treatment (ACT) and Coordinated Specialty Care for First Episode Psychosis, which are being advanced through initiatives like the BH-CONNECT demonstration. These efforts are designed to support providers in delivering coordinated, patient-centered care that addresses the full spectrum of individuals' needs.

Milestone 6 Recommendation Bullet Point 5: Strengthen Coordination with Physical Health Care: Lessons Learned: Draw from lessons learned during the CalAIM Authorization to Share Confidential Medi-Cal Information (ASCMI) Form and consent management services and the Universal Release of Information pilot. (DHCS, 2024e).

DHCS Response to Bullet Point 5: Strengthen Coordination with Physical Health Care: Lessons Learned: DHCS hosted an All-Comer Webinar on July 29, 2025, to announce the release of the Authorization to Share Confidential Member Information (ASCMI) Form and provide an overview of the previously released Data Sharing Authorization Guidance (DSAG) Toolkits focused on Medi-Cal Housing Support Services and the Medi-Cal Justice-Involved Reentry Initiative. The ASCMI Form is a release of information form that Medi-Cal Partners, including counties, agencies, providers, health plans, community-based organizations, and others, may use to obtain their clients' consent to exchange their sensitive health and social services information. DHCS is pleased to publish a revised version for Medi-Cal partners' use when seeking to exchange their members' sensitive information to coordinate their care. DSAG Toolkits illustrate real-world scenarios that will help Medi-Cal partners navigate complex data sharing and privacy laws and understand when consent is or is not needed to share information to support care coordination across sectors. DMC-ODS Plans and MCPs may choose to utilize the ASCMI to obtain their clients' consent to exchange their sensitive health and social services information. The MOU may reference the use of the ASCMI as part of its data sharing and confidentiality provisions.

Milestone 6 Recommendation Bullet Point 6: Strengthen Coordination with Physical Health Care: Focus on better coordination with primary care providers and hospitals, addressing overloaded caseloads and differing treatment paradigms. One administrator commented that some of their "medical providers subscribe to alternative [and older SUD] treatment paradigms/approaches that are not always congruent with DMC-ODS accepted practices."

DHCS Response to Bullet Point 6: Strengthen Coordination with Physical Health Care: BH-CONNECT (Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment) is part of California's historic, multi-pronged effort to transform and improve behavioral health services for California residents living with significant behavioral health needs, to create a whole-person care approach. One element of this effort, the Access, Reform, and Outcomes Incentive program, is an integral component of BH-CONNECT. Through this program, participating BHPs have the opportunity to earn incentives for demonstrating improved performance on key measures. A specific metric within this program will measure and incentivize improvements in access to ECM (Enhanced Care Management) for Medi-Cal members with substance use and mental health conditions. ECM is a Medi-Cal benefit that provides intensive, community-based care management for eligible members with complex health and social needs.

Incentivizing BHPs to improve ECM referrals and engagement in partnership with MCPs can help ensure individuals with SUD are accessing not behavioral health/SUD services, but also primary care and other services to meet their physical health needs.

In addition, as described above in response to other recommendations, DHCS is implementing a host of initiatives and supports to strengthen care coordination, including:

- Requiring BHPs to implement an Application Programing Interface (API) for payer-to-payer, prior authorization, and provider access in accordance with the CMS Advancing Interoperability and Improving Prior Authorization Final Rule. These APIs will improve care coordination by facilitating more seamless sharing of patient data. Once the payer-to-payer, provider access, and prior authorization APIs are implemented, DHCS will explore how specific use-cases can be leveraged from these APIs to improve care coordination across delivery systems.

- Issuing guidance regarding data-sharing compliance obligations derived from federal and state regulations, including AB 133, Part 2 and the interoperability rules, that require Medi-Cal MCPs, inclusive of BHPs, to implement procedures to deliver care to and coordinate services and deliver care for all members.

- BHPs are contractually required to execute MOUs with any Medi-Cal MCP that enrolls members served by the county's SMHS and DMC-ODS or SMHS programs to enable sharing of data to coordinate care for those members.

- Launching the Medi-Cal Connect population health management platform in 2025, enabling BHPs and MCPs an expanded view of member health needs and population level insight. Specifically, Medi-Cal Connect's Risk Segmentation, Stratification, and Tier (RSST) Algorithm incorporates physical and behavioral health and social risk factors providing a data-driven method of identifying members at increased risk of poor outcomes or underutilization of essential services.

- Implementing new requirements for collaborative community assessment and planning processes, meant to drive coordination among MCPs, local health jurisdictions, and County Behavioral Health Departments. MCPs are required to meaningfully participate in community health assessments (CHAs) and community health improvement plans (CHIPs) conducted by local health jurisdictions (LHJs); and complementarily, County Behavioral Health Departments are required under

the Behavioral Health Services Act (BHSA) to work with LHJs on the development of CHAs and CHIPs and to consider the CHA and CHIP in preparing a global spending plan for all available behavioral health funding. The desired outcome of the increased collaboration is that there will be improved continuity in planning processes and an enhanced ability to address community needs across managed care, public health, and behavioral health.

Milestone 6 Recommendation Bullet Point 7: Technical Assistance Care Coordination Billing: Provide technical assistance on billing for care coordination. Stakeholders suggested detailed training on how to bill for care coordination, including what codes to use and when/where to use them.

DHCS response to Bullet Point #7: Technical Assistance Care Coordination Billing: Care Coordination is available across nearly all levels of care, including outpatient, intensive outpatient, residential, inpatient, withdrawal management, medication-assisted treatment (MAT), and recovery services. This service can be billed on the same day as other treatment services, provided it aligns with the client's level of care. Care Coordination may be claimed as a standalone service, particularly when a client is not actively engaged in treatment, such as during outreach efforts or while coordinating referrals. When Care Coordination is delivered independently within residential or inpatient settings, it may be billed by outpatient, residential, or inpatient providers. Regardless of the setting, when billed as a standalone service, the reimbursement is based on outpatient rates. The DMC-ODS Billing Manual also provides detailed guidance to DMC-ODS counties about billing for Care Coordination when provided to Medi-Cal members in different levels of care. DHCS also provides ongoing technical assistance to DMC-ODS counties regarding claiming DMC-ODS services through a customer service team and maintains a detailed billing manual that provides guidance to counties. DMC-ODS county staff may submit questions about claiming, including claiming for Care Coordination, to the customer service team. The customer service team documents all questions received, conducts research, and provides written responses to DMC-ODS counties.

DMC-ODS counties are also required to submit an annual report to DHCS to provide details regarding the effectiveness of Care Coordination and referral concerns. The due date of the annual report is the last business day of January. DHCS monitors the annual report to identify any concerns with coordination of care and provides necessary technical assistance to counties.

Milestone 6 Recommendation Bullet Point 8: Technical Assistance EQRO: Work with the EQRO to highlight and disseminate lessons learned and successes from performance improvement projects focused on transitions and referrals, including Riverside County's use of regional Care Coordination Teams (Urada et al., 2019), and results from counties with projects focusing on the Follow-Up After Emergency Department Visit metric (Behavioral Health Concepts, 2024).

DHCS Response to Bullet Point 8: Technical Assistance EQRO: DHCS works directly with behavioral health plans on quality improvement projects to improve care coordination and closed loop referrals through QI learning collaboratives and 1:1 technical assistance. Riverside County is a participant in the DHCS-IHI facilitated BH Quality Collaborative where QI strategies and best practices for improving FUM and FUA are tested and shared among participants in the cohort. DHCS' Quality and Health Equity Transformation Branch (QHET) also collaborates with EQRO to identify the best practices and successes from PIPs and other QI initiatives, which are then shared with other BHPs.

Milestone 6 Recommendation Bullet Point 9: Care Coordination: Encourage use of care coordination, peer support services, family counseling, recovery support services, and recovery residences specifically to support successful transitions between LOC. Encourage or incentivize implementation of warm handoffs from residential programs, including providing graduating residential clients with visits to outpatient locations or having an outpatient counselor visit them before they graduate.

DHCS Response to Bullet Point 9: Care Coordination: Effective January 1, 2025, Enhanced Community Health Worker (CHW) Services were established as an optional DMC-ODS benefit through the approval of State Plan Amendment (SPA) 24-0052. Enhanced CHW Services are tailored preventive services for members living with significant behavioral health needs, defined as members who meet the access criteria for SMHS and/or DMC/DMC-ODS services. Enhanced CHWs may support member engagement in chronic disease management, conduct outreach to individuals with complex needs, and facilitate improved mental health and SUD outcomes, among many other diverse areas of focus. The inclusion of Enhanced CHW services helps address regulatory and knowledge barriers by enabling BHPs to educate members on available SUD services and how to access them, while also improving members' understanding of the new services they will receive. DHCS released BHIN 25-028 on July 8, 2025, guidance for county BHPs regarding coverage of Enhanced CHW Services available under Medi-Cal. County BHPs may opt-in to provide these services at any time.

In addition, Medi-Cal Peer Support Services (Peer services), a component of recovery services, are able to provide components of referrals and the coordination of services, including identifying appropriate resources, making appointments, and assisting a member with a warm hand-off to obtain ongoing services. Additionally, Peer services have expansive service settings and modalities available, which include providing services in both clinical and non-clinical settings, such as homes, community centers, and inpatient/residential facilities. Peer services are able to be delivered both individually and in groups, and may also involve family members when appropriate to support youth or individuals with complex needs, and Peer services can be delivered as standalone services or in conjunction with other Medi-Cal services (e.g., services in the Specialty Mental Health Services, Drug Medi-Cal, or DMC-ODS delivery systems), promoting a holistic and coordinated approach to care.

Recovery services are also a required benefit in all participating DMC-ODS counties. These services are designed to support members after completing treatment and include counseling, family therapy, recovery monitoring, relapse prevention, and care coordination. These services are intended to help individuals maintain recovery and prevent relapse, especially during transitions between levels of care.

While recovery residences are not directly reimbursed under DMC-ODS, counties are encouraged to establish linkages to certified recovery housing as part of ancillary services through care coordination or peer-to-peer support efforts. DHCS and DMC-ODS plans emphasize warm handoffs as a best practice – strategies that are part of broader care coordination efforts and include discharge planning, referrals to community-based services, and follow-up to ensure successful linkage.

Milestone 6 Recommendation Bullet Point 10: Readmissions: Conduct additional analyses to determine the most common reasons for all-cause readmissions among beneficiaries with SUD.

DHCS response to Bullet Point 10: Readmissions: DHCS will further examine common diagnoses among beneficiaries with SUD having a qualifying readmission event to evaluate how well physical and behavioral health services are integrated and establish a feedback loop with counties to discuss findings and strategies to reduce readmissions and improve care coordination.

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Attachments

Attachment A:

Independent Assessor Description

Independent Assessor Description

The Team conducting this Mid-Point Assessment (MPA) consisted of staff from the UCLA Integrated Substance Use and Addiction Programs (UCLA ISAP). Investigator expertise ranges from Research Psychology to Econometric Research covering both qualitative and quantitative methodologies. The team dynamic incorporates varying academic and practical viewpoints of an historian, a licensed clinical social worker, skilled statisticians managing large and complex datasets, and research associates with public health, criminal justice, and community behavioral health backgrounds.

The UCLA ISAP Mid-Point Assessment team worked in the following ways with the Program Evaluation team of the Quality and Population Health Management for the California Department of Health Care Services. We discussed the format and content of the MPA prior to its initiation, but once a design was agreed upon, we conducted the work and developed recommendations independently. On some occasions where data appeared anomalous UCLA ISAP raised this with DHCS and asked for feedback. Where relevant, this feedback is cited as such in the assessment. UCLA ISAP obtained administrative datasets and monitoring metrics from DHCS. UCLA ISAP independently merged datasets, ran statistical models, conducted surveys and interviews to ultimately identify the findings and recommendations for the MPA. Several staff at DHCS reviewed the initial draft of this report and provided critical feedback for consideration but did not influence the risk assessments or recommendations. We are grateful for their thoughtful and sensitive feedback.

Conflict of Interest Statement

Organization: University of California, Los Angeles, Integrated Substance Use and Addiction Programs

Activity/Title: California Drug Medi-Cal Organized Delivery System Mid-Point Assessment; The California Advancing and Innovating Medi-Cal (Cal-AIM) Section 1115 Demonstration Waiver Evaluation.

Key Personnel involved in conducting the mid-point assessment have been reviewed for conflict of interests and a status of "No conflict" has been determined and confirmed based on their responses.

Darren Urada, Ph.D, Principal Investigator

Signature Date

Valerie Antonini, MPH, Co-Principal Investigator

Signature Date

Brittany Bass, Ph.D., Co-Investigator-Economist

Signature Date

Howard Padwa, Ph.D., Co-Investigator-Qualitative Research

Signature Date

Anne Lee, LCSW, Co-Investigator, Clinical Program Specialist

Signature Date

Attachment B

Stakeholder Data Collection Forms

UCLA SUD County Administrator Survey 2024

On behalf of DHCS, UCLA wants your help assessing Substance Use Disorder (SUD) services among counties participating in the DMC-ODS waiver. This survey asks about your county's SUD system, experiences with the waiver, and any needs for training or technical assistance that your county may have.

This survey is intended for one SUD administrator or behavioral health director in each waiver county to complete.

There are no "right" or "wrong" answers.

We expect the survey will take about 10-15 minutes to complete.

UCLA may also follow up with you in the future. If you have any questions or need assistance with the survey, please contact Celine Tsoi (szeyicelinetsoi@mednet.ucla.edu).

Your contact information

- Name _____
- Title _____
- Email _____
- Phone _____

County

_____

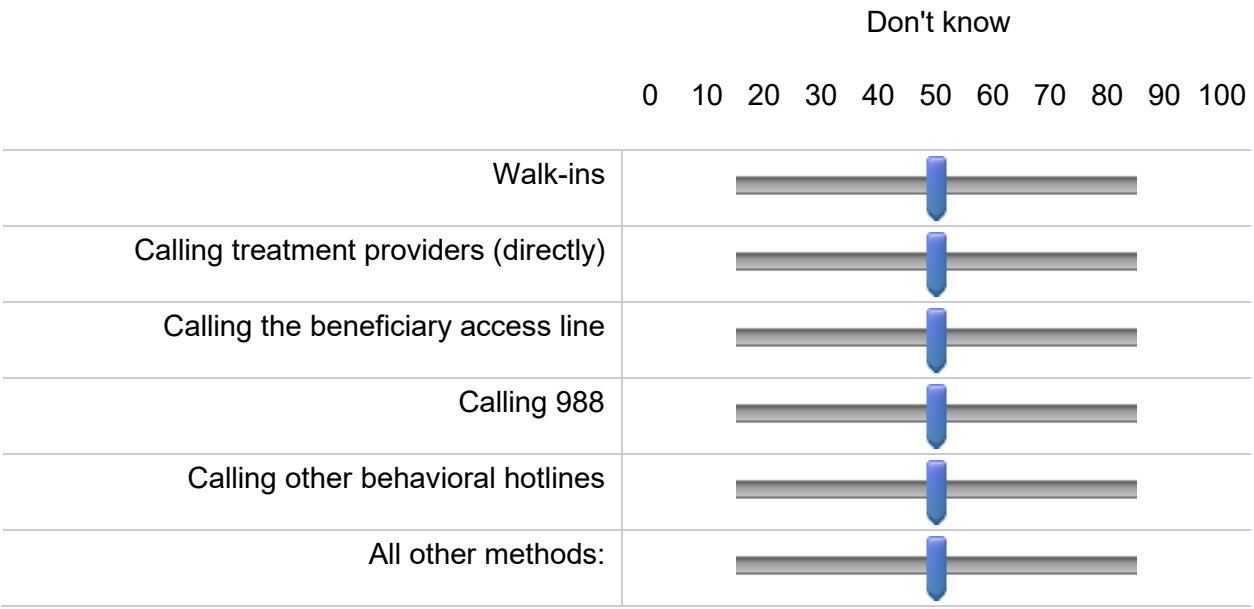
This survey asks about the time since your county went LIVE with the DMC-ODS waiver unless otherwise specified.

The first set of questions asks about access to SUD services in your county.

Q 1 Overall, how has the DMC-ODS waiver impacted access to services in your county?

- ○ Extremely positively
- ○ Somewhat positively
- ○ Neither positively nor negatively
- ○ Somewhat negatively
- ○ Extremely negatively

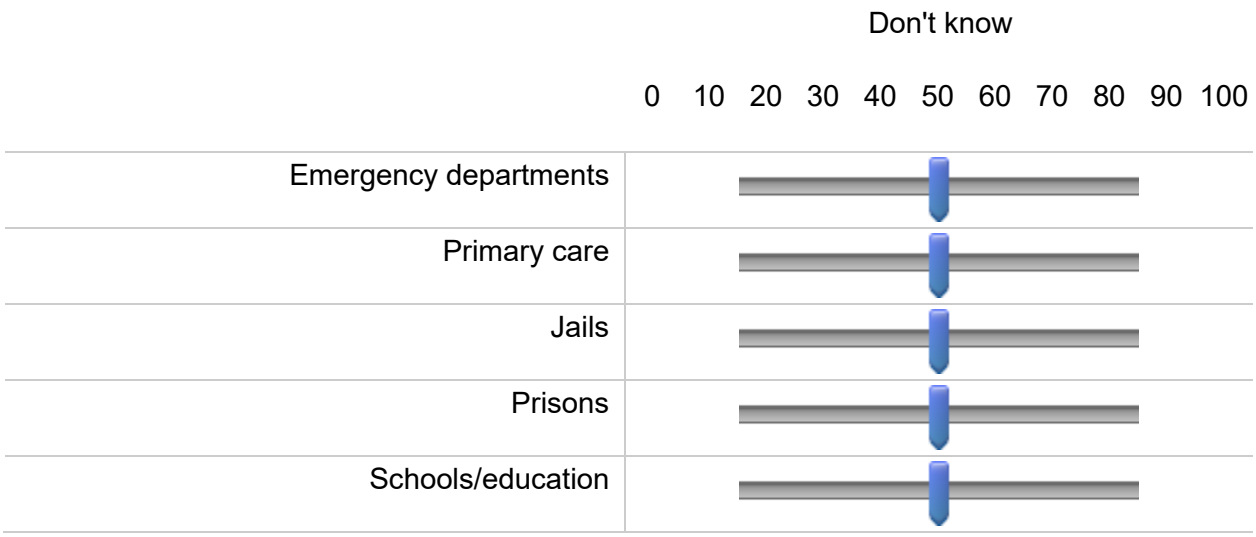
Q2 Approximately what percentage of patients enter treatment through the following methods? Please indicate your response by clicking on the scale for each option (Responses do not need to total 100%)



Q3 Please explain the other methods referenced above.

_____

Q4 Of the individuals in each of the following systems who need treatment, what proportion do you think are referred to SUD treatment?
Please indicate your response by clicking on the scale for each option.



Q5 We understand that workforce shortages have impacted access to SUD services in some areas. If your county has workforce challenges, what assistance from DHCS would help address them?

_____

_____

Q6 Please share any additional comments regarding access to SUD treatment under the DMC-ODS waiver:

_____

The following questions are related to the processes around CalOMS data reporting and billing.

Q7 Are there any technical, staffing, or other barriers your providers are encountering that may have decreased submission of CalOMS records in the last few years?

- ○ No
- ○ Yes, please describe: _____

Q8 Are there any billing-related barriers to treatment, currently or anticipated (for example, contractors being able to bill enough to stay in business, lack of billing for travel, etc)?

If so, what are the highest-priority issues you think need to be addressed?

- ○ No
- ○ Yes, please describe: _____

The following questions are related to the adoption of the American Society of Addiction Medicine Criteria (ASAM Criteria).

Q8 According to BHIN 23-068, effective January 1, 2025, DMC-ODS providers shall either use the free ASAM Criteria Assessment Interview Guide or ASAM CONTINUUM Software, or a validated tool approved by DHCS.

Which assessment are you currently using?

- ○ We use the free paper/PDF version of ASAM Criteria Assessment Interview Guide
- ○ The free ASAM Criteria Assessment Interview Guide programmed into our EHR
- ○ Our own interview guide that we have developed based on The ASAM Criteria
- ○ The CONTINUUM Software
- ○ We use another interview tool (please specify): _____

Q9 Which assessment are you do you plan to use after the January 1, 2025 deadline?

- ○ The free paper/PDF version of ASAM Criteria Assessment Interview Guide
- ○ The free ASAM Criteria Assessment Interview Guide programmed into our EHR
- ○ We will use the CONTINUUM Software
- ○ A validated tool approved by DHCS (please specify): _____
- ○ This decision has not been made yet

Q10 We have been collecting ASAM level of care data. The difficulty of collecting this data might impact the accuracy of the data. In your opinion, how accurate is the state's data on both the level of care indicated by the ASAM assessment/screener and the level of care clients actually are referred to?

- ○ Mostly accurate
- ○ Accurate more than half the time
- ○ Accurate about half the time
- ○ Accurate less than half the time
- ○ Mostly inaccurate
- ○ I don't know

Q11 What would be helpful for DHCS to know about the implementation of The ASAM Criteria Assessment tools?

_____

The following questions address elements regarding the quality of service delivery in your county.

Q12 Since the beginning of your county's participation in DMC-ODS until today, to what extent has the EQRO (External Quality Review Organization) review process had an impact on the quality of Substance Use Disorder (SUD) services in your county?

- ○ Extremely positively
- ○ Somewhat positively
- ○ Neither positively nor negatively
- ○ Somewhat negatively
- ○ Extremely negatively

Q13 Since the beginning of your county's participation in DMC-ODS until today, to what extent has the EQRO (External Quality Review Organization) review process had an impact on equity of Substance Use Disorder (SUD) services in your county (e.g. measuring and reducing health disparities)?

- ○ Extremely positively
- ○ Somewhat positively
- ○ Neither positively nor negatively
- ○ Somewhat negatively
- ○ Extremely negatively

Q14 Please describe: How has the EQRO review process impacted the quality/equity of the SUD services provided to beneficiaries?

_____

_____

Q15 What barriers make it difficult to implement Evidence-Based Practices (EBP) in your county? Check all that apply.

- [ ] Lack of available EBP trainings
- [ ] Cost of EBP training
- [ ] Insufficient guidance on which EBPs to use
- [ ] Insufficient guidance on where to receive training
- [ ] Difficulty finding providers to deliver services during times when staff are in training
- [ ] Tracking which staff receive EBP training
- [ ] Maintaining staff that receives EBP training due to turnover
- [ ] Inflexibility/inability to adapt EBP training materials
- [ ] Inability to monitor EBP implementation
- [ ] Inability to monitor EBP fidelity
- [ ] Difficulty providing appropriate clinical oversight/supervision
- [ ] Lack of staff with clinical qualifications/degrees needed to deliver EBPs
- [ ] Other _____

Q16 Thinking about youth prevention, please describe the most innovative and/or effective youth SUD prevention programs being implemented in your county. (Optional)

_____

_____

We would like to learn more about the SUD services with other systems of care.

Q17 Overall, how has the DMC-ODS waiver impacted the integration of SUD and mental health services in your county?

- ○ Extremely positively
- ○ Somewhat positively
- ○ Neither positively nor negatively
- ○ Somewhat negatively
- ○ Extremely negatively

Q18 Overall, how has the DMC-ODS waiver impacted the integration of SUD and physical health services in your county?

- ○ Extremely positively
- ○ Somewhat positively
- ○ Neither positively nor negatively
- ○ Somewhat negatively
- ○ Extremely negatively

Q 19 Please share any additional comments regarding the integration of care as implemented under the DMC-ODS waiver:

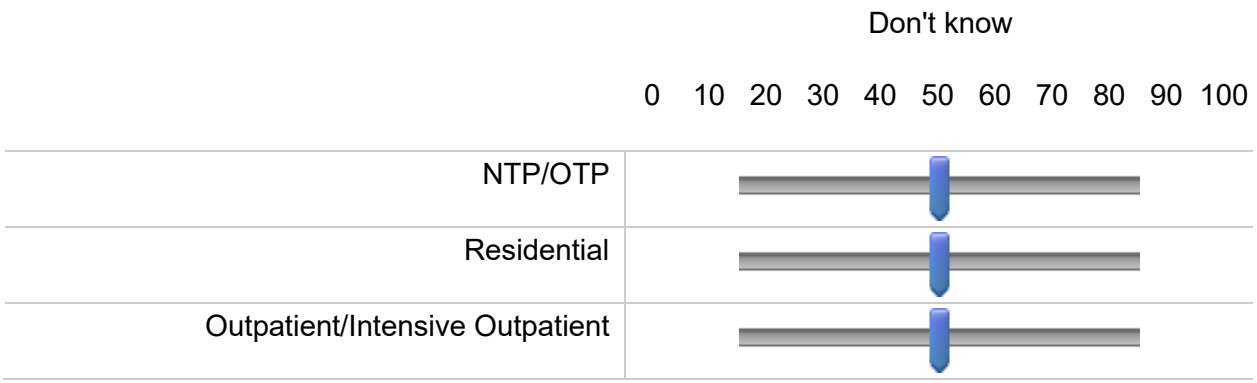
_____

_____

The following set of questions ask about the delivery of case management, recovery services, and the use of peer specialists in your county.

Q 20 Approximately what percentage of clients in each modality receive case management services, regardless of whether a claim is submitted?

Please indicate your response by clicking on the scale for each option.

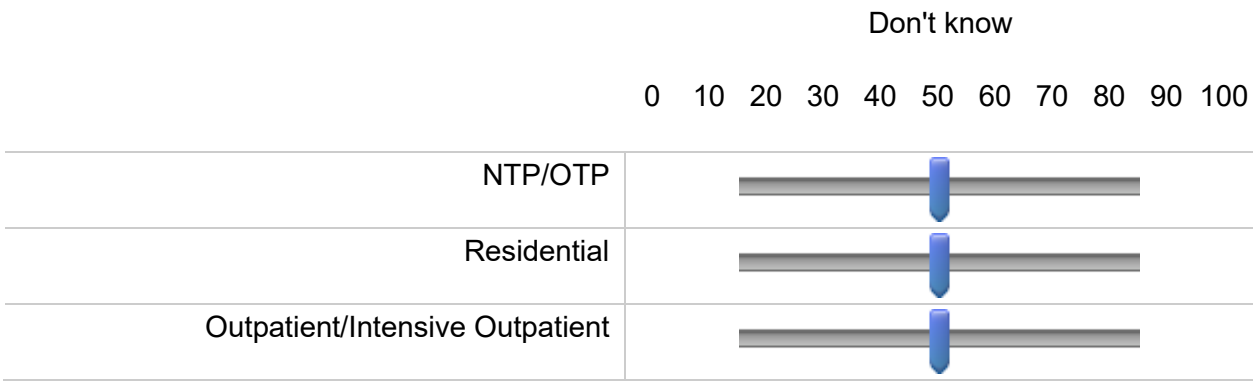


Q21 Have you seen care coordination evolve since implementation of the waiver? And at critical points (admission, transition, retention, etc)

_____

Q22 Approximately what percentage of clients in each modality receive recovery services, regardless of whether a claim is submitted?

Please indicate your response by clicking on the scale for each option.



Q23 Do your providers need more clarification of the recovery services benefit?

- ○ 1 – much more clarification is still needed
- ○ 2 – some clarification is needed
- ○ 3 – neutral
- ○ 4 – adequate understanding, but could benefit from more information
- ○ 5 – no further clarification is needed
- ○ Don't know _____

Q24 Please explain:

_____

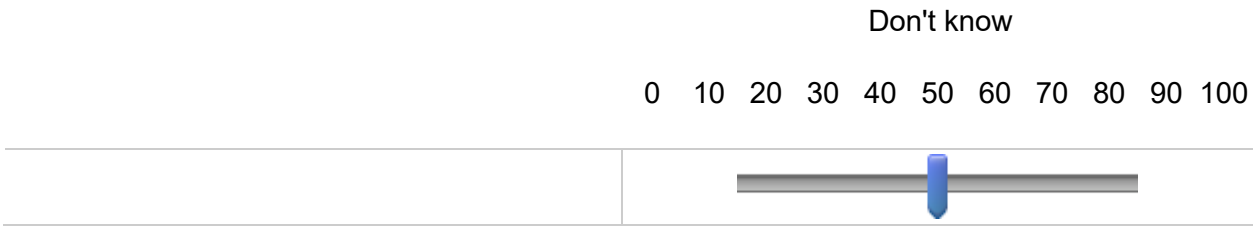
_____

Q25 What SUD services do Peer Specialists provide in your county?

- [ ] Outreach
- [ ] Engagement
- [ ] 12-step group facilitation
- [ ] Individual coaching
- [ ] Education/Employment training
- [ ] Other (please describe): _____
- [ ] We do not currently offer any peer specialist services

Q26 Approximately what percentage of peer services being delivered in your county are currently reimbursed by Medi-Cal?

Please indicate your response by clicking on the scale.



Q27 Do your providers need more clarification on the peer support services benefit?

- ○ 1 – much more clarification is still needed
- ○ 2 - some clarification is needed
- ○ 3 – neutral
- ○ 4 – adequate understanding, but could benefit from more information
- ○ 5 – no further clarification is needed
- ○ Don't know _____

Q28 What benefits or challenges have the Medi-Cal Peer Support Specialist Certification brought to your county?

_____

_____

We are interested to learn more about how your county will address existing disparities in access and health outcomes.

Q29 Please briefly describe the efforts in place, or in planning, to identify and address health disparities within your county.

_____

_____

Q30 What assistance from DHCS would help to address health disparities in your county?

_____

_____

These next questions ask about the use of contingency management in your county.

Q 31 Is your county participating in the DMC-ODS contingency management pilot (aka Recovery Incentives

- ○ Yes
- ○ No

Display This Question:

If Is your county participating in the DMC ODS contingency management pilot (aka Recovery Incentives)? = Yes

Q31a What are some strengths and shortcomings regarding Recovery Incentives Program?

_____

_____

Display This Question:

If Is your county participating in the DMC ODS contingency management pilot (aka Recovery Incentives)? = Yes

Q31b What additional information would be helpful for DHCS to know about the implementation of the contingency management pilot?

_____

_____

Display This Question:

If Is your county participating in the DMC ODS contingency management pilot (aka Recovery Incentives)? = No

Q31c Why did you opt NOT to participate in the contingency management pilot at this time?

_____

We would like to learn more about harm reduction strategies and fentanyl in your county.

Q32 Which of the following harm reduction strategies are being implemented in your county? (Check all that apply)

- ☐ Narcan/Naloxone distribution
- ☐ Fentanyl test strips
- ☐ Safe injection sites
- ☐ Public education campaigns
- ☐ Client education
- ☐ Needle exchange
- ☐ Other, please describe: _____
- ☐ ⊗None of the above

Q33 How can DHCS help counties address the challenges associated with fentanyl?

_____

_____

Q34 Please identify training and technical assistance needs in your county.

Which topics are the highest priority for training or technical assistance in your county? (Select all that apply)

- [ ] CalOMS-Tx data collection and data integrity
- [ ] DMC-ODS waiver requirements
- [ ] Drug Medi-Cal billing
- [ ] Medical necessity and utilization review procedures
- [ ] Medi-Cal Treatment Authorization Request (TAR) procedures
- [ ] Utilization management
- [ ] Problem Lists (DHCS is transitioning from Treatment Plans)
- [ ] Cognitive Behavioral Therapy (CBT)
- [ ] Motivational Interviewing
- [ ] Psychoeducation
- [ ] Relapse prevention
- [ ] Trauma-informed treatment
- [ ] Contingency management
- [ ] Dialectical Behavior Therapy (DBT)
- [ ] Buprenorphine
- [ ] Methadone
- [ ] Naloxone

- [ ] Naltrexone
- [ ] Acamprosate
- [ ] Disulfiram
- [ ] ASAM assessment and placement
- [ ] Case management
- [ ] Recovery services
- [ ] Co-occurring disorders
- [ ] Cultural competency
- [ ] Referrals/care coordination
- [ ] Youth services
- [ ] Perinatal services
- [ ] Synthetic and other emerging drugs (e.g. Spice, K2, xylazine)
- [ ] Cannabis
- [ ] Stimulants
- [ ] Fentanyl
- [ ] Telehealth
- [ ] Peer support services
- [ ] Opioids

- [ ] Social Determinants of Health/Health Equity
- [ ] Cultural Humility
- [ ] Other: _____

END

You are now done with the survey. Pressing the forward arrows will submit your response (You may go back and edit any of your answers until you submit. Thank you!

Treatment Perceptions Survey (Adult)

Print PDF as needed. 2023
Do not photocopy!

County / Provider Use Only

CalOMS Provider ID (required)

Program Reporting Unit (if required by your county):

Treatment Setting (required): ○ **OP/IOP** ○ **Residential** ○ **OTP/NTP** ○ **Detox/WM (standalone)** ○ **Partial hospitalization**

- **Please answer these questions about your experience at this program to help improve services. Use "Not applicable" if the question is about something you have not experienced. Your answers are confidential and will not influence current or future services you receive.**
- Please fill in bubbles completely Correct: ● Incorrect: ⊙ ⊗ ✓

	Strongly Agree	Agree	I Am Neutral	Disagree	Strongly Disagree	Not Applicable
1. The location was convenient (public transportation, distance, parking, etc.).	○	○	○	○	○	○
2. Services were available when I needed them.	○	○	○	○	○	○
3. I chose the treatment goals with my provider's help.	○	○	○	○	○	○
4. Staff gave me enough time in my treatment sessions.	○	○	○	○	○	○
5. Staff treated me with respect.	○	○	○	○	○	○
6. Staff spoke to me in a way I understood.	○	○	○	○	○	○
7. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).	○	○	○	○	○	○
8. I felt welcomed here.	○	○	○	○	○	○
9. As a direct result of the services I am receiving, I am better able to do things that I want to do.	○	○	○	○	○	○
10. As a direct result of the services I am receiving, I feel less craving for drugs and alcohol.	○	○	○	○	○	○
11. Staff here work with my physical health care providers to support my wellness.	○	○	○	○	○	○
12. Staff here work with my mental health care providers to support my wellness.	○	○	○	○	○	○
13. Staff here helped me to connect with other services as needed (social services, housing, etc.).	○	○	○	○	○	○
14. Overall, I am satisfied with the services I received.	○	○	○	○	○	○
15. I was able to get all the help/services that I needed.	○	○	○	○	○	○
16. I would recommend this agency to a friend or family member.	○	○	○	○	○	○

17. Now thinking about the services you received, how much of it was by telehealth (by telephone or video-conferencing)?
○ None ○ Very little ○ About half ○ Almost all ○ All

18. How helpful were your telehealth visits compared to traditional in-person visits?
○ Much better ○ Somewhat better ○ About the same ○ Somewhat worse ○ Not applicable

19. **Please let us know your comments. What was most helpful about this program? What would you change about this program?**
Please do not write any information that may identify you. For example, DO NOT write your name or phone number.

NOW TELL US A LITTLE ABOUT YOURSELF

20. What is your gender (Please select all that apply)?
○ Male
○ Female
○ Transgender: Female to Male
○ Transgender: Male to Female
○ Non-Binary (neither Male nor Female)
○ Another Gender Identity

21. Do you think of yourself as (Please select all that apply):
○ Straight/Heterosexual
○ Gay or Lesbian
○ Bisexual
○ Queer
○ Another sexual orientation
○ Unknown

22. Are you of Mexican/Hispanic/Latinx descent?
○ Yes ○ No ○ Unknown

23. Race/Ethnicity (Please select all that apply):
○ American Indian/Alaska Native
○ Asian
○ Black/African-American
○ Native Hawaiian/Other Pacific Islander
○ White/Caucasian
○ Another race
○ Unknown

24. Age Range:
○ 18-25 ○ 26-35 ○ 36-45
○ 46-55 ○ 56-64 ○ 65+

42469

Thank you for taking the time to answer these questions!

Treatment Perceptions Survey (Youth)

Print PDF as needed. 2023
Do not photocopy!

County / Provider Use Only

CalOMS Provider ID (required)

Program Reporting Unit (if required by your county):

Treatment Setting (required): ○ **OP/IOP** ○ **Residential** ○ **OTP/NTP** ○ **Detox/WM (standalone)** ○ **Partial hospitalization**

- **Please answer these questions about your experience at this program to help improve services. Use "Not applicable" if the question is about something you have not experienced. Your answers are confidential and will not influence current or future services you receive.**
- Please fill in bubbles completely

Correct: ● Incorrect: ⊙ ⊗ ✓

	Agree	I Am Neutral	Disagree	Strongly Disagree	Not Applicable
1. The location of services was convenient for me.	○	○	○	○	○
2. Services were available at times that were convenient for me.	○	○	○	○	○
3. I had a good experience enrolling in treatment.	○	○	○	○	○
4. My counselor and I worked on treatment goals together.	○	○	○	○	○
5. I received services that were right for me.	○	○	○	○	○
6. Staff treated me with respect.	○	○	○	○	○
7. I feel my counselor took the time to listen to what I had to say.	○	○	○	○	○
8. I developed a positive, trusting relationship with my counselor.	○	○	○	○	○
9. Staff were sensitive to my cultural background (race/ethnicity, religion, language, etc.).	○	○	○	○	○
10. I feel my counselor was sincerely interested in me and understood me.	○	○	○	○	○
11. I liked my counselor here.	○	○	○	○	○
12. My counselor is capable of helping me.	○	○	○	○	○
13. Staff here make sure that my health and emotional health needs are being met (physical exams, depressed mood, etc.).	○	○	○	○	○
14. Staff here helped me with other issues and concerns I had related to legal/probation, family and educational systems.	○	○	○	○	○
15. My counselor provided necessary services for my family.	○	○	○	○	○
16. As a direct result of the services I am receiving, I am better able to do things that I want to do.	○	○	○	○	○
17. As a direct result of the services I am receiving, I feel less craving for drugs and alcohol.	○	○	○	○	○
18. Overall, I am satisfied with the services I received.	○	○	○	○	○
19. I would recommend the services to a friend who is in need of similar help.	○	○	○	○	○

20. Now thinking about the services you received, how much of it was by telehealth (by telephone or video-conferencing)?
○ None ○ Very little ○ About half ○ Almost all ○ All

21. How helpful were your telehealth visits compared to traditional in-person visits?
○ Much better ○ Somewhat better ○ About the same ○ Somewhat worse ○ Not applicable

22. **Please let us know your comments. What was most helpful about this program? What would you change about this program?**
Please do not write any information that may identify you. For example, DO NOT write your name or phone number.

NOW TELL US A LITTLE ABOUT YOURSELF

23. What is your gender (Please select all that apply)?
○ Male
○ Female
○ Transgender: Female to Male
○ Transgender: Male to Female
○ Non-Binary (neither Male nor Female)
○ Another Gender Identity

24. Do you think of yourself as (Please select all that apply):
○ Straight/Heterosexual
○ Gay or Lesbian
○ Bisexual
○ Queer
○ Another sexual orientation
○ Unknown

25. Are you of Mexican/Hispanic/Latinx descent?
○ Yes ○ No ○ Unknown

26. Race/Ethnicity (Please select all that apply):
○ American Indian/Alaska Native
○ Asian
○ Black/African-American
○ Native Hawaiian/Other Pacific Islander
○ White/Caucasian
○ Another race
○ Unknown

27. Age: ☐☐

Thank you for taking the time to answer these questions!