FY 2023-24 Statewide Annual Technical

EXTERNAL QUALITY REVIEW REPORT

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

Prepared for the California Department of Health Care Services
By Behavioral Health Concepts, Inc.

November 22, 2024

BHC | Behavioral Health Concepts, Inc

Acknowledgments

Behavioral Health Concepts, Inc. (BHC) offers this report as our final deliverable as California External Quality Review Organization (CalEQRO).

We also want to acknowledge the work of California's 31 DMC-ODS Plans across 37 counties that took part in the reviews since 2017. This includes leadership, direct service staff, volunteers, contract providers, key stakeholders, and many others. We are especially grateful to all the Plan members and family members who shared their experiences in SUD treatment services, whose personal perspectives were essential to our work and are necessary for ensuring person-centered care.

BHC has appreciated and enjoyed the partnership with the research and evaluation staff from the University of California at Los Angeles Integrated Substance Abuse Programs, especially regarding the Treatment Perception Survey. We also have appreciated participating in the County Behavioral Health Directors Association of California's SUD-specific Substance Use Prevention, Treatment, and Recovery Services Block Grant Program committee, which provides county leaders and interested stakeholders with information unique to this population and an opportunity to form and maintain connections. Both organizations have long supported efforts to foster quality of care and noteworthy practices for SUD services.

Reflecting on BHC's role alongside the implementation of the DMC-ODS framework, we want to thank those staff at DHCS who provided guidance and collaborative assistance to lay the groundwork for a meaningful and robust external review model. Also, to the DHCS staff and leaders who have overseen our contract and worked with us, thank you for your partnership in delivering the highest quality reports to the Centers for Medicare and Medicaid Services.

Finally, we want to recognize the efforts of our own staff, the reviewers who have been responsible for facilitating the evaluation of the DMC-ODS Plans each year – in-person and over email, phone, and video. Their subject matter expertise enabled us to understand the systems we reviewed, and they conducted reviews through a strength-based lens, meeting systems where they were, and promoting quality improvement. As they move on to their next chapters, we extend this heartfelt gratitude to our staff – Quality Reviewers, Information Systems Reviewers, and Consumer/Family Member Reviewers – and our essential BHC colleagues behind the scenes who supported the work. They were instrumental in not only carrying out our charge to evaluate, but also to share in the efforts toward improved member care.

As always, BHC's goal is that our final statewide annual report – the findings, noteworthy practices, and opportunities for enhancement of SUD treatment systems and services – may be used to improve the care and ultimately the lives of people with SUD.

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Acronyms

CalEQRO Acronyms	
AACM	Average Approved Claims per Member
AAS	Alternate Access Standard
ACA	Affordable Care Act
ASAM	American Society of Addiction Medicine
ASP	Application Service Provider
ATA	Assessment of Timely Access
AUD	Alcohol Use Disorder
BH	Behavioral Health
BHAS	Behavioral Health Accountability Set
BHC	Behavioral Health Concepts, Inc.
BHIN	Behavioral Health Information Notice
BHP	Behavioral Health Plan
BHQIP	Behavioral Health Quality Improvement Program
CalAIM	California Advancing and Innovating Medi-Cal
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
CAP	Corrective Action Plan
CCBH	Cerner Community Behavioral Health
CBHDA	County Behavioral Health Directors Association of California
CCP	Cultural Competence Plan
CDC	Centers for Disease Control
CFR	Code of Federal Regulations
CHW	Community Health Worker
CIN	Client Index Number
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease-2019
CQS	Comprehensive Quality Strategy
CY	Calendar Year
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
DUI	Driving Under the Influence

CalEQRO Acronyms	
EBP	Evidence Based Program or Practice
ED	Emergency Department
EHR	Electronic Health Record
EQR	External Quality Review
EQRO	External Quality Review Organization
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
FY	Fiscal Year
HEDIS®[1]	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information System
IMS	Incidental Medical Services
IOT	Intensive Outpatient Treatment
IS	Information Systems
ISAP	Integrated Substance Abuse Program
ISCA	Information Systems Capacity Assessment
IT	Information Technology
ITWS	Information Technology Web Service
LOC	Level of Care
LOS	Length of Stay
LPHA	Licensed Practitioners of the Healing Arts
MAT	Medication Assisted Treatment
MCHIP	Maternal and Child Health Integrated Program
MCP	Managed Care Plan
MH	Mental Health
MHP	Mental Health Plan
MMEF	Medi-Cal Master Eligibility File
MOU	Memorandum of Understanding
NSDUH	National Survey on Drug Use and Health
NA	Network Adequacy
NCQA	National Committee for Quality Assurance

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

CalEQRO Acronyms	
NOMS	National Outcomes Measurement System
NQF	National Quality Forum
NTP	Narcotic Treatment Program
OCP	Operations Continuity Plans
OP	Outpatient
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PHC	Partnership HealthPlan of California
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
POD	Pharmacotherapy for Opioid Use Disorder
PR	Penetration Rate
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QIC	Quality Improvement Committee
QM	Quality Management
RR	Recovery Residence
RSS	Recovery Support Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Statistical Analysis Software
SDMC	Short-Doyle Medi-Cal
SUD	Substance Use Disorder
TA	Technical Assistance
TADT	Timely Access Data Tool
TEA	Treatment Effectiveness Assessment
TPS	Treatment Perception Survey
UCLA	University of California at Los Angeles
WM	Withdrawal Management
WP	Work Plan

Executive Summary

INTRODUCTION

Behavioral Health Concepts (BHC), Inc., under contract with the State of California Department of Health Care Services (DHCS), evaluated the access, timeliness, and quality of Drug Medi-Cal Organized Delivery Systems (DMC-ODS) provided to Medicaid members by all 31 of the state's DMC-ODS Plans.

This report presents statewide findings from External Quality Reviews (EQRs) conducted in California during fiscal year (FY) 2023-24, marking BHC's seventh and final year as the External Quality Review Organization (EQRO) for the substance use disorder (SUD) systems of care.

EQRs are intentionally retrospective, reviewing the DMC-ODSs' work accomplished in the prior 12 months and the prior years' service data. The performance measures (PMs) for FY 2023-24 reviews primarily focus on claims data from calendar year (CY) 2022, calculated by the California External Quality Review Organization (CalEQRO), as the most current and complete 12-month data set available at the beginning of the review year. Additionally, prior to each review, DMC-ODSs submitted data on service timeliness, which was validated and reported in the Timeliness chapter of this report. This year's statewide report also includes more tables with Plan-specific data.

DMC-ODS review findings are derived from a combination of PM analysis, documents submitted by the Plans, and qualitative information gathered from group discussions. DMC-ODS Plans submit a significant number of documents prior to reviews, demonstrating work accomplished, challenges faced, and improvements made in the prior 12 months. Each DMC-ODS's Final Report is posted online.[2]

This report presents findings from reviews of DMC-ODSs, conducted over 1 to 3 days, mostly via video conference, though some were in-person visits. Using Centers for Medicare and Medicaid Services (CMS) EQRO Protocols and involving key stakeholders, CalEQRO facilitated discussions on access, timeliness, and quality of care, including performance improvement projects (PIPs) and review of a current Information Systems Capability Assessment (ISCA). In addition, an attachment follows this report, containing the Executive Summaries from each DMC-ODS Final Report. The data extracted from the DMC-ODS Final Reports provided the basis for the statewide findings, themes, and recommendations. This statewide report includes both qualitative and quantitative findings based upon aggregated statewide information.

FINDINGS

Access

DMC-ODS Plans continued to increase the total number of members served statewide each year, reaching a total of 107,242 members in CY 2022, an almost 2 percent increase over the

[2] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

prior year. The statewide system saw a slight decrease in older adults (65 and older) served, at 7,485 members compared to the prior year's 7,744. This was offset by a 33 percent increase among youth (12-17), exceeding CY 2020 utilization but still below the pre-pandemic number of youth (5,142) (4,321 youth vs 3,248); and a modest increase in adults aged 18-64 (95,436 vs 94,294). While the number of adults served is higher than CY 2019, the increase in CY 2020 is confounded by more Plans implementing the DMC-ODS in that time frame. Additionally, 64 percent of members served qualified for Medi-Cal under the Affordable Care Act (ACA), demonstrating the significant impact that ACA has on access to this service.

Although more members were served in CY 2022, the statewide penetration rates (PRs) have steadily trended downward over the last three CYs. The decreasing PRs reflect the large annual increase in average monthly eligibles, which rose at a higher rate than members served in the last two CYs. In CY 2022, average monthly eligibles increased by 7.95 percent compared to the previous CY, while total members served had only increased by 1.86 percent.

Capacity was reported to increase in many levels of care (LOC), but some decreases in utilization were apparent in the approved claims data in CY 2022 – specifically in outpatient narcotic treatment programs/opioid treatment programs (NTP/OTPs) – showing 9 percent fewer served in CY 2021 and another decrease by 3 percent in CY 2022. While utilization of non-methadone medication assisted treatment (MAT) has increased a little each year, it is a relatively small portion of DMC-ODS services. As will be discussed later, much of the state's MAT is provided through managed care plans (MCP) as a medical service, and therefore is not apparent in the data available to CalEQRO.

Access to the clinically optimal LOC at the right time is an essential element of securing good clinical outcomes. The DMC-ODS framework provides a structure where members can enter treatment at a level commensurate to their needs. Consistent and accurate assessment with American Society of Addiction Medicine (ASAM) dimension severity scoring by trained clinicians and counselors enables placement in the LOC most likely to maximize member success in treatment. Data for this access mechanism indicated strong levels of congruence between the LOC determined by the ASAM screening and the referral made, based upon DMC-ODS Plans' ASAM reporting.[3] At all points when the ASAM is completed for members (screening, initial assessment, follow-up assessment) statewide congruence data show approximately 80 percent matches. The major reasons for non-congruence were member preference and provider clinical judgement. This variance is an indicator of adherence to the principles of member-centered care, demonstrating respect and responsiveness to member preferences.

DHCS has supported using the ASAM criteria since the beginning of the 1115 DMC-ODS Waiver (Behavioral Health Information Notice [BHIN] 15-035) and has supported screening tools, an ASAM assessment manual, and training for Plans in partnership with the University of California Los Angeles (UCLA) and the County Behavioral Health Directors Association of California (CBHDA). In 2018, California approved legislation (SB 823) that adopted ASAM as the official research-based framework for the DMC-ODS Medi-Cal continuum of care. The ASAM criteria were updated and refined during the review year, and a fourth edition of the ASAM LOC was produced. New documentation requirements under California Advancing and Innovating Medi-Cal (CalAIM) approved specific ASAM tools are to be used for documentation for DMC-ODS screenings and assessments as reflected in BHIN 24-001.[4]

[3] https://www.dhcs.ca.gov/Documents/BHIN-24-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf

[4] Ibid.

Those services under the DMC-ODS framework have required improvement and expansion for all LOCs in nearly all Plans, a necessity consistent with previous review years. Many service levels continue to require additional investment to meet member needs in various areas of the state. Even in DMC-ODS Plans with a full continuum of care, remote regions could often benefit from more readily available access or program sites. Both a paucity of local providers, expertise, staff, or economies of scale leave some Plan areas with limited options for members. This is most often seen with residential and withdrawal management (WM) programs, where availability may be outside of the county, sometimes at a significant distance, a reality that can result in members declining referrals that are offered.

A desire to reduce disparities in access to care is prevalent – a priority in the 2022 DHCS Comprehensive Quality Strategy (CQS) – and many Plans are utilizing targeted interventions to engage specific subpopulations, with much progress still to be made.[5] The Hispanic/Latino and Asian/Pacific Islander populations are under-represented in service delivery statewide compared to White members and SUD prevalence data. Youth and older adults also appear under-represented statewide. Many communities also identify other groups as under-served – African Americans, Native Americans, and lesbian, gay, bisexual, transgender, queer or questioning (LBGTQ+). Many of these groups show low levels of system access yet are disproportionately impacted by the adverse impacts of SUD. Their involvement in the criminal justice system, social and health issues associated with SUD, and overdose statistics indicate a high need for prioritized engagement and care. Some unique cultural barriers within these populations and subpopulations are a factor in making care feel welcoming and comfortable, especially for non-English speakers. Many DMC-ODS Plans have taken meaningful steps to prioritize health equity, examples of which are woven throughout this report, particularly in the Access chapter.

DMC-ODS Plans remain impacted by workforce recruitment and retention issues. The California Health Care Foundation notes California "is facing a critical shortage of mental health and substance abuse providers" a workforce shortage which creates "a significant barrier to meeting the rising demand for…mental health and SUD services."[6] Proper access to DMC -ODS treatment requires more than efficient and timely receipt of an appointment or residential bed, but also adequate or skilled staff at all service levels for delivering quality treatment. County behavioral health (BH) leadership have articulated the need for continued assistance by the state in this area as necessary, such as supporting expanded college opportunities, training, and loan forgiveness to attract more individuals into the SUD field of clinical work.

To ensure engagement in DMC-ODS services, many DMC-ODS Plans have instituted or are participating in projects that include "low barrier" access points to assist individuals who remain ambivalent about their commitment to recovery. This approach is consistent with research in the field pertaining to readiness scales and motivation.[7] Multiple Plans now include a harm reduction model designed to meet people "where they are" while reducing the harms associated with SUD. Such projects are often developed in tandem with partner agencies and have included sobering stations, community naloxone distribution and syringe replacement, and SUD

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[5] https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf

[6] California Health Care Foundation. (May 2024). *Addressing Medi-Cal behavioral health workforce shortages through non-financial incentives.* https://www.chcf.org/publication/addressing-medi-cal-behavioral-health-workforce-shortages-through-non-financial-incentives/

[7] Substance Abuse and Mental Health Services Administration. (2019). *Enhancing Motivation for Change in Substance Use Disorder Treatment*. https://store.samhsa.gov/sites/default/files/tip-35-pep19-02-01-003.pdf

staff participation in local multi-agency homeless projects. For those individuals who eventually wish to enter treatment, recurring contact with these non-traditional portals can provide the necessary opportunity for someone who may otherwise never avail themselves of treatment by way of traditional access points.

Timeliness

This chapter provides a detailed analysis and validation of the timeliness of services provided by the DMC-ODS Plans. All Plans submitted the Assessment of Timely Access (ATA) form and were also expected to provide the source data used for the calculation. Plan-level results are presented for key points in care, with data representing the vast majority of Plans.

Overall wait time to initiate care was improved over what was reported by Plans in FY 2022-23, but not quite as timely as indicated in FY 2021-22. This year, Plans reported an overall wait time to receive the initial service was 9.92 business days, though the initially offered appointment averaged 5.2 business days. The FY 2022-23 offered wait time was 6.5 business days compared to 4.9 the year prior. Nearly all Plans reported an average wait time shorter than the 10 business-day standard, though not all of them submitted source data to validate those findings. The amount of time that elapsed between the request for services and the delivery of a DMC-ODS service varied much more than the wait time for the offered services. Several Plans reported average wait times greater than 20 business days. Access to NTP/OTP was usually quite timely, offered in 2.10 business days on average, and most Plans reported average wait times well surpass the expected the 3 business-day standard.

In DHCS's 2023 Timely Access Data Tool (TADT), MHPs also reported wait times for the next service offered and delivered after the initial outpatient visit and initial MAT service.[8] CalEQRO was tasked with validating the follow-up service dates based when compared to the service date expressed in the Short Doyle Medi-Cal (SDMC) approved claims. Due to the degree of incomplete data in many of the Plans, DHCS ultimately determined that this data was not sufficient for the validation; therefore, the results are not presented in this report. DHCS notified all Plans – except for San Francisco DMC-ODS – to resubmit the 2023 TADT with the time frame April 1, 2023 – June 30, 2023. This was due to DHCS in June 2024. The timing for completion of this report did not enable validation of the resubmitted 2023 TADT data.

Quality of Care and Outcomes

CalEQRO's assessment and review tools suggest that the quality of SUD services provided within the DMC-ODS framework is strong. The various requirements that pertain to quality, incorporated into the DMC-ODS framework, have provided CalEQRO a robust picture of the quality of SUD services across California. These varied data sources, which include the ASAM LOC referral data, Treatment Perception Survey (TPS) feedback, California Outcomes Measurement System (CalOMS) results – reported as PMs in the Plan-level reports – along with stakeholder and member feedback, are essential to full analysis of improvements to the quality of care.

Identifying and analyzing those outcomes can be a challenge for many Plans which are impacted by insufficient numbers of staff, or those with proper expertise, and disparate electronic systems in various phases of implementation. Many contract providers are still unable to communicate member needs electronically, coordinate their care in real-time, and use

[8] https://www.dhcs.ca.gov/Documents/BHIN-23-041-Network-Cert-Req-for-MHP-DMC-ODS.pdf

resources efficiently. With an extremely high percentage of services provided by contract providers rather than county-operated programs, this limitation to effective communication and coordination across programs that serve the same member cannot be overstated. As CalAIM is implemented, this challenge has become more apparent, though many BH departments are now upgrading their electronic health records (EHRs) systems and including their provider organizations, some in a multi-county initiative; these efforts should assist them in meeting data collection and reporting standards as well as improve care for members. While a key and challenging question for DMC-ODS Plans is whether the services they provide are effective and result in favorable clinical outcomes, most are making annual strides in this area.

ASAM congruence data on the placement of members into appropriate treatment indicates the quality of care with high ratings consistent with ASAM-based evaluation results. The ASAM results support the finding that screeners and assessors are relying on this evidence-based tool for treatment placement throughout the course of care. CalEQRO actively reviewed ASAM congruence results with each Plan, as they provide insights into local variance and the antecedents of which are elevated. The review of these variance patterns allows clinical managers, quality staff, and DMC-ODS leadership to formulate additional review and improvement strategies or to increase monitoring to ensure sound referral patterns as members move through the continuum of care.

Care coordination and recovery support services (RSS), sometimes coordinated with MCP whole person care initiatives, continue to expand and work to identify, coordinate, and support members from initial requests through transitions in care. It is also important to ensure transitions from residential to outpatient care, as CalEQRO's approved claims analysis only demonstrates 21 percent of members receiving an outpatient service within 30 days of residential treatment discharge. Member feedback in the TPS surveys statewide showed results between 80 and 94 percent satisfied or highly satisfied with the questions asked. The lowest satisfaction in the three-year period was regarding collaboration with mental health (MH) and physical health providers, suggesting that there is room for more care coordination in these areas.

Each year showed significant increases in RSS, in CY 2022 delivering this service to 75 percent more members statewide than two years prior. Some Plans, however, have implemented relatively little RSS, a service that member feedback suggested was critical to their successful path of recovery.

CalOMS data in CY 2022 displayed significant improvements in member outcomes of housing status and employment. Upon discharge, 28.7 percent of members reported being unhoused, compared to 39.9 percent at admission, which represented a 28.7 percent reduction in the unhoused status. An increase in dependent living reflects the value of recovery housing (also referred to as sober living environments) in enabling success in treatment. Plans have demonstrated commitment across LOC to connect members to housing resources. A similarly positive improvement in outcomes in employment status occurred. The percentage of members who were employed (full-time or part-time) at discharge was 22.3 percent compared to 17.7 percent at admission, representing a 26 percent improvement in employment.

CalOMS data also reflect whether members complete treatment, or, if they end treatment early, if they achieved progress in treatment. Statewide, just over 20 percent of treatment episodes reflected treatment completion. However, when achieving goals is taken into account nearly 50 percent of members in treatment indicate success. This varies tremendously across Plans, but the extent to which this variation may be impacted by local practices and training, versus actual outcomes of care, is unclear.

PIPs represent a significant undertaking to analyze and improve outcomes of care. All DMC-ODS Plans submitted two PIPs, and 54 percent were rated at moderate or high confidence based upon the project's design, implementation, and outcome measures.

CONCLUSIONS

There is substantial variation among DMC-ODS Plans across the state, including in size, region, demographic composition, service delivery systems, and EHR functionality. Local and statewide factors influence both the strengths and weaknesses of a system. Challenges are often statewide, impacting many or all DMC-ODSs, while strengths tend to be specific to Plan. Examples of both challenges and strengths are provided throughout this report. The Conclusions chapter includes a list of recommendations directed to MHPs as well as to DHCS for addressing the themes identified as challenges.

A concerted approach to the workforce crisis requires state leadership and participation across all LOCs in the DMC-ODS Plans. Strong recruitment and retention practices are needed to stabilize the workforce and the programs they sustain. This is even more critical in light of the service expansion necessary in many DMC-ODS Plans for youth, older adults and underserved ethnic populations. Paraprofessionals and peers can contribute valuable case management functions and augment the professional workforce during this time of critical workforce needs. Also, while telehealth considerations remain valuable, so does the need to provide in-person services that more readily promote a strong therapeutic alliance and mutual support among members in treatment, especially in group modalities. This is particularly important for Plans that do not offer sufficient service capacity at particular LOCs, noted in particular for RSS.

To the extent that DHCS can encourage and incentivize the State Plan counties to participate in the DMC-ODS, it would benefit California's Medi-Cal members to have the full array of services available to them regardless of where they live. Some members fear moving to another county Plan and the interruption in their treatment a move could cause. Additionally, if DHCS established time or distance standards with special rates or incentives for residential WM and treatment in lower-density rural areas, these LOCs could be more widely accessible. This is a complex challenge, but these are important LOCs that many members with more severe SUD need. Also, clarification of 24-hour Access line requirements related to clinical screening, local program information, and assessment scheduling assistance is warranted to optimize member engagement when initially seeking care. "Secret shopper" interviews could enhance feedback on how this requirement is being implemented.

Despite the numbers served increasing somewhat each year, continued outreach geared toward equity, and other efforts to improve access to care, remain a necessary priority. Plans that only provide program phone numbers rather than an ASAM-based brief screening at the initial contact should implement screenings that enable program referral upon requesting services. Additionally, those Plans with longer wait times, including for NTP/OTP, need to examine their service capacity and make process or program adjustments where necessary.

Data stored in disparate systems and a lack of interoperability or electronic data exchange make optimal outcomes analysis challenging. The lack of unified EHRs across DMC-ODS Plans and the various provider organizations impacts the ability to readily create the data sets necessary to analyze and create essential outcome findings. Quality management (QM) and quality improvement (QI) require stronger reporting capacity from EHRs and easier access to outcome reports, including CalOMS, which could be correlated with patterns of care.

Each organization in the DMC-ODS needs an EHR that can coordinate data and related care elements focused on successful treatment for members. A requirement for interoperable EHRs

for all provider organizations in a Plan should be a goal, along with providing some targeted funding. This data infrastructure gap continues to limit Plans' ability to monitor system-level outcomes that rely highly on contract providers.

Information exchange efforts are needed between MCPs and the DMC-ODS Plans, especially for Behavioral Health Accountability Set (BHAS) measure reporting. Pharmacy information associated with MAT in particular requires data from MCPs, to ensure the best possible access and clinical outcomes. DMC-ODS Plans report that this coordination and exchange is challenging. DHCS's efforts with emergency department (ED) events and Behavioral Health Quality Improvement Program (BHQIP) incentives related to data exchange and coordination were positive for DMC-ODS participation. Expanding DHCS-supported improvement efforts would improve the effectiveness and quality across health and BH systems of care.

Recommendations are based upon apparent themes throughout the report and are further detailed in the Conclusions chapter, divided into two sections: one for MHPs and the other for DHCS. The Plan-level recommendations are broadly applicable, though not all recommendations are suited to every Plan. Recommendations to DHCS are made to further and operationalize the goals outlined in the CQS, build upon the policy framework of CalAIM, and promote Plan-level improvements.

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Introduction

OVERVIEW OF THE EQR AUTHORITY

The United States Department of Health and Human Services CMS requires an annual, independent, external evaluation of state Medicaid managed care programs by an EQRO. EQR is the analysis and evaluation of aggregate information on quality, timeliness, and access to health care services offered by Prepaid Inpatient Health Plans (PIHPs) and their contractors to members of State Medicaid managed care services. CMS rules (42 Code of Federal Regulations [CFR] §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) specify the requirements for the evaluation of Medicaid managed care programs, termed "Medi-Cal" in California. These rules mandate an annual EQR for each DMC-ODS Plan. California DHCS contracts with 31 DMC-ODS Plans in 38 counties to deliver Medi-Cal SUD treatment services. BHC has served as the EQRO since the inception of the DMC-ODS, conducting reviews since 2017.

California's authority to implement DMC-ODS began with the 1115 Demonstration Waiver in CY 2015, but actual DMC-ODS treatment services did not begin until early CY 2017. Utilizing a staged approach to implementation, DHCS approved planned launches of DMC-ODS services from CY 2016 through the end of CY 2021, when the demonstration Waiver was set to expire and become governed by CalAIM. By FY 2023-24 DHCS contracted with 33 active DMC-ODS Plans, representing 32 counties and one regional model comprising seven counties partnered with Partnership Health Plan (PHC). Seven counties – Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano – have PHC as an MCP and elected to contract with PHC to implement the DMC-ODS on their behalf. (Other counties have PHC operating as an MCP in their counties but are not contracted with PHC to implement the DMC-ODS.)

There are currently 19 California counties not participating in the DMC-ODS, primarily smaller rural counties. It should be noted that the two most recent counties that opted in are not included in this report as they have not had their first EQR.

Reviews are retrospective for the previous year of services, and the criteria are based primarily on CMS 42 CFR Part 438, subpart E, which outlines the major requirements of the CMS EQR Protocol, updated in February 2023:

- Protocol 1 – PIPs both clinical and non-clinical
- Protocol 2 – PM validation – applied to the timeliness measures
- Protocol 4 – Network adequacy (NA) validation
- Protocol 6 – Survey results
- Protocol 7 – PM calculation
- Appendix A – ISCA

Additionally, BHC's contract with DHCS requires CalEQRO to evaluate Plans regarding the delivery of services addressing diversity, equity, and inclusion; coordination of care to improve outcomes and address social determinants of health; member satisfaction, and participation

through focus groups. CalEQRO also reports on the DHCS audit of Plan compliance with Medicaid rules, Protocol 3, in the statewide annual technical report, but not in the Plan-specific reports. Additionally, the BHC NA Form, NA requirements and the most recent DHCS NA Findings Report were reviewed with each DMC-ODS. This year's statewide report attempted to include a NA validation review and validation of Plans' TADT submissions, specifically regarding timeliness to the follow-up service after a non-urgent initial visit.

At the conclusion of each FY EQR cycle, CalEQRO generated an aggregate technical report of the EQRs conducted in that year. This report summarizes statewide findings, highlighting common themes and applicable recommendations to both DMC-ODS Plans and DHCS, which are outlined in the report's Conclusion section.

CalEQRO's recommendations are derived from individual DMC-ODS reports, which assess how Plans addressed the previous year's EQR recommendations, their performance in timeliness, access, and quality, and their use of information systems (IS). The reports also identify Plan-specific strengths, improvement opportunities, and recommendations for the next review.

The findings are the result of data collection and analyses and qualitative review of the DMC-ODS documentation by CalEQRO. Additional information, including CalEQRO resources, the individual DMC-ODS reports and summaries, presentations, data analyses, and archived materials, were historically posted on CalEQRO's website, which is no longer available. This information will be posted, but the specific website address was not available to BHC at the time of this report.

In April 2016, CMS issued the Medicaid and Children's Health Insurance Program Managed Care Final Rule, which aligned the Medicaid managed care program with other health insurance programs. Included in the Final Rule was the requirement for states to establish NA standards that became effective in July 2018. These requirements are specific to timely access as well as time or distance standards. States must also annually certify networks to CMS, which demonstrates compliance with Assembly Bill 205, signed into law on October 13, 2017, and California's NA standards (California Code of Regulations, Chapter 738, Statutes of 2017). The NA standards are determined by each county's population density.

BHC'S EQR APPROACH

As the California EQRO, BHC is required to conduct an annual review of each Plan to assess access, timeliness, and quality. This is done by significant document review prior to the on-site or virtual review, which entails questions tailored to the specific Plan. To promote data-driven approaches, BHC produces PMs based on the most recent 12 months of approved claims data available at the start of the review cycle – for this year, PMs were based on CY 2022 data. Review of the PM data, as well as data produced by the Plans, launches discussions regarding quality of care to evaluate a Plan's progress, improvements, setbacks, and goals related to access, timeliness, and quality. While adhering to the CMS EQRO Protocols, BHC's approach is one of curious questions and meaningful group discussions to better understand each DMC-ODS. Interviews with stakeholders, including groups of members in care and their families, as well as DMC-ODS leaders and staff (county and contract providers) representing a variety of perspectives and focused areas throughout the system, help round out understanding of the systems and improvements. Document review and discussions enable CalEQRO to identify improvements compared to the prior year and the strengths demonstrated in a Plan, as well as recommendations to address opportunities that the review identified. The approach is further detailed in the Methods chapter of this report.

The CQS guiding principles align with CalEQRO's review priorities: eliminating health disparities, data-driven improvements, transparency and accountability, community partnerships, and member involvement. These CQS principles are foundational to CalEQRO's work.

GOALS OF THE DMC-ODS

California's DMC-ODS 1115 Demonstration Waiver was the first in the nation to respond to a substance use crisis with a comprehensive, organized system of care. The Waiver's development represented a partnership between the State of California, local county BH leadership, and the federal government through CMS. Years of work were devoted to examining noteworthy practices and clinical models, identifying strengths and barriers within federal and state requirements, and crafting a framework to encompass financing and service delivery as well as workforce development. The services were to be member-focused, implement evidence-based practices (EBPs) to improve treatment outcomes, and support the integration and coordination of care across health and social service systems. Additional goals included reducing ED and hospital inpatient admissions, and placing members in the least restrictive LOC that was clinically appropriate. The waiver model would require program and fiscal oversight, quality assurance activities, managed care model administrative systems, and enhanced clinical workforce requirements.

Effective January 2022, the managed care components of the DMC-ODS framework were incorporated into the CalAIM Section 1915(b) Waiver. The benefits coverage of the DMC-ODS was incorporated into the State Plan, while the CalAIM Section 1115 demonstration project continues to provide expenditure authority for covered services provided to members receiving short-term inpatient and residential SUD treatment in qualifying institutions.[9]

The Waiver's development represented a partnership between the State of California, local county BH leadership, and the federal government through CMS. Years of work were devoted to examining noteworthy practices and clinical models, identifying strengths and barriers within federal and state requirements, and crafting a framework to encompass financing and service delivery as well as workforce development. Strong collaboration and teamwork by each of the key partners led to CMS's approval of the Section 1115 demonstration for DMC-ODS, and since January 2022, the combined CalAIM waiver.

Now part of the integrated CalAIM waiver and initiative, the DMC-ODS Plans are part of an overall comprehensive health approach designed to transform how Medi-Cal services are delivered. CalAIM also outlines a plan for integrating MH services and SUD into one BH managed care program. The goal is to improve member outcomes and health equity through care that is better integrated across systems and to reduce administrative burdens on the Plans, and in alignment with the 2022 CQS. Payment reform was implemented in July 2023, and ultimately, mental health plan (MHP) and DMC-ODS programs are to be integrated administratively by January 2N027.

CalAIM implementation began in CY 2022, with each policy change implemented through the following DHCS BHINs which impact the DMC-ODS Plans:

[9] https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Waiver-Renewal-Application.pdf

- BHIN 22-011 described the No Wrong Door policy for accessing MH services, which also specifically states that a co-occurring diagnosis must not preclude the provision of clinically appropriate MH care, either at the MHP or MCP service levels.[10]
- BHIN 23-068 outlined documentation requirements intended to be less which took effect July 2022; intended to be less burdensome and adopting problem lists in lieu of treatment plans for most services (excluding NTPs and peer support services).[11]
- BHIN 24-001 provided updates to DMC-ODS access criteria based pursuant to CalAIM.[12] It also provided some flexibility regarding completion of the initial assessment, including clarification that services may be provided prior to determination of a diagnosis or development of treatment plan (for those services that require a treatment plan). In addition, it outlines the covered services and their components that must be available based upon member needs in accordance with the ASAM determination.

Plans continue to adjust, expand, and improve this relatively young system of care. Plans that launched the DMC-ODS in FY 2020-21 faced the additional workforce and system challenges presented by the Coronavirus Disease-2019 (COVID-19) pandemic. Despite this, many notable examples of clinical and program improvements were observed and documented across the 31 DMC-ODS EQRs conducted in FY 2023-24. The reviews conducted by CalEQRO revealed many noteworthy practices to support timely access, including skilled screenings at first contact, a full continuum of treatment options, and prompt linkages to the right LOC. Practices and strategies that focus on engagement and coordination of care are highlighted throughout this report.

THE DMC-ODS ENVIRONMENT

The environment in which Plans operate will directly or indirectly affect access, timeliness, and quality of DMC-ODS services. This required evaluating the DMC-ODS within the context of its local systems and as part of the larger statewide system. Local and statewide factors influence both the strengths and weaknesses of a system. Challenges are often statewide, impacting many or all Plans, while strengths tend to be specific to individual Plans. The EQR aims to consider DMC-ODS strengths when making recommendations for improvement. Additionally, when evaluating Plans' activities in response to recommendations, their environmental context is considered as a basis for the evaluation.

Similarly, as in recent review cycles, Plans faced various adverse impacts in their local communities or regions, including rain, flooding, widespread electrical outages, and large catastrophic wildfires. Like the pandemic, these events directly impacted the service delivery system, staff, and communities, often diverting Plan employees and resources from their regular duties to assist with emergency and recovery activities. Such ad hoc assignments strained resources, both clinical and administrative, prioritizing routine service delivery tasks and leaving non-clinical tasks unattended or deprioritized.

Impacts of the pandemic persisted and were most evident in the service capacity for many of DMC-ODS Plans. Those that were significant are noted in the Final Reports issued in each Plan

[10] https://www.dhcs.ca.gov/Documents/BHIN-22-011-No-Wrong-Door-for-Mental-Health-Services-Policy.pdf

[11] https://www.dhcs.ca.gov/Documents/BHIN-23-068-Documentation-Requirements-for-SMH-DMC-and-DMC-ODS-Services.pdf

[12] https://www.dhcs.ca.gov/Documents/BHIN-24-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf

report and this report as it applies. High employee turnover and workforce shortages remain significant challenges. Policies on attracting quality staff, increasing pay, offering remote work options, enhancing diversity, training new staff after high turnover, and retaining long-term staff vary across Plans. There is significant strain on the systems to continue to implement and expand their DMC-ODS systems due to both vacancies and newly hired staff. The greatest strain is likely on the smallest MHPs, where a limited number of clinical staff must cover ongoing services across the continuum and lead expansion efforts.

Policy changes and requirements related to CalAIM implementation continue to add increased demands to DMC-ODS administrative and operational resources, while simultaneously working to improve equity in access and outcomes, and strengthen the service delivery systems and the care provided to members. Plans are leveraging the unique aspects afforded under CalAIM[13], including the prioritization of health equity and quality, and are more focused on population health, with an even greater emphasis on prevention and wellness.

Opioid and Overdose Crises

The serious health challenge SUD poses in the United States served as a national impetus to develop an effective SUD treatment delivery system. This was clearly articulated with a positive and hopeful paradigm change in CY 2016 by the report *Facing Addiction in America*, from the Surgeon General of the United States, the first national report on SUD and treatment.[14] The report recommended a major shift to a clinical, scientifically based treatment approach, similar to prior successful efforts to address the toll of smoking and tobacco on the nation's health. This required that SUD treatment shift its focus from attributing SUD-related problems to deficiencies in personal strength and will power toward a brain science model that draws on population-based treatment and prevention approaches informed by research.

The Surgeon General's report could not have been timelier, as the rising rate of opioid related deaths had by then reached the point of acute national crisis. Fueled in part by prescribing patterns involving the dispensing of newer, highly addictive opioid medications for pain, and an increased emphasis on the assessment of pain as "the fifth vital sign" (thus warranting aggressive treatment) in healthcare settings, many Americans became addicted to opioids. According to the Centers for Disease Control (CDC) reporting, there are approximately 3.7 million Americans suffering from an opioid use disorder (OUD).[15]

Some of the byproducts of the COVID-19 pandemic, including job loss, isolation, and depression have lingered and continue to correlate with a significant rise in the use of synthetic opioids, along with an ongoing epidemic level of overdose deaths nationwide. However, the CDC's National Center for Health Statistics indicates that there was a 3.1 percent decline in fatalities, with 107,543 dying in 2023 compared to 111,029 confirmed drug overdose deaths in the United States in 2022. As noted in the last annual report, the largest number of deaths were

[13] https://www.dhcs.ca.gov/calaim

[14] U.S. Department of Health and Human Services, Office of the Surgeon General. (September 2018). *Facing addiction in America: The Surgeon General's spotlight on opioids.* Washington, DC: HHS. https://www.hhs.gov/sites/default/files/OC_SpotlightOnOpioids.pdf

[15] Dowell, D., Brown, S., Gyawali, S., Hoenig, J., Ko, J., Mikosz, C., Ussery, E., Baldwin, G., Jones, C. M., Olsen, Y., Tomoyasu, N., Han, B., Compton, W. M., & Volkow, N. D. (June 2024). *Treatment for opioid use disorder: Population estimates — United States, 2022.* Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/73/wr/mm7325a1.htm

due to an opioid. Synthetic opioids, including both fentanyl[16] and tramadol[17], accounted for the largest number of those opioid-related deaths (74,702), with the rest of the deaths in the opioid class (including heroin) accounting for 8,198 fatalities. According to the CDC, overdose deaths from psychostimulants, including methamphetamine (and laced with synthetic opioids), resulted in nearly 36,000 deaths. Significantly, heroin deaths have seen a real decline over recent years, from some 16,000 in 2017 to much lower 4,065 deaths in 2023. However, while some states saw significant rises or drops in their overall overdose fatalities, California was one of seven states that saw a small increase. Similarly, review activities and data supplied by local Plans and the California Opioid Surveillance Dashboard[18] indicates that many counties have continued to see a spike in overdoses and deaths, despite the national trends.

A recent study published in the International Journal of Drug Policy notes that while OUDs have grown more than 100 percent in the past decade, the use of MAT has not even begun to keep pace.[19] In fact, the vast majority (86.6 percent) of individuals with an OUD are not receiving MAT.[20] Given the obvious need for treatment, it is even more important to enhance and improve both the access to and the quality of SUD treatment as well as outcomes for the people of California.

While the recent national decline in overdose deaths is encouraging, California remains deeply affected by the ongoing substance use epidemic. A study in the International Journal of Drug Policy highlights OUDs have more than doubled in the past decade, yet the availability of SUD treatment has not kept pace. This underscores the urgent need to improve both access to and the quality of SUD treatment to achieve better outcomes for Californians.

Notable again this year, administrative functions and reporting responsibilities for the Plans have increased with CalAIM, other state initiatives, and the fact that 65 percent of Plans elected to change their EHR rather than work with vendors for multiple upgrades in order to adjust to new requirements. Frequently QM staff were redirected to support these functions while ongoing tasks have suffered. Additional impact came from many experienced staff resigning, new staff and leadership teams, slow growth of analytic staff, and shortages/staff turnover in supportive units such as human resources.

The EQRs were focused on obtaining qualitative and quantitative information to understand a system's operations and ways in which each Plan's processes positively or negatively affect the quality of care. This report will detail statewide themes, findings, and recommendations that CalEQRO hopes will be meaningful to the state, the Plans, the members served – and the unserved individuals with SUD that hopefully will become engaged in treatment through the DMC-ODS systems.

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[16] Medscape. (2024). *Fentanyl (Rx)*. https://reference.medscape.com/drug/sublimaze-fentanyl-343311

[17] Medscape. (2024). *Tramadol (Rx)*. https://reference.medscape.com/drug/ultram-conzip-tramadol-343324

[18] California Department of Public Health. (n.d.) *California overdose surveillance dashboard.* https://skylab.cdph.ca.gov/ODdash/?tab=Home

[19] Krawczyk, N., Rivera, B. D., Jent, V., Keyes, K. M., Jones, C. M., & Cerdá, M. (December, 2022). Has the treatment gap for opioid use disorder narrowed in the U.S.?: A yearly assessment from 2010 to 2019. *International Journal of Drug Policy, 110*, 1-11. https://doi.org/10.1016/j.drugpo.2022.103786

[20] Ibid.

Methods

BACKGROUND

The core elements of EQRO evaluations are mandated by federal law and associated regulations and are operationalized by CMS (42 CFR §438.350; Medicaid Program, EQR of Medicaid Managed Care Organizations), which specifies the requirements for the evaluation of Medicaid managed care and prepaid inpatient health plans. The 2023 CMS protocols for EQRs focus on the core themes of improving access, timeliness, and quality.[21] These protocols for evaluation assist states in the oversight of the programs as funded by state and federal governments.

In doing so, CalEQRO reviews emphasized the DMC-ODSs' data use in alignment with the CQS, ensuring accurate data-driven decisions across the BH continuum of care for Medi-Cal members. The objective of all technical data collection and analysis was to assess and validate the performance of the DMC-ODSs in service to Medi-Cal members. This chapter provides detailed information on data collection and analysis methods, including the entities responsible for validation. Further details, including the validated data and conclusions, are available in the specific chapter dedicated to each EQR activity.

BHC review teams were composed of three distinct roles – Lead Quality Reviewer, IS Reviewer, and Consumer/Family Member Reviewer. Depending on the size and complexity of the DMC-ODS, additional BHC staff may also have been required. BHC's staff have public MH expertise in their respective areas, some having served in DMC-ODSs in leadership, including former executive staff, IS administrators, and individuals with lived experience as consumers or family members served by DMC-ODS systems of care. All team members are subject matter experts, fully qualified to validate their respective portions of the review.

The review teams used both quantitative and qualitative techniques to analyze data, review DMC-ODS-submitted documentation, and conduct interviews with county leadership and staff, contract providers, advisory groups, members, family members, and other stakeholders. At the conclusion of the EQR process for each DMC-ODS, CalEQRO produced a technical report that synthesizes information, builds on the previous year's findings, and identifies system-level strengths, opportunities for improvement, and recommendations across four domains: access, timeliness, quality, and IS. Although there is overlap and dually qualified staff, the Lead Quality Reviewer validated PIPs using Protocol 1, while PMs were validated by the IS Reviewer using Protocol 2.

EQR Protocol 3, compliance with Medicaid regulations, is formally conducted by DHCS staff through its triennial compliance review. The relevant compliance topics were considered throughout the annual DMC-ODS review process, Plan-level reports, and are discussed throughout the chapters of this aggregate report. More specifically, Protocol 3 topics – including the availability of services, assurances of adequate capacity, coordination and continuity of care, grievances, subcontracted relationships, health information systems (HIS), and the Plans'

[21] Department of Health and Human Services & Centers for Medicare and Medicaid Services. (February 2023). *CMS external quality review (EQR) protocols.* https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf

Quality Assessment and Performance Improvement (QAPI) programs – were evaluated during the pre-review, the review, and post-review periods. In accordance with 42 CFR 438.360, DHCS provided the Triennial Audit summary level results for the prior 3 years for inclusion in the Compliance chapter of this report.

Protocol 4, the validation of NA, has been conducted by DHCS staff through the review of significant documentation submitted by DMC-ODSs, with CalEQRO evaluating the Plans' adherence to time or distance as well as alternative access standards (AAS). These NA findings are detailed in the DMC-ODS reports. DHCS's NA Findings and Corrective Action Plan (CAP) reports can be found on DHCS's NA webpage.[22] At the time of this report, DHCS had posted 2022 results, provided CalEQRO and DMC-ODSs with the 2023 results (and re-submission requirements where needed), and Plans recently submitted the 2024 data. For this report, DHCS provided CalEQRO with Plans' 2023 TADT with the intent to validate the timeliness for two elements: follow-up outpatient services after the initial non-urgent outpatient service for new members, and follow-up OTP services after the initial OTP service, based upon the extent to which the service dates were substantiated in the claims data. As DHCS ultimately determined that the Plans' data as submitted was insufficient for validation, this analysis is not presented in this report.

CalEQRO used various data sources to create PMs and other analyses, including the MEDS (Medi-Cal Eligibility Data System) Monthly Extract File (MMEF), SDMC approved claims, CalOMS, ASAM referral data, TPS data, NA Findings Reports, and Plan submission documents. Plan documents included materials already maintained by the DMC-ODS and those specifically prepared for the review. Reviews conducted in FY 2023-24 used local data provided by DMC-ODSs, while PM data produced by CalEQRO focused on CY 2022 approved claims data, often with a 3-year trend starting from CY 2020. The MMEF data set covered 15 months of eligibility for the same period and forms the denominators for the PMs created. CalEQRO received these large data files through secure file transfer and stored them on BHC's secure network. Only BHC's Statistical Analysis Software (SAS) programmers and the Information Technology (IT) Director can access these servers.

As part of the pre-review process, each DMC-ODS received a description of the data sources and a summary reports of Medi-Cal approved claims data. Data compiled by the DMC-ODSs and submitted to CalEQRO was also reviewed. This data often provided a more comprehensive reflection of the entire system, including services not billed to SDMC or that were funded by other resources such as grants, including the Substance Abuse Block Grant or Mental Health Services Act funds.

The reviews were retrospective, covering the prior year of services since the last review. Five to six MHP reviews were conducted monthly, typically 10 to 12 months after the prior review. The schedule for FY 2023-24, developed with input from the MHPs, was produced and published in March 2023. When MHPs identified conflicts with planned review dates, such as key staff vacations or other audits, CalEQRO worked to find mutually acceptable alternative dates.

Additionally, CalEQRO provided individualized technical assistance (TA) to Plans. Guidance on developing PIPs was the most common subject of TA, but DMC-ODSs also requested TA regarding the approved claims data and PMs compiled by CalEQRO so that they might better understand what the data reflected and what it did not. CalEQRO's goal is that Plans would produce these measures independently and in real time. Therefore, it is important to note that

[22] https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx

nearly all PMs (except where noted: Assessment of Timely Access [ATA], NA) were produced by CalEQRO.

MEDI-CAL POPULATION

California DMC-ODS Plans serve diverse populations in need of SUD treatment services. The EQR evaluation focuses on the Medicaid population – Medi-Cal in California – including elderly, disabled, and financially eligible residents. The term "eligible" describes a person enrolled in Medi-Cal and eligible to receive services funded through Medi-Cal, irrespective of whether they needed or received any DMC-ODS services. The term "member" describes a person who is enrolled in Medi-Cal and has received one or more DMC-ODS service – referred to as "beneficiary" in previously published EQR reports.

DHCS has assigned specific aid codes to identify the types of recipients eligible under Medi-Cal. These aid codes indicate the types of services for which members are eligible. Benefits may be full or restricted, depending on the aid code. They also indicate certain groups with special needs such as foster care, disabled, ACA, and enable analysis by aid code. While Plans are required to serve those who meet access criteria and have Medi-Cal, they may also provide services to individuals who are uninsured, have Medicare, or have both Medicare and Medi-Cal.

PHASE-IN OF DMC-ODS PLANS

This is the seventh year of EQR activities since the launch of treatment services under the DMC-ODS framework. In FY 2023-24, CalEQRO reviewed the 31 DMC-ODS Plans, and no new Plans were reviewed this year.

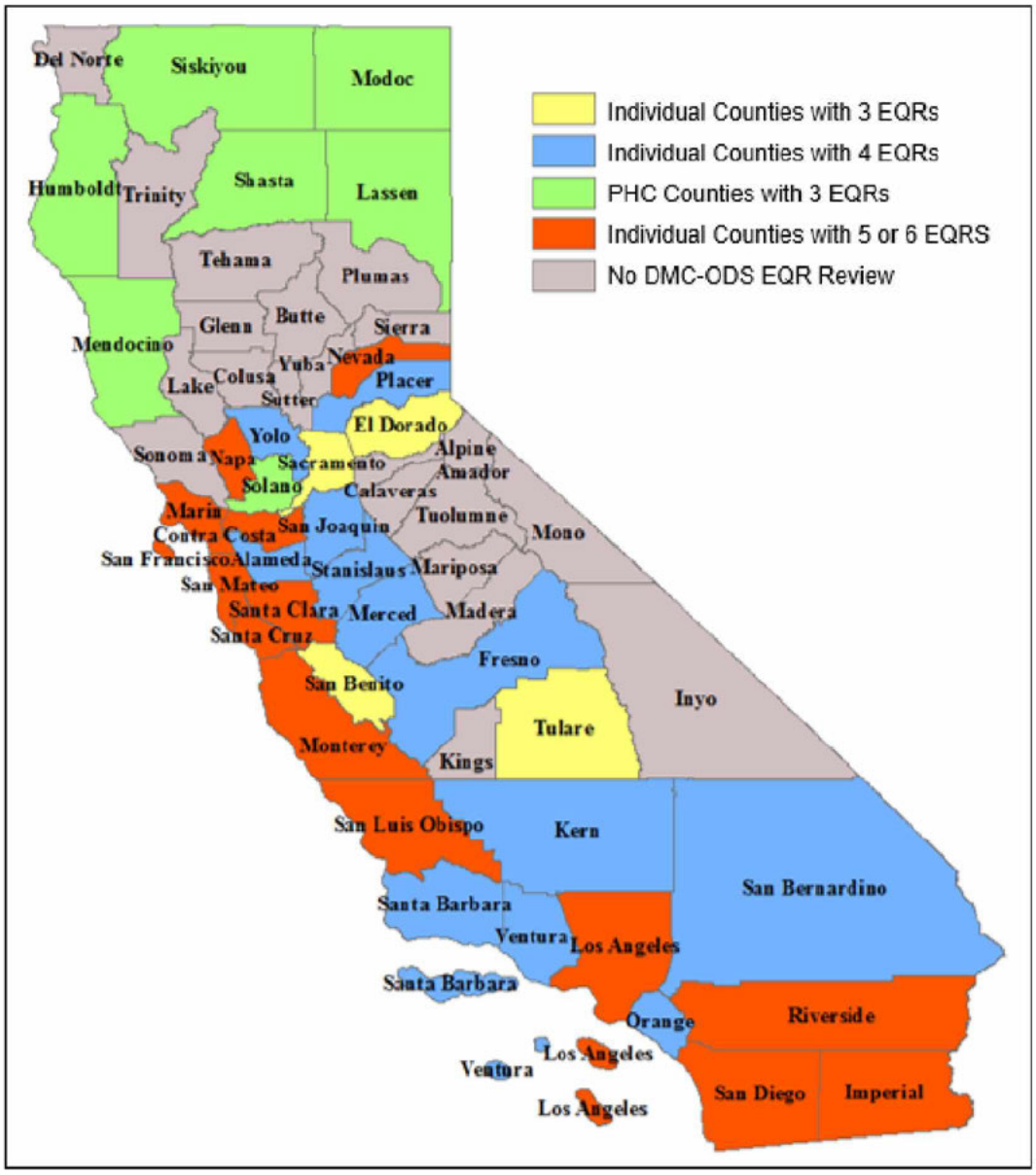
Phasing-in of DMC-ODS Plan reviews began the year after the Plan launched its DMC-ODS program:

- FY 2017-18 reviews were launched for the first three Plans: Riverside, San Mateo, and Marin.
- FY 2018-19 involved 11 additional reviews of new Plans: Santa Clara, Contra Costa, San Francisco, Los Angeles, Napa, San Luis Obispo, Santa Cruz, San Diego, Monterey, Nevada, and Imperial.
- In FY 2019-20, 12 additional Plans were reviewed: San Bernardino, Yolo, Orange, Alameda, San Joaquin, Placer, Ventura, Santa Barbara, Fresno, Merced, Kern, and Stanislaus.
- In FY 2020-21, CalEQRO provided the first EQRs to five additional Plans: San Benito, El Dorado, Sacramento, Tulare, and the seven-county PHC DMC-ODS.

This phase-in implementation is important to consider when reviewing historical approved claims data, where CY 2020 and CY 2021 data all show statewide increases in eligibles and members served due to the inclusion of more Plans. In CY 2020, the five Plans implemented at various times of the year. Both CY 2021 and CY 2022 data are the first 2 years to include all 31 Plans reviewed in the FY covered in this report.

Figure 3-1 displays a map of California depicting the phase-in period for each DMC-ODS county. There are 19 counties – primarily rural areas – not participating in the DMC-ODS framework. Although Mariposa implemented the DMC-ODS in FY 2023-24, it is not reviewed or included in this report. Additionally, Lake DMC-ODS began implementation in FY 2024-25, also not included in this report.

Figure 3-1: DMC-ODS Implementation and Number of EQRs as of FY 2023-24



PERFORMANCE MEASURES

The data sources used in the analyses for this report are described below. Medi-Cal claims data involves a lag time between service delivery by providers, claims submission by the Plans to DHCS, and final claim approval by DHCS. To report on the most recent period with relatively complete data, FY 2023-24 reviews used CY 2022 data for tables and figures of calculated PMs, with most measures displayed over a 3-year period (CYs 2020-22).

Data used to generate the Approved Claims Summaries and PM tables and graphs throughout individual Plan reports and this statewide report, unless otherwise specified, are derived from the following source files:

- MMEF – includes eligibility, demographic, and aid code data for all individuals enrolled in Medi Cal at any point in CY 2022; generates most denominators for PMs.
- SDMC approved claims file – all DMC-ODS claims that were submitted by Plans and approved for services delivered in CY 2022; generates most numerators for PMs.
- CalOMS for CY 2022 – provided by UCLA through DHCS as submitted by Plans for assessments and discharges.
- ASAM referral data for members evaluated for care in CY 2022 – provided by UCLA through DHCS as submitted by Plans for screenings, assessments, and re-assessments.
- TPS annual survey files for administration in CY 2023 – provided by UCLA through DHCS; online versions were submitted directly to UCLA and paper surveys sent to UCLA.

The PMs that present data by Plan are outlined in Table 3-1, with reference to its table number and page number in this report.

Table 3-1: PMs with Plan-level Data, Table Numbers and Page Location

PM	Number of Table	Page(s)
PR by Race/Ethnicity by Plan	Table 4-4	45
Wait Time (business days) to Initial Non-Urgent Outpatient Service Offered	Table 5-3	69
Wait Time (business days) to Initial Non-Urgent Outpatient Service Delivered	Table 5-4	71
Wait Time (business days) to Initial MAT Service Offered	Table 5-5	73
Wait Time to Urgent Services	Table 5-6	75
Follow-Up After Residential Treatment at 7 and 30 Days	Table 5-7	77
Follow-Up After Residential Treatment, Adult vs Youth	Table 5-8	78
Readmission to WM within 30 Days	Table 5-9	79
Average No-show Rates	Table 5-10	81
Compliance Findings	Table 10-3	169

It is important to note that Plans reported that, on average, 81 percent of their services are billed to Medi-Cal. Therefore, the PMs represent the vast majority of, but not the entirety of, services provided by DMC-ODSs.

Plans provided a required report in preparation for the EQR called the ATA. The ATA provided an overview of timely access to care, and included specific population counts, averages, ranges, and means for timeliness data including first non-urgent service, first delivered service, first non-urgent NTP/OTP appointment, urgent services, follow-up after residential treatment discharge, WM readmission rates, and no-show rates for initial services. This comprehensive form was to be submitted with de-identified source data, which was then validated by CalEQRO. An IS Reviewer familiar with these data conducted the ATA validation, as described later in the Timeliness chapter. The ATA also requested the definitions and methods used to calculate these measures, which can vary across the Plans and with the analytic staff who populate the

form. To review these results and learn more about the ATA measures, please refer to the Timeliness chapter of this report.

CalEQRO calculated the remaining PMs throughout all chapters of this report, as required by DHCS, using the data sources indicated above, and provided a copy to the DMC-ODSs prior to the review. Additionally, a Health Insurance Portability and Accountability Act (HIPAA)-compliant version was provided to the Plan and included in the published DMC-ODS report. All PMs were discussed during the review in the context of the main domains: access, timeliness, and quality of care. Points of underperformance identified during calculation or discovered in the prior year often drove specific discussion during the review sessions. Numerator and denominators are defined in each section where a new PM is introduced.

Except for the Plan-submitted ATA data, all measures calculated by CalEQRO are compared to statewide data, and most are also compared to subgroups of counties in the same size category. Size categories are defined by DHCS. Los Angeles is in a size category of its own ("very large" and its own region) but is compared to large county numbers for most PM analyses, unless otherwise specified. Where Los Angeles' large numbers will unduly skew the large MHPs' data, it is separated into its own size category. Large MHPs have a population of 750,000 or more; medium MHPs have 200,000 to 749,999; small have 50,000 to 199,999; and small-rural have less than 50,000 individuals in the county's population. Fifty percent of California's counties are small or small-rural.

CalEQRO produced the following measures in each DMC-ODS report and from a statewide perspective for this report:

- PRs for members, including racial/ethnic group, age group, and aid code.
- Total approved claims per member served by each Plan by racial/ethnic group, age group, and aid code.
- Timely access to medication for those referred to NTP/MAT services.
- Number of members receiving a DMC-ODS service after screening and referral – calculated by identifying members who initiate services as those who did not have a DMC-ODS claim in the preceding 30 days.
- Number of DMC-ODS service types utilized by members – an analysis of the number of members receiving each service type and the total units of service delivered in those categories.
- Access to non-methadone MAT focused upon those members who initiated this service as well as those who received three or more MAT services.
- Timely coordinated transitions of members between LOCs, focused upon transitions to other services after leaving residential treatment, identifying services delivered at 7, 14, and 30 days after residential discharge.
- Identification and coordination of the special needs of high-cost members based on the percentage of members at or exceeding two standard deviations above the mean.
- Percentage of members with three or more WM episodes and no other treatment, to improve member engagement in necessary outpatient care.
- Initiation and engagement in DMC-ODS services across the continuum of treatment services – identifying those members that did not have a DMC-ODS service in the 30-day period prior to the service as initiating care.

- Retention, or length of stay (LOS), across an uninterrupted sequence of treatment services within the DMC-ODS continuum of care, for members who have exited care, as indicated by 30 days with no approved claims.
- Readmission into Level 3.2 residential WM within 30 days.
- Use of ASAM Criteria in screening and referral of members and the percent of such members referred to the criteria-indicated LOC.[23]
- CalOMS results comparing admission to discharge.

Analysis Tools

The quantitative approved claims data were compiled and analyzed with SAS. Graphs were created using Microsoft Excel, generated to highlight key findings. Data in the annual report are largely presented in a statewide aggregate form, with some measures comparing similar sized counties, and provided with comparisons over time.

Analytic staff manually extracted key themes from the extensive qualitative data to highlight the most salient ones. Discussions with key informants during the review, along with MHP documentation, provided programmatic context for understanding the PMs.

Collecting member feedback was a cornerstone of the reviews, providing significant qualitative data about services across the continuum. The Plan member focus groups were interviews that engaged members in discussing their nuanced experiences of receiving services from the DMC-ODS. The focus groups were designed to include members from various service locations or treatment programs, ages, and ethnic groups, including those for whom English is not the preferred language and who require translators.

This mixed methods approach is used to generate highlights, key findings, noteworthy practices, and areas for improvement.

California Outcomes Measurement System

Another important data set used in the reviews is CalOMS, which was utilized to fulfill county, state, and federal reporting requirements. Service providers who receive public funds for SUD treatment services, including all NTPs, are mandated to report CalOMS data to DHCS for each service episode. Regardless of insurance type, providers must collect member information at admission, discharge, and an annual update from the treatment program to determine drug use, drug-free social supports, MH status, living status, employment status, and legal status. Any of these elements can be used by Plans for pre/post treatment measures of enrolled members or member outcomes, and some counties have begun doing so through routine QI processes and within PIPs. At the annual review for each Plan, CalEQRO provides Plans with their aggregated admission summary data on members' living status, employment status, and legal status compared with the statewide rates. This data can be useful to DMC-ODS Plans in resource planning for the special needs of their members diagnosed with a SUD.

[23] Plans are required to administer an ASAM-based assessment to determine the recommended LOC for members. The ASAM Criteria for screening/assessment and referral of members examines the congruence rate of assessed LOC to referred LOC, and also tracks the reason(s) for noncongruence. Details about the ASAM LOC Data Collection System are available here: https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-035_ASAM_Data_Submission.pdf

At discharge, providers must indicate the type of discharge, including whether the member experienced an administrative discharge by self-terminating services without an exit interview. Providers must also rate whether their members successfully completed treatment, made satisfactory progress without treatment completion, or did not make satisfactory progress. At the annual review for each Plan, CalEQRO provides Plans with their aggregated discharge summary data compared to statewide rates. This data can be useful to DMC-ODS Plans as indicators of the effectiveness of their treatment services and possible areas for improvement. To maximize the usefulness of the data, DHCS produced the CalOMS Tx Data Dictionary, which serves as a training tool for standardizing procedures and ensuring inter-rater reliability.[24]

Treatment Perception Survey

The TPS is a survey designed to measure members' perceptions of their care. The adult version consists of 14 items that yield findings in five domains of access to care, quality of care, care coordination, outcomes, and general satisfaction with services. The youth version consists of 18 items that yield findings in the same five domains as the adult version, plus an additional domain of therapeutic alliance. Both instruments were developed in accord with psychometric research that established their reliability and validity as well as the differentiation of the domains.[25]

DMC-ODS Plans are required by DHCS to administer both forms of the TPS during one specified week during the fall of each CY to all members in active treatment who are served that week.[26] The Plans collect the completed surveys and upload the entries to DHCS. The UCLA Integrated Substance Abuse Program (ISAP) team is tasked with analyzing the data and sending a report of each Plan's results to the counties; they also receive line level data that can be further stratified by demographic categories for additional analysis at the local level. The report includes the Plan's overall results for each item and domain, as well as a comparison with the statewide results. It also contains the results by item for each provider program, age group, gender identification, race and ethnicity, and LOC in which the respondent was enrolled at the time of the survey. DMC-ODS Plans can study the provider-differentiated results, identify outliers with lower performance as well as model programs with stronger performance, and use the data with the providers to promote QI efforts.

PRE-SITE ACTIVITIES: REVIEW PREPARATION

CalEQRO issued a notification packet to each DMC-ODS via email 60 days prior to the date of the scheduled review. The letter identified the requested member focus groups based on a review of PM data or concerns from the prior year's review, or determined in collaboration with the DMC-ODS if a particular population or program type was of interest to the DMC-ODS.

The DMC-ODS was also referred to the BHC website for documents that the DMC-ODS completed or updated, including the following CalEQRO Forms:

- Response to prior-year report recommendations

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[24] https://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Dictionary_JANUARY_2014.pdf

[25] Teruya, C., Joshi, V., Urada, D., Trabin, T., Iturrios-Fourzan, I., Huang, Y. (April 2022). Development and measurement of the treatment perceptions survey (TPS) for members with substance use disorders. *The Journal of Behavioral Health Services & Research*, *49*(2), 190-203. DOI: 10.1007/s11414-021-09776-y

[26] https://www.dhcs.ca.gov/Documents/BHIN-23-024-DMC-ODS-Treatment-Perception-Survey.pdf

- Key changes and new initiatives
- ISCA
- NA Form
- ATA
- Two PIP Development Tool submissions – one clinical and one non-clinical
- Access Call Center Form
- Continuum of Care Form
- ATA Form, which should be submitted with the source data used to complete the form
- Two PIP submissions – one clinical and one non-clinical

The DMC-ODS plans were instructed to submit those documents, along with other key documents they maintain throughout the year, to a shared, secure website folder. These additional documents included:

- QAPI Work Plan (WP)
- QAPI WP Evaluation
- Quality Improvement Committee (QIC) meeting minutes
- Cultural Competency Plan
- Cultural Competency Committee meeting minutes
- Current organizational chart(s) of the DMC-ODS
- MCP memoranda of understanding
- Strategic Plans, if applicable
- Any other documents that demonstrate the DMC-ODS's management of access, timeliness, quality, IS, or outcomes of care

In addition, Plans were encouraged to provide examples of activities conducted to enhance the provider network, expand the continuum of care, build community partnerships, and any other documents that demonstrated the DMC-ODS's management of access, timeliness, quality, IS, or outcomes of care.

DMC-ODSs were advised to contact the Lead Quality Reviewer by a specified date to begin review preparation discussions and to upload all review documentation to CalEQRO's HIPAA-compliant web-based platform 4 weeks prior to the review for comprehensive review by the assigned team.

During the COVID-19 pandemic, reviews transitioned to being conducted via video conference due to safety protocols. It became clear that virtual reviews offered the advantage of allowing for a more robust agenda within the allotted time frame, as there was no need to move between conference rooms or travel between sites. For FY 2023-24, Plans were given the option to choose between an on-site or virtual review format. Most reviews conducted in FY 2023-24 were conducted via a video conferencing platform. Four of the Plans were reviewed on-site – Santa Cruz, Fresno, Los Angeles, and Ventura (all on-site reviews except Los Angeles were conducted jointly with the MHP review). Riverside preferred an on-site joint review but due to

changes that occurred in EQRO staffing this review was conducted in a hybrid fashion, facilitating the member focus groups on-site; it was held as a joint review with the MHP.

If a given county also participated in an MHP review, the option to combine the EQRs was provided. The seven counties participating in the PHC regional model did not have the option of combining agendas for the MHP and DMC-ODS reviews due to logistical reasons. Twenty-one reviews were conducted virtually as joint or integrated reviews with the MHP – Kern, Contra Costa, El Dorado, Fresno, Marin, Merced, Monterey, Napa, Nevada, Orange, Placer, Riverside, San Benito, San Bernardino, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Stanislaus, Tulare, and Ventura. Only six DMC-ODS reviews were conducted solely as DMC-ODS reviews. For integrated EQRs, additional days were usually not required when the MHP and DMC-ODS teams worked concurrently or collaboratively, depending on the session topic, the degree of Plan integration, and behavioral health plan (BHP) staff preference and availability. Sometimes, what would have been two separate 2-day reviews was conducted as a comprehensive 3-day review.

The review agenda was prepared in consultation with each DMC-ODS, following CMS protocols. Discussions were planned to address improvement in areas identified in the prior year's EQR report and to provide the DMC-ODS an opportunity to showcase additional accomplishments since the previous review, particularly those impacting access, timeliness, and quality of care. EQR agendas were tailored to specific topic areas or key informant groups (e.g., contract provider management, clinical line staff, peer providers), with sessions typically lasting between 90 to 120 minutes long. For those that opted to combine the MHP with the DMC-ODS EQRs, sessions were more frequently 2 hours long to ensure comprehensive collection and clarification of review materials for each distinct report. However, member focus groups remained specific to either MHP or DMC-ODS and occurred concurrently. It was discovered that integrated reviews allowed for additional input about the DMC-ODS that might not have been gathered by a DMC-ODS-only review. For example, integrated reviews provided a more comprehensive look at the extent of MH treatment integration, its impact on services for co-occurring populations, prevention services, and justice system collaboration.

Plans were asked to invite members to participate in focus groups where they shared their experiences with care and offered recommendations for improvement. Virtual reviews can present challenges for member focus groups, though many members are familiar with telehealth services. For members in rural areas, virtual reviews have been beneficial for reducing transportation barriers but challenging due to limited internet bandwidth. In some cases, a few members who had confirmed their attendance did not participate in the focus groups. Additional member feedback results are detailed in the Perceptions of Care chapter.

Reviews were conducted over the course of 1 to 3 days, depending upon the size of the DMC-ODS. Generally, larger counties are the most complex and require an additional Quality Reviewer and 3 days to both gather information and validate it in interviews with key informants. Small/small-rural Plan reviews were 1 day or 1.5 days, and medium-size DMC-ODS reviews were conducted in 2 days. The Los Angeles review is the only one that required 4 days and an expanded review team, each review year focusing on two of the eight "service areas," in addition to the overall system operation. The PHC review was conducted in 3 days.

In finalizing the agenda and preparing for the review discussions, the review team examined all the CalEQRO-created PM data and DMC-ODS documents submitted. This preparation allowed the review team to identify areas where additional questions or discussion were needed to fully understand the DMC-ODS's processes or operations. Before the review, the team held a pre-site meeting to discuss priority areas based on the prior year's report, the DMC-ODS's documents reviewed, and any other Plan-specific information. For integrated reviews, both

review teams held a meeting to coordinate and discuss the extent of BHP integration as it applied to the joint agenda, as well as to find ways to minimize duplication for reviewers and Plan participants.

CONDUCTING THE DMC-ODS REVIEW

During the review, up to three sessions, but usually two, were held concurrently, depending on county size, the roles of the participants, system complexity, and the size of the review team. An integrated review included as many integrated sessions as necessary based on the BHP's structure, operating concurrently with both the MHP and DMC-ODS review teams. Each CalEQRO review team included at least one Quality Reviewer, IS Reviewer, and Consumer/Family Member Reviewer, with each potentially conducting review discussions simultaneously. DMC-ODS participants varied based on the session focus and the availability of informants who could address the topic, ideally including both leadership and line staff involved in implementation. Participation included leadership and staff, contract agency leadership and staff, members and families, partner agencies, and various community stakeholders. Additional documents could be submitted during the review, and CalEQRO permitted the submission of relevant information up to 2 weeks after the review, "post-site."

Review activities were held on-site or virtually and include, but not limited to: member focus groups; stakeholder interviews; reviews of ongoing plans and projects such as Quality Improvement Work Plans, Cultural Competence Plans (CCP), and PIPs; NA issues; ISCAs; care coordination arrangements with managed health care plans and physical health service providers; coordination with other partners, such as the criminal justice and child welfare systems; access call center staff interviews; new program site visits or focus groups; MAT provider group interviews; contract provider management interviews; supervisor and line staff interviews. Discussions were facilitated based upon a common set of questions and topics but tailored to the DMC-ODS based upon review of documents and an understanding of the Plan's issues. Detailed discussion helped illuminate progress and challenges.

Throughout the review process, the CalEQRO teams rated the items and sub-items that form the Key Components based on their review of PMs, submitted documents, and discussion sessions used to validate impressions and conclusions. This document, historically available on the CalEQRO website, outlines the number of items that must be met to achieve a Partially Met or Met rating.[27] There are 24 Key Component items, categorized by Quality, Access, Timeliness, and IS. The ratings of the Key Components, analysis of the PMs, and other quantitative and qualitative information from the review were consolidated into a set of strengths and opportunities for each broad category. Tailored recommendations were provided where opportunities for improvement were identified.

CalEQRO focused on how DMC-ODS Plans used data to promote quality and improve performance. Critical elements of successful performance management include a focused organizational culture with strong leadership and stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These issues aligned with the CQS's broad view of quality and its goal of using data-driven analytics to represent care and outcomes. Analyzing PMs by race/ethnicity and making recommendations on access to care was intended to help advance equity goals and identify care gaps, which are key priorities in the CQS. The CalEQRO review used data analyses from DMC-ODS reviews to identify strengths,

[27] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

opportunities for improvement, and recommendations for addressing areas needing enhancement. Each review also assessed the work done in response to the recommendations made the prior year, with a documented assessment of whether those items were fully, partially, or not addressed.

POST-SITE: REPORT OF DMC-ODS-SPECIFIC FINDINGS

The Plan-level report consolidated quantitative and qualitative data into an initial draft report. Preliminary drafts were reviewed and edited iteratively by internal staff and leadership. The core report template followed the general CMS protocol, incorporated areas of interest to DHCS within the CalEQRO scope of work, and aligned with the DHCS 2022 CQS.

The Plan-level report consolidated quantitative and qualitative data into an initial draft report. The preliminary drafts were iteratively reviewed and edited iteratively by internal staff and leadership. CalEQRO then sends the completed draft of this report to DHCS for their feedback. The core template for the report follows the general CMS protocol plus other areas of interest to DHCS within the CalEQRO scope of work, in alignment with the 2022 DHCS CQS.

CalEQRO was expected to produce a draft report within 30 days of the DMC-ODS review conclusion. Both DHCS and the DMC-ODS were then invited to provide feedback or request additional clarification or information be included before the Final Report was delivered within 90 days of the review. DMC-ODSs were requested to provide feedback within 2 to 3 weeks, while DHCS provided its feedback within 30 days. If Plans requested additional time due to competing demands, a new deadline was negotiated and approved. As this is the last year BHC will serve as the state as BH EQRO, historical BHP reports will be posted on a DHCS web page.[28]

The DMC-ODS Final Report included:

- A summary of the changes and initiatives identified by the DMC-ODS that significantly impacted access, timeliness, and the quality of the service delivery system. Additionally, a section identifying external events outside the MHP's control that may have impacted services, such as wildfires or mudslides affecting staff or members, was included.
- Ratings of the Responses to Recommendations as Fully Addressed, Partially Addressed, or Not Addressed, with a summary of related DMC-ODS activities. It also indicated whether the same recommendation would be repeated based on the relative need. When a partially or not addressed recommendation was not repeated, reasons were provided, such as other more important recommendations or a substantive plan from the DMC-ODS for addressing the issues.
- Ratings of Met, Partially Met, or Not Met for each of the four Key Component categories: Access, Timeliness, Quality, and IS. Document review and review session discussions to validate the documentation were essential to this process. At a minimum, any ratings of Not Met included a brief explanation.
- Analysis and validation of Access, Timeliness, Quality, and IS PMs per 42 CFR 438.358(b)(1)(ii).
- Evaluation of the DMC-ODS's two contractually required PIPs per Title 42 CFR Section 438.330 (d)(1)-(4).

[28] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

- Member perception of the DMC-ODS's service delivery system based on focus groups with members and family members. The report included a brief overview of the feedback and specific recommendations made by the participants.
- Assessment of the extent to which the DMC-ODS and its subcontracting providers met Federal data integrity requirements for HIS.
- Summary of the DMC-ODS's strengths, opportunities for improvement, and recommendations for the coming year. These findings were maintained in a database for statewide analysis.

STATEWIDE AGGREGATE TECHNICAL REPORT

This statewide aggregate technical report includes comparable information from each DMC-ODS Final Report, aggregated at a statewide level to provide a comprehensive view of access, timeliness, and quality across California's DMC-ODSs. The chapters are organized by the major categories of the EQR scope of work:

- Methods
- Access
- Timeliness
- Quality
- PIPs
- Member Perceptions of Care
- Information Systems
- Compliance

The PMs, focused on CY 2022, are embedded throughout this report. They are often presented as part of a three-year trend using tables or figures, with various stratifications with a variety of stratifications (e.g., age, race/ethnicity, DMC-ODS size, DMC-ODS region), accompanied by narrative descriptions of meaningful trends or conclusions based on the data.

To facilitate the analysis of the information from 31 DMC-ODSs, CalEQRO maintains several databases that correspond with CalEQRO forms, DMC-ODS submissions, and information extracted from the DMC-ODS final reports. The following databases enabled analysis from a statewide perspective:

- NA
- ISCA
- ATA
- Continuum of Care
- Access Call Center
- Member Focus Groups
- PIPs
- Strengths, opportunities, and recommendations from each DMC-ODS final report.

This report includes four Appendices. The first is a comprehensive list of definitions used in the programming and calculations of the PMs from the approved claims data. The second appendix defines each DMC-ODS by size and by region, as both categories are used for comparative purposes in the PM analysis. The third appendix shows each county on a California map, by size and by region. The fourth appendix details the DHCS EQR Protocol 3 Compliance results, provided by DHCS to include in this report to remedy DHCS's ongoing deficiencies identified by CMS.

An additional attachment includes the Executive Summaries from all 31 DMC-ODS reports. This provides the reader with the summary information at the DMC-ODS level. The Executive Summaries include the DMC-ODS's Response to Recommendations – how many were Fully Addressed, Partially Addressed, or Not Addressed; a summary of the 24 Key Component ratings by domain; details regarding the PIP topic, phase, and confidence validation ratings; types of member focus groups held as well as the number of participants; and finally, conclusions which describe strengths, opportunities for improvement, and recommendations based upon the review findings.

This report was submitted to DHCS first in draft form. After a 45-day period for DHCS to review and submit feedback, the finalized version is submitted to DHCS 30 days thereafter. Ultimately, DHCS submits it to CMS via public posting on its website in April 2025.

INTRODUCTION

When initiated under the DMC-ODS 1115 Waiver, 24-hour access to SUD information, screening, and referral was a priority to promote rapid access to appropriate treatment for members seeking care. The goal of this focus has been to facilitate immediate access followed by effective treatment, symptom relief, and more positive outcomes. Upon initial implementation, the waiver's Special Terms and Conditions included the access line requirements as a key gateway that DMC-ODS Plans must maintain an access line with 24-hour availability to provide information, screenings, and referrals into treatment. This chapter describes access performance across the state and explores factors that may contribute to variations in performance.

CalEQRO identifies the following Key Components as representative of a broad service delivery system that provides access to Plan members and their families. These are linked to likely improved outcomes and include examining culturally appropriate service accessibility and availability, system capacity, and integration and collaboration of SUD services with other health providers.

Each access component summarized in Table 4-1, composed of individual subcomponents, are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met.[29] Table 4-1 shows the overall results of the Access Key Components and the number of Plans with each rating, further detailed below.

Table 4-1: Key Components: Summary of Oversight of Access - Statewide FY 2023-24

KC #	Key Components – Access	Met	Partially Met	Not Met
1A	Service Accessibility and Availability are Reflective of Cultural Competence Principles and Practices	31	0	0
1B	Manages and Adapts its Network Adequacy to Meet SUD member Service Needs	30	1	0
1C	Collaboration and Coordination of Care to Improve Access	30	1	0
1D	Service Access and Availability	26	5	0

Key Component 1A evaluates service accessibility related to cultural competence and available systems and practices to facilitate access for different cultural groups. Results for this domain saw the most improvement during the last review year. Cultural competence is discussed further later in this chapter.

Many DMC-ODS Plans, including **Los Angeles** and **Contra Costa**, focused on expanding access to treatment beyond jail incarceration for criminogenic behaviors linked to an individual's

[29] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

SUD. Specialty courts also expanded their focus on treatment for members, including expanded access to MAT. More Plans met this component than in the prior year with all 31 Plans achieving a Met rating compared to just 24 (77 percent) last year.

Key Component 1B relates to the management of service capacity through analysis of system demand, service providers, and efforts to increase program capacity based upon need. The ASAM continuum includes a range of available treatment modalities with different levels of intensity and treatment focus. Despite the persistent impacts of COVID-19, workforce challenges and ongoing funding challenges, most Plans continued to add or modify SUD services and service capacity, including expanded use of technology for telehealth. Some Plans expanded program hours and sites and added mobile capacity. There were 30 Plans (97 percent) with a Met rating for FY 2023-24 compared to 26 (84 percent) for last year.

Key Component 1C documented LOC coordination and care integration for members as they navigate between LOC and with ancillary services or systems. This Key Component represented the highest scoring area statewide for the last three cycles of reviews. Most Plan administrators and medical directors reported the enhanced need for coordination and integration of care related to both member needs and CalAIM goals. In addition to collaborative efforts with partners in criminal justice, education, and MH, this need was particularly noted as a shared objective this past year among medical healthcare providers. Plans expanded this focus, and 30 Plans (97 percent) achieved a Met rating, an improvement from the prior year's 28 Plans (90 percent). Many attributed their improved levels of coordination to health integration and collaboration established with their CalAIM BHQIP Milestone 3d PIPs which focused on treatment follow-up after ED discharge.

Key Component 1D focused on service availability and capacity. This includes website information, the access line, hours of operation, telehealth and field-based services, and transportation services. In this area, 26 Plans (84 percent) achieved a Met rating for this Key Component, the same as FY 2022-23. More than 18 Plans have streamlined their admission process this year to lower barriers and get members into treatment more quickly, and with fewer interviews needed before they reach the treatment site's door. As members of focus groups reported, this is most problematic at night and on weekends. Five Plans had CalEQRO recommendations for improvements in their access lines.

Not Met ratings did not occur and there were few Partially Met ratings under these Key Component which pertain to Access, demonstrating a keen awareness by Plans of the critical role ease of access plays in the success of SUD treatment programs and member care.

Table 4-2 shows the rating for each Key Component by Plan.*

Table 4-2: Access Key Components by Plan, FY 2023-24

DMC-ODS	1A	1B	1C	1D
Alameda	M	M	M	M
Contra Costa	M	M	M	PM
El Dorado	M	M	M	M
Fresno	M	M	M	M
Imperial	M	M	M	M
Kern	M	M	M	M
Los Angeles	M	M	PM	M
Marin	M	M	M	M

DMC-ODS	1A	1B	1C	1D
Merced	M	M	M	M
Monterey	M	PM	M	M
Napa	M	M	M	M
Nevada	M	M	M	M
Orange	M	M	M	M
Partnership	M	M	M	PM
Placer	M	M	M	M
Riverside	M	M	M	M
Sacramento	M	M	M	M
San Benito	M	M	M	PM
San Bernardino	M	M	M	M
San Diego	M	M	M	M
San Francisco	M	M	M	M
San Joaquin	M	M	M	M
San Luis Obispo	M	M	M	M
San Mateo	M	M	M	M
Santa Barbara	M	M	M	PM
Santa Clara	M	M	M	PM
Santa Cruz	M	M	M	M
Stanislaus	M	M	M	M
Tulare	M	M	M	M
Ventura	M	M	M	M
Yolo	M	M	M	M

*Note: M = Met, PM = Partially Met, NM = Not Met

ACCESS PERFORMANCE MEASURES

PRs are used by the EQR to measure access to care and are calculated by including a member in the numerator if they receive at least one service in the time frame, with the denominator being the total of the average monthly eligibles throughout the year.

Table 4-3 shows the total number of Medi-Cal eligibles versus those served, which form the PR, total claims and average claims per member. The numerator for the PR is the unduplicated number of members served, and the denominator is the total eligibles. The average approved claims per member (AACM) is calculated by dividing the total approved claims by the number of members served.

Table 4-3: Statewide PR and AACM, CY 2020-22

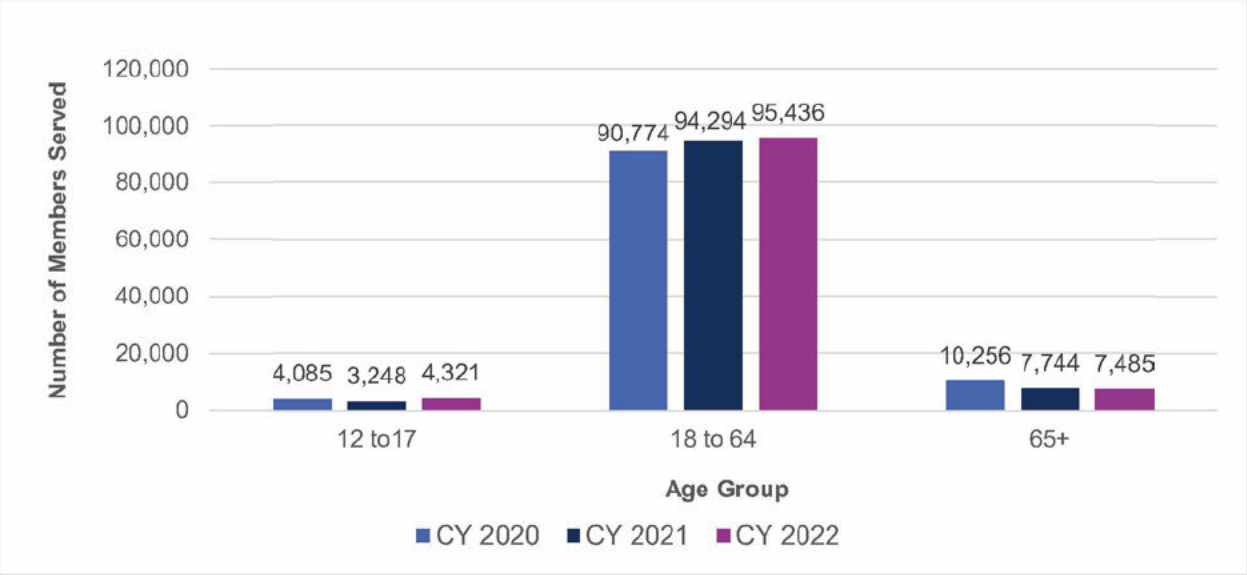
	Total Eligibles	Total Members Served	Penetration Rate	Total Approved Claims	AACM
CY 2020	9,529,458	105,115	1.10%	$530,935,865	$5,051
CY 2021	10,433,025	105,286	1.01%	$590,022,744	$5,604
CY 2022	11,262,866	107,242	0.95%	$643,237,516	$5,998

More members were served in CY 2022 than the prior year, but statewide PRs have steadily trended downward over the last three CYs. The decreasing PRs reflect the large annual increase in average monthly eligibles, which rose at a higher rate than members served in the last two CYs. In CY 2022, average monthly eligibles increased by 7.95 percent compared to the previous CY, while total members served had only increased by 1.86 percent.

Total approved claims increased over the last three CYs, with AACM also increasing.

Figure 4-1 presents the numbers of members served by age group over the past 3 CYs.

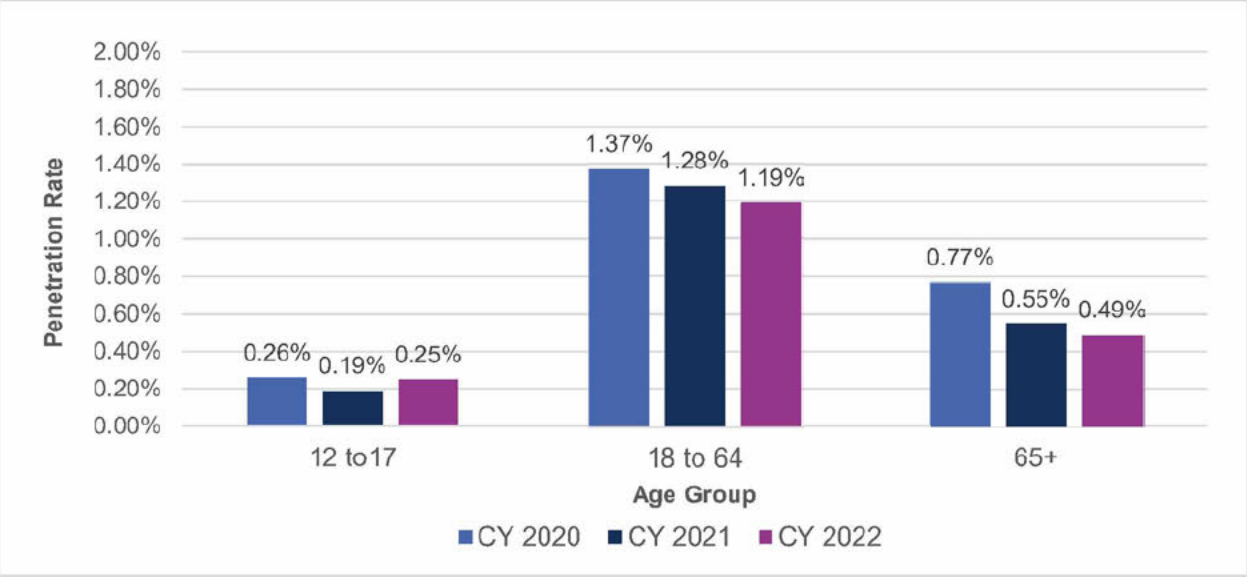
Figure 4-1: Members Served by Age Group, CY 2020-22



Overall, DMC-ODS Plans continued to increase the number of members served statewide in CY 2022, reaching 107,242. The growth was seen in the youth and adult populations. Though the numbers are comparatively smaller, the number of youth served increased by 33 percent between CY 2021 and CY 2022. The number of adults served increased modestly by 1.21 percent, while the older adults decreased by 3.34 percent. When comparing older adult numbers to CY 2020, it is a marked decrease of 27 percent.

Figure 4-2 illustrates the PRs by age group over the past 3 CYs. For the PRs, the numerator is reflected in Figure 4-1 above, and the denominator is the unduplicated count of eligibles in that age category (not displayed). The age of the members and eligibles are determined from their birthdate and age on January 1 of the year represented according to the MMEF for that year.

Figure 4-2: Penetration Rate by Age Group, CY 2020-22



The youth PR decreased in CY 2021, compared to CY 2020, and increased in CY 2022 to just below the CY 2020 PR. This is notable, as the number of eligible youth members increased in CY 2022 by 2.5 percent from the prior year; therefore, youth accessing SUD services in CY 2022 increased at a higher rate than the growth in eligible members (33 percent in the same time period).

CalEQRO reviews indicate that most DMC-ODS Plans have established or are planning QI goals and activities to increase services to youth, especially with the post-pandemic attention given to youth BH needs. This is reflected in feedback from focus groups and stakeholders and on the well-being of youth indicated by current suicide and overdose rates for youth.[30] [31] Formalized goals to increase prevention and treatment for youth are included in more than 57 percent of the DMC-ODS QI and SUD Prevention Plans.

The adult and older adult PRs continued trending downward in CY 2022, as they had in the previous two CYs. The adult and older adult groups had increases in members eligible, which was reflected in the decreases in PRs for both groups. However, only the older adult category showed fewer members served.

Coordinated efforts with county-wide partners have been utilizing data found on the state's Public Health Overdose Surveillance Dashboard.[32] With the statewide number of fatal overdoses having increased in 2022 and 2023, Plans continue to address an elevated concern for the adult and older adult populations. Community education on risk and realities of overdose,

[30] Johns Hopkins Medicine. (March 26, 2024). *Johns Hopkins Children's Center study shows negative impact of COVID-19 pandemic on youth minority mental health.* https://www.hopkinsmedicine.org/news/newsroom/news-releases/2024/03/johns-hopkins-childrens-center-study-shows-negative-impact-of-covid19-pandemic-on-youth-minority-mental-health

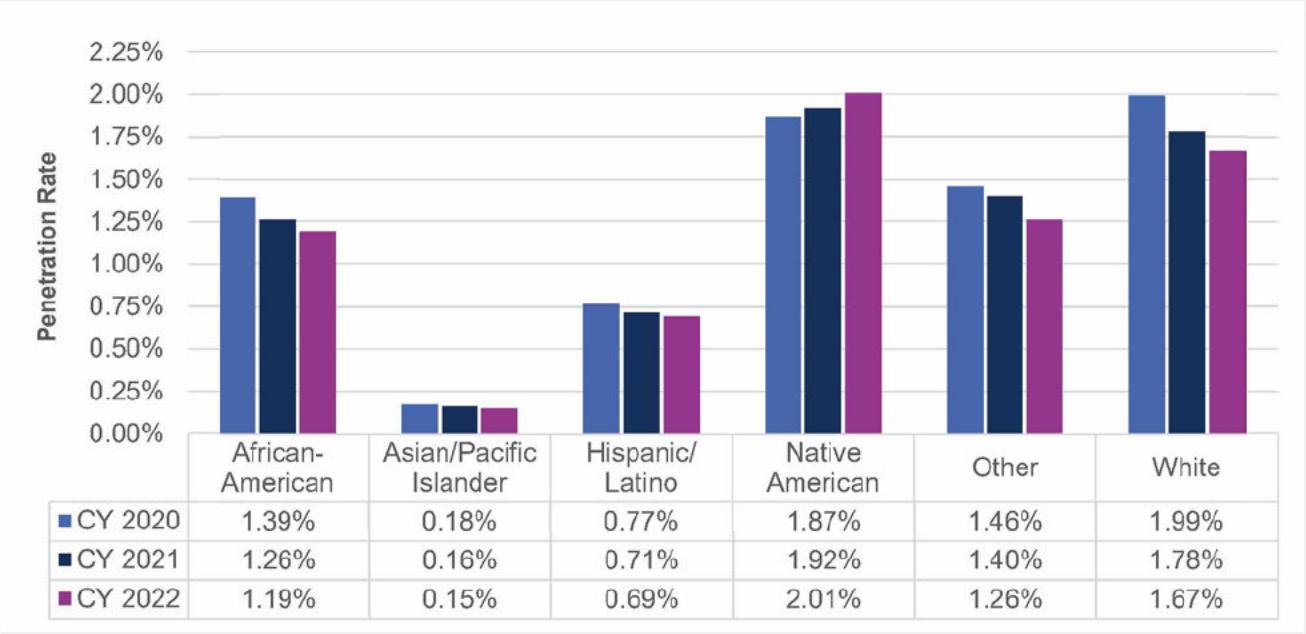
[31] U.S. Centers for Disease Control and Prevention. (May 1, 2024). *Mental Health.* Adolescent and School Health. www.cdc.gov/healthyyouth/mental-health/index.htm

[32] California Department of Public Health. (n.d.) *California overdose surveillance dashboard.* https://skylab.cdph.ca.gov/ODdash/?tab=Home

along with reinforcing pathways individuals can take into treatment, remain a priority in no small part due to the recognition of the high availability of fentanyl and other dangerous high-potency synthetic opiates. Low-barrier access with navigators and other similar programs have been documented in **Santa Cruz** and **San Joaquin**, as reflected by the impact of their navigator programs on enhanced access for engagement in care.

Figure 4-3 shows the PR changes over time in access by racial/ethnic groups. The numerator is the number of unduplicated members served and the denominator is the unduplicated count of eligibles in that race/ethnicity category. The race/ethnicity of the members and eligibles are determined according to the MMEF for that year.

Figure 4-3: Penetration Rates by Race/Ethnicity, CY 2020-22



	African-American	Asian/Pacific Islander	Hispanic/ Latino	Native American	Other	White
CY 2020	1.39%	0.18%	0.77%	1.87%	1.46%	1.99%
CY 2021	1.26%	0.16%	0.71%	1.92%	1.40%	1.78%
CY 2022	1.19%	0.15%	0.69%	2.01%	1.26%	1.67%

All PRs except for Native American PR, which was highest in CY 2022, were slightly lower than prior years. In all 3 years, Asian/Pacific Islander had the lowest PR, followed by Hispanic/Latino. The White PR was decreased slightly in CY 2022. Hispanic/Latino and Asian/Pacific Islander PRs had the smallest decreases in CY 2022 compared to CY 2021, while the Other and White groups had the largest decreases.

San Luis Obispo DMC-ODS has high PRs for all racial/ethnic groups relative to its Medi-Cal eligible population and reflects an accessible treatment system with low barrier access. The Plan has a no-wrong-door policy, walk-in appointments, and a convenient geographical distribution of program sites across the LOCs. While all Plans are required to have implemented a no-wrong door policy, many do not have walk-in ASAM assessment centers or such geographically distributed clinic and program sites. Members shared the convenience of accessing care at this Plan's sites.

Plan-level data for PR by race/ethnicity in CY 2022 is displayed in Table 4-4 below. The PR is calculated using the same methodology as for the statewide PR, using Plan-specific numbers identified by the County Code in the MMEF.

Table 4-4: PR by Race/Ethnicity versus Plan PR, CY 2022

DMC-ODS	African American	Asian/Pacific Islander	Hispanic/ Latino	Native American	Other	White	Plan PR
Alameda	1.74%	0.10%	0.60%	2.66%	1.12%	1.52%	0.90%
Contra Costa	1.44%	0.21%	0.52%	2.55%	1.28%	2.06%	1.07%
El Dorado	0.00%	0.52%	0.72%	1.94%	1.15%	1.52%	1.28%
Fresno	1.34%	0.31%	0.80%	2.48%	1.63%	2.22%	1.19%
Humboldt	1.90%	0.45%	1.09%	3.40%	1.11%	2.13%	1.90%
Imperial	2.41%	0.73%	1.19%	0.00%	1.64%	2.68%	1.29%
Kern	1.25%	0.31%	0.84%	3.27%	0.85%	2.46%	1.20%
Lassen	2.36%	0.00%	1.11%	1.41%	[redacted]	[redacted]	0.90%
Los Angeles	1.05%	0.11%	0.64%	1.71%	0.68%	1.25%	0.72%
Marin	2.97%	0.48%	0.58%	6.10%	2.16%	2.67%	1.54%
Mendocino	1.83%	0.00%	0.60%	1.96%	0.96%	1.91%	1.40%
Merced	1.46%	0.26%	0.63%	1.16%	0.75%	2.10%	0.91%
Modoc	6.45%	0.00%	[redacted]	3.38%	[redacted]	2.78%	2.33%
Monterey	2.12%	0.62%	0.75%	3.89%	1.11%	2.84%	1.04%
Napa	1.93%	0.34%	0.97%	2.13%	1.80%	2.95%	1.60%
Nevada	4.58%	1.35%	1.34%	7.50%	1.98%	3.16%	2.83%
Orange	0.93%	0.10%	0.60%	2.22%	1.13%	1.38%	0.75%
Placer	0.97%	0.24%	1.03%	3.45%	1.42%	2.00%	1.54%
Riverside	1.10%	0.16%	0.91%	1.87%	0.85%	2.13%	1.13%
Sacramento	1.19%	0.18%	0.70%	1.75%	1.14%	1.86%	1.09%
San Bernardino	0.53%	0.12%	0.52%	1.13%	0.46%	1.23%	0.63%
San Diego	1.65%	0.26%	0.92%	2.90%	1.71%	2.17%	1.42%
San Francisco	3.60%	0.10%	0.77%	6.53%	2.25%	3.41%	1.51%
San Joaquin	1.22%	0.16%	0.72%	2.55%	0.87%	2.16%	0.95%
San Luis Obispo	1.97%	0.75%	1.20%	4.63%	4.75%	3.08%	3.05%
San Mateo	1.57%	0.18%	0.36%	3.39%	1.02%	1.60%	0.67%
Santa Barbara	2.11%	0.35%	1.27%	3.15%	2.33%	1.57%	1.64%
Santa Clara	1.35%	0.14%	0.77%	1.81%	0.92%	1.57%	0.73%
Santa Cruz	3.67%	0.31%	0.96%	5.58%	2.89%	2.93%	1.99%
Shasta	3.10%	0.88%	1.50%	2.90%	1.92%	3.08%	2.71%
Siskiyou	0.96%	0.00%	1.21%	1.85%	0.96%	1.64%	1.47%
Solano	1.27%	0.28%	0.60%	3.59%	1.40%	2.43%	1.22%
Stanislaus	1.60%	0.26%	0.84%	3.57%	1.51%	2.58%	1.37%
Tulare	0.96%	0.23%	0.66%	1.76%	1.45%	2.09%	0.99%
Ventura	1.10%	0.23%	0.96%	2.07%	2.18%	2.02%	1.44%
Yolo	1.54%	0.32%	0.76%	1.43%	1.47%	1.80%	1.17%
Statewide	**1.19%**	**0.15%**	**0.69%**	**2.01%**	**1.26%**	**1.67%**	**0.95%**

Four Plans (**San Luis Obispo**, **Nevada**, **Shasta**, and **Modoc**) have an overall PR higher than 2 percent, but the highest Hispanic/Latino PR is in Shasta (1.50 percent), followed by Nevada (1.34 percent) and Santa Barbara (1.27 percent). Hispanic/Latino PR was also much lower than the overall, with a few exceptions. **Santa Clara**'s Hispanic/Latino PR was 0.77 percent compared to its overall PR of 0.73 percent; at the same time, all groups except Asian/Pacific Islander were higher than the Hispanic/Latino PR.

Most Plans showed PRs for African American and White populations that were significantly higher than other populations. Further, Plans' Asian/Pacific Islander PR tended to be only one-fifth of the overall PR. The Native American PR tended to be higher than the overall PR in most Plans, but this was often also a result of small numbers.

San Luis Obispo DMC-ODS demonstrated high PRs for all racial/ethnic groups relative to its and reflects an accessible treatment system with low barrier access. The Plan has a no wrong door policy, walk-in appointments, and a convenient geographical distribution of program sites across the LOCs. While all Plans are required to have implemented a no-wrong door policy, many do not have walk-in ASAM assessment centers or such geographically distributed clinics and program sites. Members shared the convenience of accessing care at this Plan's sites.

CalEQRO analyzes data by aid code to compare relative access to care by populations. Table 4-5 shows the PR by aid code category. The numerator is the number of unduplicated members served and the denominator is the unduplicated count of eligibles in that aid code category. The aid code for the members and eligibles are determined according to the MMEF for that year.

Table 4-5: PR by Aid Code Category, CY 2020-22

Eligibility Categories	CY 2020	CY 2021	CY 2022
ACA	1.65%	1.56%	1.42%
Disabled	1.80%	1.63%	1.37%
Family Adult	1.08%	1.10%	0.94%
Foster Care	2.42%	2.11%	1.84%
Maternal and Child Health Integrated Program (MCHIP)	0.19%	0.14%	0.18%
Other Adult	0.20%	0.08%	0.09%
Other Child	0.27%	0.21%	0.27%

The largest population served in the DMC-ODS was in the ACA eligibility category (n=68,690), followed by Family Adult (n=22,165), and Disabled (n=13,798). The other aid categories contributed comparatively fewer members to DMC-ODS services. The ACA-eligible members represent the expansion population who did not previously qualify for Medi-Cal until passage of the ACA, which made SUD treatment accessible to this large segment of formerly under- or un-insured individuals. Though the PRs for foster care (FC) were higher, there are significantly fewer eligibles in that aid code category.

The AACM by aid code category are displayed below in Table 4-6. The AACM is calculated by dividing the total approved claims associated with that aid code category by the number of members in the aid code category.

Table 4-6: AACM by Aid Code Category, CY 2020-22

Eligibility Categories	CY 2020	CY 2021	CY 2022
ACA	$5,303	$5,793	$6,216
Disabled	$4,660	$5,278	$5,707
Family Adult	$4,369	$4,838	$5,296
Foster Care	$2,115	$2,777	$2,716
MCHIP	$2,884	$3,703	$3,594
Other Adult	$3,126	$3,614	$4,075
Other Child	$2,750	$3,360	$3,194
Overall AACM	**$5,051**	**$5,604**	**$5,998**

Based on the AACMs for all eligibility categories, DMC-ODS approved claims increased each of the years displayed for ACA, Disabled, Family Adult, and Other Adult.

The ACA eligibility category remained the highest in approved claims across all three CYs, followed by the disabled category. The ACA eligibility category has consistently resulted in the highest amount of approved claims since the inception of the DMC-ODS framework. From CY 2021 to CY 2022, AACMs increased for ACA, disabled, family adult, and other adult eligibility categories. MCHIP, FC, and Other Child showed decreases in AACM in CY 2022 compared to CY 2021.

During the time frame covered by this data, local DMC-ODS Plan administrators reported cost impacts from a variety of issues that impact access, but one of the most significant impacts was from workforce challenges. Most reported increased salaries and benefits to recruit and retain licensed practitioners of the healing arts (LPHAs), SUD counselors, and physicians, particularly for integrated MAT services. Some were offering recruitment bonuses as well as increased incentive pay for bilingual staff. Obtaining prescribers was reported as critical for improving MAT access, particularly to assure seamless access and continuation of care for those members coming from the EDs that initiated non-methadone MAT. A similar focus has been assuring reentry for those transitioning from MAT while in detention settings. **Los Angeles** has been particularly innovative in this regard, with built-in startup costs and payment incentives for MAT outpatient and residential programs to add both prescribers and integrated treatment capacity, and to increase licensed and credentialed staff to enrich the treatment options available.

IMPROVING ACCESS TO CARE

Cultural Competence

Each DMC-ODS service provider is required to provide culturally competent services. This is a critical issue for both quality of care and access to appropriate care for many racial/ethnic groups and non-English speakers. DMC-ODS Plans and their providers must ensure that their policies, procedures, and practices are consistent with the national Culturally and Linguistically Appropriate Services (CLAS) standards.[33] The CLAS Standards are a “set of 15 action steps

[33] U.S. Department of Health & Human Services Office of Minority Health. (n.d.) *National CLAS standards*. https://thinkculturalhealth.hhs.gov/clas

intended to advance health equity, improve quality, and help eliminate health care disparities." There should be evidence that they are embedded in the organizational structure and upheld in day-to-day operations. Translation services must be made available for members if bilingual staff are unavailable.

Strengths seen in the CCP included the adoption of the CLAS standards, consistently using outreach and educational activities within diverse communities, and employing methods to improve threshold language resources as well as awareness of cultural norms associated with SUD treatment. This is an important CQS goal related to health equity and access to appropriate clinical care. More DMC-ODS Plans added a focus on addressing the diversity, equity, and inclusion challenges unique to their SUD systems of care with specialty programs for specific ethnic and language needs. Some Plans have implemented CCP initiatives with an SUD focus positively impacting access and retention.

CalEQRO recommended that DMC-ODS systems update their plans to include action items that are relevant to SUD-impacted communities, with timed and measurable goals and objectives. While most Plans provided an annual update on CCP-related activities, they continued to report waiting for announcement of anticipated revised statewide guidelines before embarking on a full update of their entire CCP.

It is now common practice for courts, law enforcement, and probation to promote and refer to treatment versus incarceration and prosecution whenever possible, as reflected in stakeholder groups with criminal justice partners and members. This includes when the community calls for law enforcement.

DHCS added Medi-Cal mobile crisis services implementation as an MHP/DMC-ODS benefit as part of the crisis services continuum.[34] This initiative added new program development activities to Plans with the goal of implementing this significant new service directly or via contract providers as DHCS approved their implementation plans. In anticipation, many Plans began to include substance use specialists to their crisis teams in order to better address SUD-related crises in the community. Many Plans continue to coordinate joint response models with 911 emergency response agencies to facilitate BH assistance with assessment and intervention using mobile crisis providers.

The link between criminogenic behaviors and SUD has continued to foster stigma. Bias against those who have an SUD and these associated behaviors remain a barrier to promoting treatment access in many communities, and the location of treatment facilities has continued to trigger fear and community concerns.[35] Ultimately, CalEQRO notes that Plans seek ways to ensure equity in access and resources for service delivery elements that resonate with partners and are relevant to ethnic communities.

Some examples of notable practices in terms of cultural competence are described below. These examples reflect strategies aligned with CQS goals for engaging members in their health and reducing health disparities.

Contra Costa enhanced access and retention by expanding its RSS model to include early intervention, access support, treatment support, and community transitions. This outreach and support staff included many trained peers with lived experience who were also bilingual.

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[34] https://www.dhcs.ca.gov/Documents/BHIN-23-025-Medi-Cal-Mobile-Crisis-Services-Benefit-Implementation.pdf

[35] Pullen, E. & Oser, C. (June 2014). Barriers to substance abuse treatment in rural and urban communities: A counselor perspective. *Substance Use & Misuse, 49*(7), 891-901. https://doi.org/10.3109/10826084.2014.891615

Members noted these peer services and providers were very helpful for the ultimate success of their recovery and served as much-welcomed additional support. Also, the staff were mobile which enabled engaging unhoused members, school-based youth, and their families.

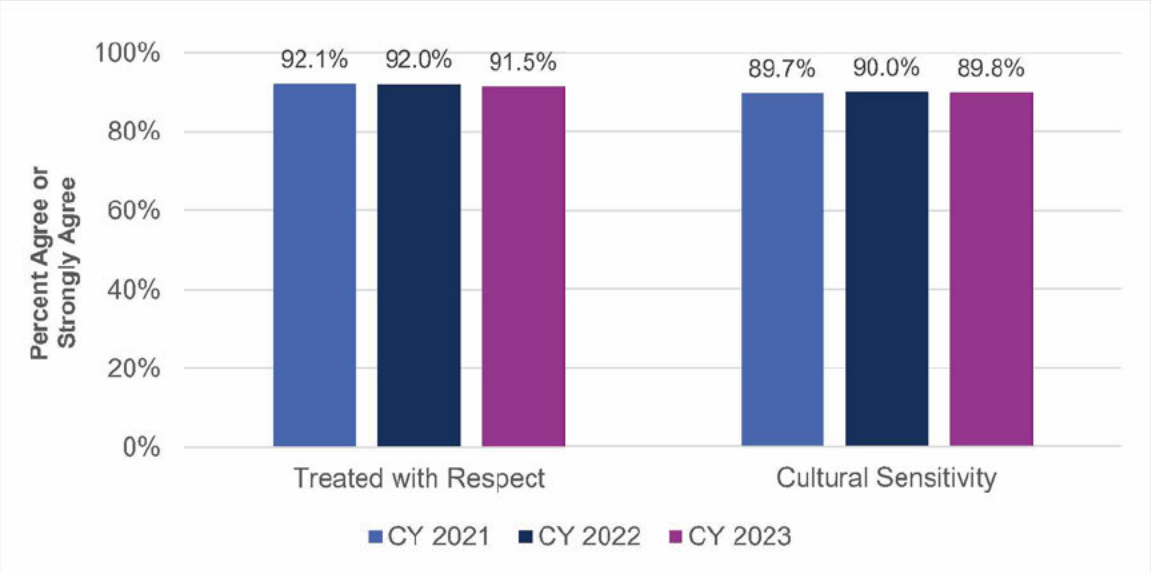
Alameda established four special subcommittees – individuals with hearing impairments, spiritual communities, threshold language groups, and the African American community – of the Cultural Humility Program that conducted in-person focus groups and feedback sessions on barriers to treatment and successful approaches relevant to these different communities. Reports and recommendations were reviewed by all levels of the Plan, including executive leadership, for action items and improvements.

Sacramento conducted extensive community outreach events and dialogue with African American, Spanish-speaking, and immigrant communities – more community participation resulted. Sacramento increased its bilingual staffing through more engagement with grass-roots organizations that were not necessarily BH providers, but had staff and volunteers interested in social services and community health. With these relationships, Sacramento shared recruitment and career opportunities in a range of SUD and MH programs, identifying more individuals in local communities who ultimately became hired by the county or contracted providers.

Member Feedback on Cultural Competence

Figure 4-4 represents results from the TPS Survey Measures for "Treated with Respect" and "Cultural Sensitivity" for adults over the 3-year period.

Figure 4-4: TPS Survey Measures, Respect & Cultural Sensitivity Rating Adults, CY 2021-23



Statewide data from the TPS shows that Plans have maintained gains previously achieved in the provision of culturally competent services based on member ratings. Figure 4-4 illustrates a slight decrease in "treated with respect" in CY 2023. Cultural sensitivity in the delivery of services remained stable in 2023 at 89.8 percent – well above the 84.5 percent rating from the CY 2019 TPS.

Results from surveys like the TPS reinforce that member-centeredness and culturally meaningful treatment are essential to success in SUD recovery. Accurate and useful

measurements of equity indicators such as those found in the TPS member survey, are essential to system efforts to reduce healthcare inequities. Plan-specific TPS results can be found in each Plan's FY 2023-24 Final Report. The statewide TPS results are discussed in detail in the chapter on Member Perceptions of Care.

Initial Access to Care and ASAM Placement

SUD treatment initiation is most successful when individualized needs and readiness to change are accurately evaluated and services are matched to those needs. The ASAM screening and assessment process is designed to accomplish these goals and is critical to access. The ASAM assessment includes six dimensions of treatment needs as well as denoting member readiness to change. The ASAM evaluation includes an initial screening and referral, a full assessment of treatment needs, or a follow-up assessment when there are changes in LOC or condition. Reason identifiers are applied when the referral differs from the results of the ASAM evaluation.

All Plans required staff who conduct screenings and assessments to have ASAM training and updates based on evolving changes to the criteria and treatment models. Additionally, DHCS requires that Plans start using DHCS-approved ASAM tools in January 2025.

ASAM as it relates to screening and assessment is discussed here in Table 4-7. This data is also displayed later in the Quality chapter in that context.

Table 4-7: Congruence with ASAM Assessment LOC Recommendations, CY 2022

Category	Brief Screening		Initial Assessment		Follow-up Assessment	
	# of Members	% of ASAM Results	# of Members	% of ASAM Results	# of Members	% of ASAM Results
Placement Decision Match	37,152	79.45%	70,344	80.56%	36,856	80.85%
Reasons for Placement Decision Mismatch						
Patient Preference	2,667	5.70%	5,931	6.79%	2,389	5.24%
Level of Care Not Available	112	0.24%	283	0.32%	123	0.27%
Clinical Judgment	1,069	2.29%	5,066	5.80%	3,091	6.78%
Geographic Accessibility	27	0.06%	88	0.10%	44	0.10%
Family Responsibilities*	41	0.09%	127	0.15%	32	0.07%
Legal Issues	435	0.93%	213	0.24%	135	0.30%
Lack of Insurance/Payment**	27	0.06%	38	0.04%	36	0.08%
Other	5,127	10.96%	4,806	5.50%	2,544	5.58%
Actual LOC Missing	107	0.23%	16,975	19.44%	333	0.73%
Total Non-Congruence	**9,612**	**20.55%**	**16,975**	**19.44%**	**8,727**	**19.15%**
Total ASAM	46,764	100.00%	87,319	100.00%	45,583	100.00%

* Family responsibilities refer to obligations to family members (e.g., childcare) that may conflict with a recommended LOC, such as residential treatment or an intensive outpatient program schedule.

** Lack of insurance generally applies to individuals with private insurance or Medi-Cal with a share of cost. ASAM and CalOMS data are submitted to the State for all members in treatment, whether or not they are Medi-Cal eligibles.

Data represented in Table 4-7 above indicates that approximately 20 percent of ASAMs completed resulted in referrals to a LOC other than the ASAM determination. Overall, the largest reason was Other (n=12, 477), followed by patient preference (n=10,987) and clinical judgement (n=9,226). The "Other" category comprises many situation-specific reasons. Feedback from multiple Plans indicated issues with obtaining complete data during the implementation of new EHRs, especially in those Plans that were more reliant on contract providers.

The higher volume of initial assessments compared to screenings indicates that not everyone entering the DMC-ODS receives a brief screening before the referral to an assessment. This is particularly true for Plans with decentralized points of entry into the care system. When prospective members contact a program directly for treatment services, they may be scheduled for a full assessment without a brief screening, which is an allowable practice. Additionally, some members receive a screening but then fail to attend their assessment. Moreover, the brief screening tracking typically occurs outside the full EHR because the caller is not yet enrolled in the EHR as an open case. Most Plans have not yet developed effective solutions to link screening data for prospective members with treatment data in the EHR, making it challenging to provide reporting that covers the entire experience of care for reporting and analysis.

The congruence of 79.45 percent at Brief Screening represents an 11-percentage point decrease from the previous year's 90.63 percent. This is reflected in increased variance due to patient preference, clinical judgment, and "other" reasons for not linking the member to the optimal ASAM service (reasons for incongruence not covered by the predefined list). During the screening phase, many programs lack access to historical clinical information needed for clinical judgment. There was a notable 350 percent increase in the "other" category of non-congruence, suggesting the presence of complex needs not covered by the predefined list. Additional analysis of staff selection of the Other category may shed light onto this change.

To enhance rapid linkage to treatment, many Plans encouraged providers to do more walk-ins and immediate ASAM assessments of members requesting services and fewer screenings followed by waiting for an assessment appointment. The practice of screenings with a later scheduled assessment appeared to result in losing members based on no-show data, which was used in some cases to inform PIPs and in local review of data.

Immediate ASAM screenings and warm hand-offs with a navigator or care coordination support staff have been linked to improved timeliness and access.[36] Notably, many DMC-ODS systems have lowered no-show rates by instituting rapid screening, walk-in services, and direct linkage to treatment, along with transportation support. Swift engagement of the member in a meaningful therapeutic alliance by way of a thorough and prompt referral process into treatment is a critical first step. This is essential given the goal of higher levels of initiation and engagement. Several Plans immediately assign a navigator or care coordinator to help with all aspects of access, including benefits, transportation, and culturally optimal treatment settings. Research has

[36] Druss, B. G., von Esenwein, S. A., Compton, M. T., Rask, K. J., Zhao, L., & Parker, R. M. (2010). A randomized trial of medical care management for community mental health settings: The primary care access, referral, and evaluation (PCARE) study. *The American Journal of Psychiatry, 167*(2), 151–159. https://doi.org/10.1176/appi.ajp.2009.09050691

supported this effort's importance in producing meaningful change for those seeking and participating in SUD treatment.[37]

Additionally, member input provided to CalEQRO conveyed a desire to have fewer steps to enter treatment, particularly for WM and residential treatment. They spoke unfavorably regarding some Plans' admission processes requiring a screening, followed by an intake assessment at a central site with a new clinician, and then a referral to a treatment provider for another intake appointment at that program. A few Access lines provided only contact information on SUD services and no screening or appointment scheduling assistance at all. Other Access programs referred only to centralized evaluation appointments without a screening prior to the assessment appointment. These practices can result in three or more contacts before the member experiences an actual treatment visit.

Some of the noteworthy practices designed to improve initial access to care include:

- A 24/7 access center or member access line utilizing ASAM screenings or assessments with call center software, three-way calling capacity, and real-time SUD resource directories online to help link members to the appropriate LOC.
- Diverse workforces including enhanced bilingual capacity, making initial contacts not wholly reliant on language line programs or telehealth contractors that operate remotely and do not know local resources or communities.
- Linkages to historical medical records to streamline screenings, assessments, and referrals.
- The program sites are geographically well distributed for convenient, full ASAM assessments, including telehealth assessments and after-hours capacity.
- Walk-in appointment hours for screening, assessments, information, and direct referrals into treatment.
- Warm hand-off practices in transitions between LOCs, including care coordination and using peers for support.
- Up-to-date appointment and bed vacancy information in the practice management system or website, enabling appropriate coordination between the access line and treatment staff.
- Access to navigators or case managers to help members access their first face-to-face appointment after making requests for services.
- Data tracking alerts when system services are full or over capacity.
- Performance standards for time to service and tracking of no-shows to make system or staff adjustments, thereby ensuring efficiency in the workflow to optimize timely access.

Provider Capacity

A key measure of access quality is whether individuals can gain access to the services recommended in their ASAM screening assessment in a reasonable time and for each

[37] Stallvik, M., Gastfriend, D. R., & Nordahl, H. M. (2015). Matching patients with substance use disorder to optimal level of care with the ASAM Criteria software. *Journal of Substance Use*, *20*(6), 389-398. https://doi.org/10.3109/14659891.2014.934305

treatment recommended therein. Service capacity and accessibility are critical for the rapid engagement of the member in care. Additionally, access to transportation is particularly essential if it is a daily or frequently scheduled service, such as MAT or intensive outpatient treatment (IOT). Transportation is also crucial for all services, and especially for an urgent service such as WM.

Thus, all DMC-ODS Plans must consider their service capacity, site locations, and hours for outpatient, MAT, WM, and residential treatment. Many of these elements are evaluated for NA, addressed further in its own chapter. The DHCS annual NA evaluations and subsequent findings reports are all based on CMS and DHCS requirements. The EQR process assists with the assessment of these elements of access and related NA issues as part of annual reviews.

This topic is visited more in-depth in the Quality chapter discussion on the Continuum of Care.

Table 4-8 shows a small overall annual growth in members served by LOC within each DMC-ODS treatment modality. For each service type, the percentage is the number reflected as served in the service category divided by the sum of the members served in each service category. Within a service category, the number of members served is an unduplicated count. Members may be represented in multiple service categories.

Table 4-8: Statewide Members Served by Service Type, CY 2020-22

Service Category	CY 2020		CY 2021		CY 2022	
	#	%	#	%	#	%
Ambulatory Withdrawal Management *	29	0.02%	31	0.02%	56	0.04%
Intensive Outpatient Treatment	12,538	9.02%	14,367	9.92%	14,422	9.58%
NTP/OTP	42,086	30.28%	38,307	26.46%	37,134	24.67%
Non-Methadone MAT	6,111	4.40%	7,113	4.91%	7,782	5.17%
Outpatient Treatment	41,272	29.69%	42,992	29.69%	46,441	30.85%
Partial Hospitalization *	18	0.01%	19	0.01%	13	0.01%
Recovery Support Services	3,644	2.62%	4,939	3.41%	6,400	4.25%
Residential WM	9,296	6.69%	10,486	7.24%	10,429	6.93%
Residential Treatment	24,004	17.27%	26,529	18.32%	27,841	18.50%
Total	**138,998**	**100.00%**	**144,783**	**100.00%**	**150,518**	**100.00%**

*Note: Ambulatory WM and partial hospitalization are optional services in the DMC-ODS.
Total percentages are forced to be 100 percent due to rounding.

In CY 2022, the total of 150,518 represents 105,286 members utilizing an average of 1.38 service types per person. It is common for members to participate in two programs or service types sequentially. An individual may, for example, utilize residential WM, followed by residential treatment, followed by outpatient treatment.

Members experienced increased access across many LOCs between CY 2020 and CY 2022 despite the initial and ongoing impacts of the pandemic on programs and the workforce. However, some service modalities saw a decrease in utilization, including NTP/OTP, partial hospitalization, and residential WM. That said, changes in the numbers and proportions of members served varied across modalities in CY 2022, with increased rates of member utilization of ambulatory WM, non-methadone MAT, outpatient treatment, RSS, and residential treatment as compared with the prior year. The most significant change in service delivery was seen in RSS, which had 75.63 percent more members receiving that service category compared to CY 2020. The positive use of RSS was highlighted by members in several focus groups, especially when they had difficulty stepping down to recovery housing from residential treatment. These additional support services were often credited with helping to avoid relapses by members. Also, administrators reported that with the new DMC-ODS continuum, RSS was a new clinical billable activity, and some staff did not understand how to use it and when. Now, they were seeing its potential for benefiting the course of treatment. However, a few Plans still had no RSS service claims in CY 2022 – El Dorado, San Benito, and Sonoma. Other Plans delivered RSS to comparatively few members, pointing to a lack of uniformity in implementation.

Ambulatory (outpatient) WM and partial hospitalization, both optional service offerings, remain very low in use throughout the system. In fact, partial hospitalization was only claimed for 13 members in Riverside. Ambulatory WM was provided in Los Angeles, Marin, Riverside, and Ventura (n=26) – with Ventura serving the most members (n=26). [redacted] in Sacramento received ambulatory WM, though it is possible that [redacted] received the service in another county's Plan. The relative convenience of ambulatory WM may warrant review among Plans as a mechanism to increase access to WM.

Access to Methadone and Non-Methadone MAT

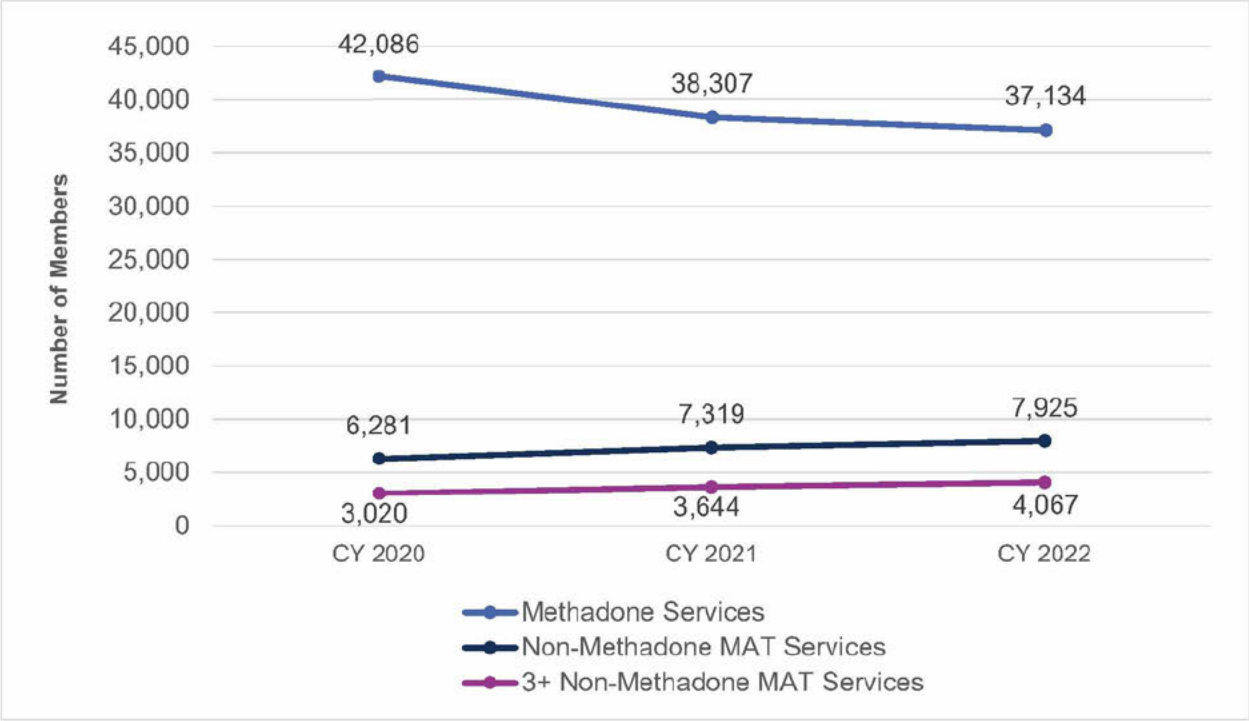
Medications offered in this metric primarily address opioid dependence and include methadone (the most common medication), buprenorphine, buprenorphine extended-release, and naltrexone. The DMC-ODS waiver requires NTP/OTPs to dispense all three OUD medications, though methadone remains the primary MAT medication they provide. Methadone has been a standard of care in the field for many years and is a proven and effective way to treat opioid addiction; together with the addition of other forms of MAT, they are considered a best practice to reduce cravings and enhance long-term recovery. While buprenorphine has the potential for misuse, it has advantages such as its ease of use, provider flexibility, and member preference, especially for those working full-time.[38] Providers should evaluate which MAT option is ultimately best on an individualized basis.

Methadone services for the treatment of OUD are provided through NTP/OTPs, but most non-methadone MAT services are reported to be outside of the DMC-ODS network and/or Medicare-funded. These sources include hospitals, primary care, Federally Qualified Health Centers (FQHCs), and private clinics funded as medical services covered by Medi-Cal, Medicare, private insurance, or patient payment. MAT services are a prime example of how the DMC-ODS provides member-centered care by giving members and the public a variety of options for accessing treatment. This makes DMC-ODS approved claims data a limited source to track full NTP/OTP capacity and utilization.

[38] Yokell, M. A., Zaller, N. D., Green, T. C., & Rich J. D. (2011). Buprenorphine and buprenorphine/naloxone diversion, misuse, and illicit use: An international review. *Current Drug Abuse Reviews, 4*(1), 28-41. https://dx.doi.org/10.2174/1874473711104010028

Figure 4-5 displays the number of members using methadone and non-methadone MAT, including the number of members who receive three or more visits of non-methadone MAT, as reflected in the SDMC approved claims.

Figure 4-5: Members Served with Methadone and Non-Methadone MAT, CY 2020-22



There has been a general trend of increased non-methadone MAT services in DMC-ODS programs. Starting in 2020, Medicare also covered non-methadone MAT services provided by NTP programs, thus impacting these numbers for members billed to the DMC-ODS. When Medicare coverage began for NTP services in 2020, 18 percent of members were estimated to be covered by both Medi-Cal and Medicare. The California Healthcare Foundation subsequently examined all data sources, including Medicaid and Medicare, and documented increased MAT utilization across the state.[39]

Non-methadone MAT only accounts for 6 percent of dosing claims from NTP/OTP providers. Notably, with rising fentanyl use, methadone has been shown to be an extremely effective form of MAT specifically for fentanyl use.[40] Methadone use was at its peak in CY 2019.

As displayed in Figure 4-5, concurrent with the decrease in methadone was an increase in non-methadone MAT services each year from CY 2020 to CY 2022. The number of members receiving three or more non-methadone MAT services also increased in each of the last three CYs. Many Plans included QI goals for adding integrated MAT into outpatient programs, including those

[39] Valentine, A. & Brassil, M. (January 27, 2022). *2022 edition – substance use in California.* California Healthcare Foundation. https://www.chcf.org/publication/2022-edition-substance-use-california/

[40] Johns Hopkins Bloomberg School of Public Health. (May 9, 2023). *Fentanyl, heroin use substantially decline in patients receiving methadone treatment for opioid use disorder during first year.* https://publichealth.jhu.edu/2023/fentanyl-heroin-use-substantially-decline-in-patients-receiving-methadone-treatment-for-opioid-use-disorder-during-first-year

providing outpatient MH and SUD treatment and residential treatment. The proportion of members who received non-methadone MAT services and went on to receive three or more non-methadone MAT services has also increased since CY 2020 (48 percent in CY 2020, 50 percent in CY 2021, and 51 percent in CY 2022).

NTP services utilization continued to decrease and the use of non-methadone MAT has increased only marginally. At the same time, members in focus groups reported more flexible and accessible access to non-methadone MAT, particularly in primary care sites (who were actively partnering more with DMC-ODS programs), and more flexibility related to jobs and school. It is possible that the lower NTP utilization is associated with less methadone use and transitions to primary care for non-methadone MAT. State MCP data for non-methadone MAT services has increased according to MCP data on the DHCS website for MAT in Medi-Cal for OUD by County.[41] However, the members in at least three NTP member focus groups with fentanyl use reported that methadone was a more successful treatment for them in coping with fentanyl withdrawal, as well as sustained recovery.

During the pandemic, a face-to-face visit with a physician was still required of incoming new members to begin methadone services, likely reducing initiations on methadone in that time frame.[42] However, there were other significant enhancements, such as take-home doses and eased requirements for starting buprenorphine (non-methadone MAT) prescriptions using telehealth.

DMC-ODS Plans use a variety of programs and approaches to continue strengthen responses to OUD. DHCS has supported MAT expansion through numerous grants, programs, and TA. This has resulted in a small but consistent increase in non-methadone MAT services billed through the DMC-ODS. However, there has been a parallel emphasis on the use of non-methadone MAT obtained through the medical healthcare system. This has been assisted by the planned expansion of services, the training of physicians who prescribe MAT and hospital-based MAT expansion grants.

In many DMC-ODS Plans, these efforts have resulted in a formal LOC coordination between DMC-ODS Plans and providers and the managed healthcare system, comprising both EDs and primary care clinics. The California DHCS Opioid Response, formerly referred to as MAT Expansion Project, remains a prominent strategy.[43] Collaboration SUD Navigators at EDs and criminal justice expansion were particularly impactful in enhancing member access to treatment within local systems, and these investments have positively impacted both the access to and the quality of SUD services.[44] Increased ED adoption of SUD care navigators, as well as MAT adoption in State Corrections facilities, have provided access to individuals known to have OUD needs. The initiation of SUD treatment in detention settings has increased demand for community-based MAT options, both in DMC-ODS programs and in primary care settings.

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[41] https://data.chhs.ca.gov/dataset/medication-assisted-treatment-in-medi-cal-for-opioid-use-disorders-quarterly-by-county

[42] Valentine, A. & Brassil, M. (January 27, 2022). *2022 edition – substance use in California.* California Healthcare Foundation. https://www.chcf.org/publication/2022-edition-substance-use-california/

[43] https://www.dhcs.ca.gov/individuals/Pages/MAT-Expansion-Project.aspx

[44] Public Health Institute. (May 2, 2023). *PHI's CA bridge serves as best practice model for substance use navigators in hospital emergency departments*. https://www.phi.org/press/phis-ca-bridge-serves-as-best-practice-model-for-substance-use-navigators-in-hospital-emergency-departments/

Even with MAT services provided outside of the DMC-ODS network, service coordination and case management activities are flexible and responsive to individual preferences and needs, based on member feedback–particularly for OUD. Similarly, input provided during focused interview sessions indicates that 28 of the 31 DMC-ODS Plans (90 percent) have begun working directly with healthcare providers and inmate health services to either continue or initiate MAT. There has also been formalizing of re-entry protocols, required under CalAIM, which allows individuals who are most likely to overdose to seamlessly continue care when released into the community.

Because of expanding access to primary care BH services, many members are served for their SUD needs within other health systems. Plans' efforts to integrate services by adding co-locations and coordinating counseling and medication services supported this expanded access by MCP sites. **Contra Costa**, **Los Angeles**, **PHC**, and **Santa Cruz** have obtained non-methadone MAT data through partnering with MCPs (and PHC has the data internally) for data exchange and directly coordinating with providers, with member permission.[45] This data is reported to be available, but most DMC-ODS Plans report having challenges accessing it as most Plans have not begun data exchange with their MCP partners.

Some Plans expressed interest in the new long-acting injectable buprenorphine medication, but indicated that they were not yet available in the Medi-Cal formulary. The **Los Angeles** Plan was using it[46] in detention settings and with members transitioning from detention to the community as part of the evaluation process testing the efficacy of this medication.

Six DMC-ODS Plans had EQR recommendations to improve MAT access. Barriers shared by members and staff included the longer distances to NTPs and challenges with transportation access, and Plans also reported that some communities were opposed to having NTP clinics in their neighborhoods. The new DHCS efforts related to mobile MAT access are a positive solution to this particular barrier. Also, there is more flexibility with the hours during which access to needed medications can occur. In addition, Plans that have worked to educate local physicians of allied systems on the risks and realities of SUD, along with benefits and supports for individuals on MAT, have reported success in addressing known hesitancy of doctors to prescribe MAT.[47] [48] Some have facilitated forums, medical grand rounds with local healthcare systems, and providing support physician-to-physician to assist new prescribers in overcoming reluctance to offer MAT.

Notable practices in MAT access are also demonstrated by these Plans:

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[45] Bresnick, J. & Taylor, S. (September 12, 2023). *Improving behavioral health through data-driven collaboration: A Santa Cruz County case study.* California Health Care Foundation. https://www.chcf.org/publication/improving-behavioral-health-through-data-driven-collaboration-a-santa-cruz-county-case-study/

[46] Braeburn Inc. (May 23, 2023). *Braeburn's BRIXADI™ (buprenorphine) extended-release subcutaneous injection (CIII) receives FDA approval for moderate to severe opioid use disorder*. https://braeburnrx.com/braeburns-brixadi-buprenorphine-extended-release-subcutaneous-injection-ciii-receives-fda-approval-for-moderate-to-severe-opioid-use-disorder/

[47] Von Klimo, M. C., Nolan, L., Corbin, M., Farinelli, L., Pytell, J. D., Simon, C., Weiss, S. T., & Compton, W. M. (July 17, 2024). Physician reluctance to intervene in addiction: A systematic review. *JAMA Network Open, 7*(7), 1-27. https://doi.org/10.1001/jamanetworkopen.2024.20837

[48] Lovett, L. (July 17, 2024). *Doctors hesitant to intervene in addiction treatment, citing institutional environment barriers.* Behavioral Health Business. https://bhbusiness.com/2024/07/17/doctors-hesitant-to-intervene-in-addiction-treatment-citing-institutional-environment-barriers/

Santa Cruz DMC-ODS is most notable for the widespread offerings of MAT services to its members and the high degree of MAT integration with other SUD treatment levels. Both the percentages of their members that received between one and those who obtained three non-methadone MAT services are substantially higher than the statewide average. This is in no small part due to the leadership of the DMC-ODS Plan partnering with the MCP primary care clinics and taking intentional steps to make the use of all forms of MAT normative within the community. This included encouraging providers to obtain approval for incidental medical services (IMS) in all of their residential programs. With IMS approval, they can provide MAT services on-site in their Level 3.2 WM, Level 3.1, and Level 3.5 LOCs, respectively. Per the DMC-ODS Plan, over 60 percent of members with an OUD have been able to access MAT through providers of methadone and non-methadone treatment. These additional IMS services, which include testing, monitoring health status, overseeing self-administered medications, and WM activities, have been beneficial in improving quality and access to treatment, particularly in residential treatment sites.[49] DMC-ODS Plans were also using a range of rate incentives and contract requirements to enhance IMS based on the needs of members to have access and consistent program support to access methadone and non-methadone MAT for both opioid and alcohol treatments.

DMC-ODS Plans such as Orange, Kern, and San Luis Obispo have established MAT services in their DMC-ODS Plan-operated outpatient clinics, with referrals initiated when indicated from the initial ASAM assessment. Also, Los Angeles has built incentives into payment reform rates that encourage outpatient and residential providers to add MAT within their programs by hiring prescribers and implementing memoranda of understanding (MOUs) with key MAT-providing partners.

Access to Care Coordination

The provision of care coordination services is one set of activities regularly linked to improved outcomes. Such improvements can be seen within the discharge CalOMS data set and, qualitatively, are a frequently noted request from CalEQRO member focus groups. Members perceive a high level of correlation between sustained recovery and the very helpful assistance obtained from case managers, system navigators or peer support staff, particularly in managing LOC transitions. As reported in member focus groups and stakeholder meetings, these services assist members who frequently present with complex multi-diagnosis profiles with obtaining a continuity of care, access to benefit entitlements, and housing they likely might not achieve on their own.

According to feedback from CalEQRO reviews, case management services are also particularly helpful when initiated as members first request services from the access line or a treatment provider. Moreover, Plans noted that such supports and navigation assistance, which occur as part of coordinated care, are associated with improved initial engagement and more successful transitions between LOCs.

Data also indicates that billable care coordination services are most often linked to outpatient and residential treatment related to care transitions. Another indicator that DMC-ODS Plans have prioritized care coordination is that it has become a common focus for PIPs including Follow-Up After Emergency Department Visit for Substance Abuse (FUA) and Pharmacotherapy for Opioid Use Disorder (POD).

[49] www.dhcs.ca.gov/provgovpart/Pages/Incidental-Medical-Services.aspx

While care coordination is available at all LOCs within the DMC-ODS program structure, some Plans have used it in more comprehensive ways to enhance member success in access and continuity of care. Below are notable examples:

In **PHC**, there was a major expansion of Plan care coordination staff assigned throughout the region, with 80 current staff working to achieve several goals compatible with CalAIM initiatives and CQS objectives. These included enhanced communication, care coordination, and engaging members in their health. The Plan care coordinators worked to link members requesting services to appointments for treatment access if either the access team did not provide an appointment, or the member was hesitant to start treatment. Care coordinators continue to engage with the members to problem-solve any barriers or challenges that emerge during treatment and directly assist with care transitions to lower LOCs and with aftercare planning. PHC had higher PRs for all racial/ethnic groups, youth, and adults than statewide and similar size counties (medium size group). The PR overall was 1.95 percent compared to 0.95 percent statewide and 1.11 percent for similar size Plans.

San Benito also assigns a care coordinator at the initial assessment. These staff members, who are usually also the SUD counselors providing treatment, assist with access issues, including transportation and other needs such as benefits and transitions in care from residential to outpatient. They had an outside firm review 100 percent of cases transitioning from residential treatment to outpatient in FY 2022-23, revealing that these engaged care coordinators were able to achieve a 83.03 percent transition rate from residential to outpatient for these members. They maintained ongoing contact between members and their residential treatment staff; members reported that this was very helpful to their successful transitions and ongoing treatment. CalOMS data problems were occurring in this Plan due to the new EHR system, and this data was not available to CalEQRO to review transitions in care.

The trend of making care coordination a focus is reinforced by data from the **Los Angeles** DMC-ODS, which has been tracking case management data annually since CY 2018. Its efficacy is born out in data, which indicates improved outcomes in CalOMS for those members who have received case management services compared to those who did not. Based on CalOMS treatment outcomes, CY 2022 data showed a 59 percent rating of treatment progress for members provided with case management versus 43.5 percent without it.

Care coordination activities, including with SUD navigators and peer counselors, were also important interventions frequently cited in the POD and FUA FY 2023-24 PIPs reviewed. These interventions targeted improving transitions in care and follow-up treatment after SUD-related ED events for members.

Additionally, 90 percent of Plans (n=28) expanded formal levels of interagency collaboration and joint projects, particularly with hospitals, primary care, MH, and detention. Key goals for these efforts were enhanced treatment access for members and continuity of care across LOCs – in line with CQS goals. These collaborative processes were focused on the prevention of overdose events, rapid access to appropriate treatment, and successful transitions from acute care to DMC-ODS providers, and other priority member needs.

ACCESS STRENGTHS AND CHALLENGES

Positive Changes Impacting Access to Services for Members

- Expanded use of case management to coordinate care and navigation services to provide critical support, positively impact member transitions in care, and improve early treatment engagement all enhance the overall access and continuity of care.
- Expanded telehealth and call-in kiosks for screenings, assessment, and outpatient treatments, based on members served, providers, and service units, also benefited access to care. Telehealth availability was very important in rural and isolated areas and was expanded in many plans.
- Increased number of MAT provider sites and NTP treatment slots along with levels of coordination through grants in partnership with hospitals and FQHC primary care clinics.
- Expanded outreach and education to prevent overdose and drug use by youth and adults, including videos, social media, and community forums. These included Narcan vending machines and other easy to access methods of distribution.
- Expanded night and weekend clinics, including NTPs. Models of street medicine and mobile crisis teams with overdose prevention capacity were expanded in urban sites, particularly in the **Los Angeles** and **San Francisco** Plans. A DHCS November 8, 2022, All Plan Letter supported the expansion of integrated street medicine.[50]
- Improved initiation of treatment coordination with criminal justice programs and hospital EDs improved overall access to care.
- Changes to streamline access systems noted in five Plans to rapidly link members to treatment sites after screenings, along with expedited appointment or walk-in options. These rapid access options positively impact engagement and timeliness, which appears to be reflected in the data and is consistent with stakeholder feedback.
- CalAIM changes to medical necessity eligibility were reported in all Plans to have enhanced efficient and rapid access to treatment.
- Modest increases in recovery residence (RR) housing options, as documented in Plan submissions in CalEQRO's Continuum of Care form. This important adjunct to care allows for more stability for those leaving residential treatment settings, and it was reported by members as critical for them retain recovery after transitioning from residential treatment into other outpatient and RSS.

Noteworthy Practices for Access

Plan examples of noteworthy practices were plentiful. With access line centers, Plans such as Marin, San Mateo, Contra Costa, PHC, and Los Angeles invested in improved call center systems, enhanced care coordination for access line member needs, additional mobile capacity linkage, and public-facing website enhancements. These actions improved their access processes and member support management as they entered the care system. Community outreach and education regarding SUD realities along with processes for early identification of these disorders has also encouraged low-barrier access.

[50] https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-023.pdf

Additional noteworthy practices for access to care include:

- The use of effective access call center software was a positive improvement. The software included standard reports for complete caller information, analytics on wait times, dropped calls, and call volume analysis by day and time of day.
- Enhancements to the Plan websites helping members and families seeking care included more complete treatment site information regarding language capability, site capacity, locations, access for those with disabilities, and adjunct services such as care coordination and transportation. Several Plans could provide vacant bed capacity in real-time for those seeking residential treatment.
- ASAM-based screening software with links to EHRs was being added to many Plans with new software upgrades.
- Walk-in, phone, and video services for assessments and screening linked to referrals, including after-hours and weekends at the provider program level, were expanded with efforts to create low-barrier timely treatment access.
- Most Plans were implementing mobile crisis services to respond to crisis needs for people with SUD or MH needs. The complexity of this service related to staffing, training, and interfaces with first responders, was observed to be taking some time to become fully functional, and others are still working on implementation.
- Some “street medicine” teams also included overdose reversal response capacity and were collaborative with FQHCs.
- SUD staff are being embedded in a variety of community access points, including inmate services, ambulatory care, hospital sites, local probation, child welfare offices, and within homeless outreach projects, with the intention of engaging potential SUD members “where they are.”

Challenges for Member Access

- Neighborhood resistance to adding recovery housing or NTP treatment sites exists, with community concerns about the impact of persons with SUD residing in their neighborhoods. While housing is not a component of the DMC-ODS, the availability of recovery housing affects member success in outpatient care, NTP programs, and transitions from residential treatment.
- Workforce shortages of licensed clinicians, SUD counselors, and physicians/prescribers are challenging given comparatively lower compensation, increased working requirements, and competition, particularly in rural areas and for those with needed bilingual capacity. There were 22 Plans (71 percent) with recommendations in this area.
- Lack of providers was noted most often in rural areas with limited populations and more challenging transportation options.
- Members cite lack of sufficient personal finances (e.g., securing childcare, transportation, and taking time off from work, etc.) and lack of possession of mobile technology that reliably access internet or telehealth, as barriers to access and treatment.
- Relative proximity of residential WM location and resources for urgent SUD conditions – as well as the availability of associated transportation services – was evident as a limitation for access. This was articulated in member focus groups and consequently in

terms of low levels of service utilization when sites were a significant distance or outside of the county. Members of three MAT focus groups shared this as important, as they were aware of or personally experienced more acute withdrawal symptoms due to fentanyl use.

- Daily transportation needs for members in NTP/OTP treatment, particularly for those more than 30 miles away, was also noted as a barrier.
- Lack of hospital access for members with acute needs due to advanced alcohol use disorders (AUD) identified distances as identified by SUD staff in rural areas. Also, medical staff in two Plans suggested that hospital Medi-Cal protocols need updating related to the documentation processes for medical necessity to bill and receive reimbursement for current AUD treatment and assessment protocols.
- Timely access to needed MH service, including medications and therapy, was regularly identified by members in focus groups when in residential treatment.
- Developing the administrative capacity to identify and analyze system-wide access barriers is challenging, especially when providers have different EHRs or simply no EHRs.
- Continued fears of COVID-19 infection, in particular by older adults with SUD, was identified as a barrier.

SUMMARY OF ACCESS

Progress was made in this last review cycle by streamlining access systems to decrease barriers, with a goal of rapid linkage to treatment and establishing a therapeutic alliance to retain them in care. This resulted in increases in total numbers in CY 2022; however, the number served of older adults age 65+ decreased each year.

Challenges remain in elevating all access systems and services to their full potential. Youth and non-English-speaking services still need to be adequately represented in treatment relative to their needs. While PRs improved overall, many Plans are still substantially low relative to overall SUD prevalence rates, especially for youth, Hispanic/Latino, and Asian/Pacific Islander members. While California is not unusual with relatively low access the Substance Abuse and Mental Health Services Administration (SAMHSA) notes that California is one of ten states that account for nearly 65 percent of all treatment admissions, and yet nationally the vast majority of individuals in need of SUD treatment are not receiving it.[51]

In rural areas, treatment services face additional challenges for access due to a lack of internet and, in some areas, limited cell service capacity. These barriers related to technology were mentioned in member focus groups and with staff wanting to use telehealth services. Federal Infrastructure legislation and funding attempted to address this challenge to some degree with discounted equipment and rates for coverage.[52]

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[51] Substance Abuse and Mental Health Services Administration. (January 5, 2024). *National survey on drug use and health (NSDUH) 2022 highlighted population slides*. https://www.samhsa.gov/data/report/nsduh-2022-highlighted-population-slides

[52] Federal Communications Commission. (April 10, 2024). *Affordable connectivity program.* https://www.fcc.gov/affordable-connectivity-program

Based on input across all reviews, the provider workforce numbers for SUD counselors and licensed BH professionals are not adequate for the needs of most public sector programs. There were 22 Plans (71 percent) where specific recommendations were made related to their workforce challenges. Continuing efforts at bolstering policymaking and educational institution capacity are needed to support SUD counselor and LPHA workforce expansion within the BH field as an attractive, educationally affordable career choice. Despite these challenges, CY 2022 service levels and the expansion of provider networks in most Plans improved slightly over CY 2021.

Mobile services have increased, often in partnership with law enforcement, MH, medical teams, and public health. Plans have expanded linkage to health treatments instead of incarceration wherever possible and expanded embedded SUD treatment in detention settings. Similarly, 28 DMC-ODS Plans (90 percent) have embedded SUD staff within probation, schools, crisis teams, and/or homeless outreach projects to advance early member engagement and treatment initiation. Multiple pathways to treatment enable systems to reach more people.

Timeliness

INTRODUCTION

Rapid access to care is essential for members addressing SUD, as it promotes timely initiation and engagement in treatment. The DMC-ODS continuum of care prioritizes this access at the entry point. While many members use a standardized telephone access line for initial screenings, others may directly contact providers for appointments. The first appointment typically includes a psychosocial assessment and ASAM screening to determine the appropriate LOC. However, achieving successful engagement often requires multiple treatment episodes at various LOCs. Delays in initial access can lead to premature dropouts and decrease the likelihood of positive treatment outcomes.

Tracking timely and responsive assessments is crucial to ensuring effective resources and adequate capacity for bringing members into treatment when they seek it. The motivation to seek treatment can be fleeting, and long wait times can increase the likelihood of no-shows for initial appointments. Many Plans are addressing this issue by using case managers, system navigators, or peer support staff at the intake point to reduce delays and improve appointment adherence and initiation of care.

Tracking and monitoring timeliness in care necessitates a robust infrastructure that includes:

- Data Collection: Implement forms and data-entry screens in EHR systems to capture essential details such as request dates, appointment offers, service delivery dates, and urgency levels. Additionally, develop ancillary reports to ensure that all users, both county and contractor staff, submit information consistently and also to assess the integrity of the data.
- Technical Support: Secure sufficient IS staff or contracted application service provider staff with the technical expertise needed to maintain and enhance EHR systems. Furthermore, maintain an adequate staffing level of dedicated data-analytic staff to handle the extraction, analysis, and reporting of timeliness data.
- Quality Feedback Loops: Create continuous quality feedback mechanisms by integrating timeliness data into summary reports. Distribute these reports regularly to supervisors and leadership to support decision-making and improve timely access to care.
- Implement improvements: Regularly monitor and develop strategies, as needed, aimed at improving system capacity and responsiveness to ensure services are delivered with minimal wait times.

In line with the approach used in all CalEQRO review areas, a continuous QI model underpins the review and analysis of this material, both for the statewide analysis and within the individual EQRs.

The DMC-ODS Plans' quality oversight systems need a robust infrastructure to effectively document performance trends, identify and evaluate root causes, and implement strategies to address delayed care. If data access or analysis is obstructed, improvement activities are hindered. Many individuals seeking SUD treatment do not go through access call centers, so DMC-ODS Plans must gather data from multiple providers, often using spreadsheets instead of

a common EHR. This disparate data must be compiled for systemic analysis, causing delays in timely systemic intervention. Additionally, manually collected data is prone to errors or omissions, especially in large systems without an EHR. Contracted agencies typically do not use the same EHR as the county, complicating the monitoring and coordination of systemwide performance.

Routine data analysis and review help identify both well-functioning performance areas and those that need improvement. Poor timeliness can indicate various issues, such as workflow problems that cause service delays or the need for more service capacity. To meet member needs, this may involve adding staff, programs, or contracts.

CalEQRO evaluates timeliness performance based on two main sources:

- The DMC-ODS report of wait times, submitted through the ATA. This report includes raw data, average wait times, and the percentage of appointments and services meeting DHCS or Plan-defined standards at key points in care.
- Key Components 2A through 2F is used by the review team to evaluate whether the DMC-ODS sets standards, tracks and trends data, assesses performance through regular analysis, and initiates performance improvement processes.[53]

CalEQRO reviewed the source data to validate the ATA measures. Some Plans did not submit source data for validation, but for those that did, CalEQRO could largely replicate the data in their ATA submissions.

DHCS sets the following standards for timely access to care:

- First non-urgent appointment offered – 10 business days
- First non-urgent request for MAT NTP/OTP appointment offered – 3 business days

The ATA and the Key Component items correspond in their review of six metrics:

- Initial non-urgent outpatient SUD service
- Initial non-urgent outpatient NTP/OTP service
- Urgent services
- Follow-up post-residential treatment
- WM readmissions
- No-show rates for initial services

The two evaluation methods and data sources (ATA versus Key Components) may yield different findings for the same timeliness metric. For example, a Plan might submit its ATA data showing compliance with the DHCS timeliness standard, but fail to provide evidence of routine tracking, trending, or performance improvement processes outside of the EQR preparation. In this case, despite the annual report showing compliance, the Plan might receive a Key Component rating of Partially Met or Not Met due to a lack of ongoing monitoring and evaluation.

[53] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

Conversely, a Plan might not meet the timeliness standard but demonstrates robust tracking mechanisms, routine data review, and rigorous performance improvement processes aimed at enhancing timely access. Under these circumstances, the Key Component rating could be Met because it credits active performance improvement activities. Overall, DMC-ODSs have prioritized reporting on timeliness metrics, as this has been a long-held requirement for the EQR. However, the quality of reporting and the follow-up activities for poor timeliness results vary significantly. This variation is an important factor in determining the Key Component ratings.

Additionally, DHCS evaluates Plan timeliness using the TADT. This tool covers a 9-month period and requires 80 percent of offered appointments to meet timeliness standards to receive a Pass rating.[54]

This chapter starts with findings related to the Key Components for timely access to care. It then presents the timeliness findings reported by the DMC-ODS, highlighting where these submissions were validated by CalEQRO's review of the submitted data.

Each timeliness Key Component, as summarized in Table 5-1, includes several subcomponents. These subcomponents are evaluated together to determine an overall Key Component rating of Met, Partially Met, or Not Met.

Table 5-1: Key Components: Summary of Oversight of Timeliness – Statewide FY 2023-24

KC #	Key Components – Timeliness	Met	Partially Met	Not Met
2A	First Non-Urgent Request to First Offered Appointment	24	3	4
2B	First Non-Urgent Request to First Offered MAT/OTP Appointment	23	6	2
2C	First Urgent Appointment Offered	15	12	4
2D	Follow-up from Residential Treatment	22	9	0
2E	WM Readmissions	28	1	2
2F	No-Show and Cancel Tracking	15	7	9

Timeliness performance was strongest in tracking WM readmissions, followed by the initially offered outpatient appointment, offered MAT/OTP appointment, and follow-up after residential treatment. Performance in urgent timeliness and no-show/cancel tracking was lowest with 48 percent of Plans rating Met on these elements.

Plan-level performance for each of the timeliness components follows in Table 5-2.*

Table 5-2: Timeliness Key Components by Plan, FY 2023-24

DMC-ODS	2A	2B	2C	2D	2E	2F
Alameda	M	M	M	M	M	PM
Contra Costa	M	M	PM	M	M	NM
El Dorado	PM	PM	M	PM	M	M

[54] Meeting a Key Component for timeliness is not the same as receiving a "Pass" from DHCS Network Adequacy on timely access to care. CalEQRO utilizes the ATA submitted prior to each review. DHCS utilizes the annual TADT.

DMC-ODS	2A	2B	2C	2D	2E	2F
Fresno	M	M	PM	M	M	M
Imperial	M	M	PM	M	M	PM
Kern	M	M	M	M	M	PM
Los Angeles	M	M	M	M	M	NM
Marin	M	M	M	M	M	M
Merced	M	M	PM	M	NM	M
Monterey	M	PM	PM	M	M	PM
Napa	M	M	M	PM	PM	M
Nevada	PM	M	PM	M	M	M
Orange	M	M	M	M	M	M
Partnership	M	PM	M	M	M	M
Placer	NM	M	PM	M	M	NM
Riverside	NM	NM	NM	PM	M	NM
Sacramento	NM	NM	M	M	M	NM
San Benito	M	PM	NM	M	M	M
San Bernardino	M	M	M	PM	M	NM
San Diego	M	M	M	M	M	M
San Francisco	M	M	M	M	M	PM
San Joaquin	M	M	M	M	M	NM
San Luis Obispo	M	M	PM	M	M	PM
San Mateo	PM	PM	PM	PM	M	NM
Santa Barbara	M	M	PM	M	M	M
Santa Clara	M	M	NM	PM	M	M
Santa Cruz	M	M	M	PM	M	M
Stanislaus	M	PM	PM	M	M	M
Tulare	M	M	M	M	NM	NM
Ventura	M	M	PM	PM	M	M
Yolo	NM	M	NM	PM	M	PM

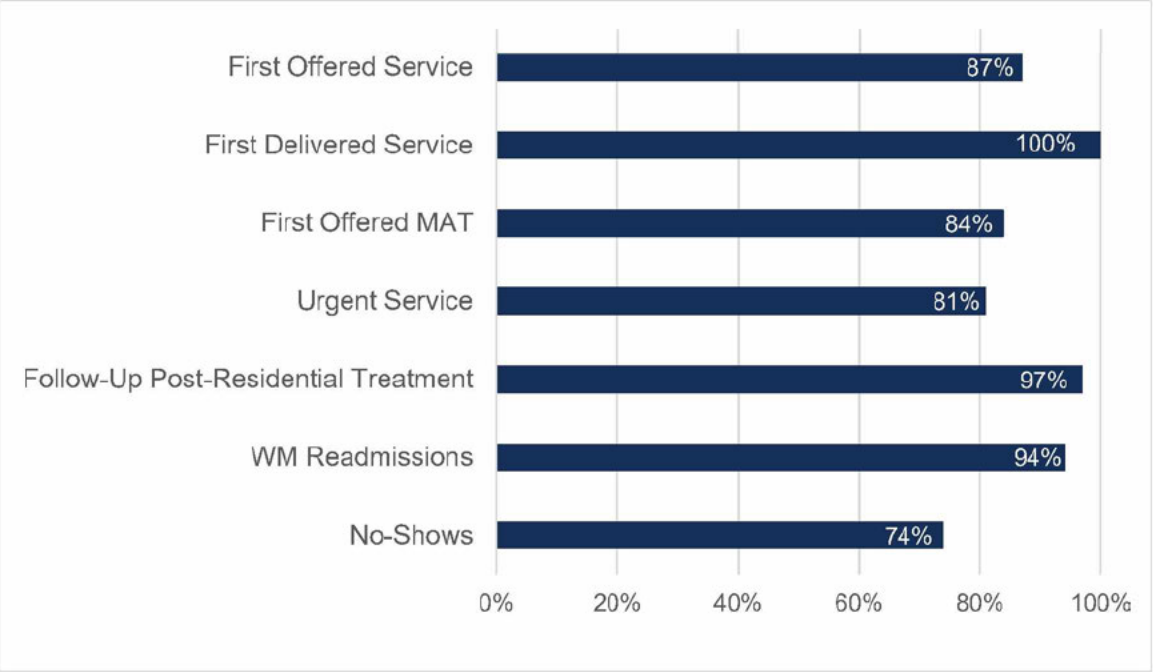
*Note: M = Met, PM = Partially Met, NM = Not Met

Tracking Timeliness for ATA Submissions

Most DMC-ODS Plans track a majority of the timeliness metrics, but complete reporting across all ATA metrics did not occur for all Plans. Fifteen Plans (48 percent) were unable to report on one or more of the metrics reported in this chapter. Among those, many were unable to track urgent and NTP services, in contrast to non-urgent initial services and follow-up after residential treatment. As noted in the FY 2022-23 Annual Report, reporting on no-shows and cancellations remained the least tracked and monitored metric.

Figure 5-1 shows the percentage of Plans with that reported each of the timeliness metrics in FY 2023-24.

Figure 5-1: Percentage of Plans that Reported Timeliness in the ATA, FY 2023-24



Over 87 percent of the Plans (N=27) submitted timeliness findings for 12-month periods. Among these, 22 Plans used data from FY 2022-23, while five Plans used data from CYs 2022 or 2023, or from a self-defined 12-month interval. The remaining four Plans provided data for periods ranging from 6 months to just under a year.

Time to Initial Offered Appointment

Key Component 2A assesses whether the county tracks the first offered non-urgent appointment, analyzes this data regularly, and implements improvement activities based on performance. Four DMC-ODSs received a rating of Not Met because they lacked the required mechanisms or activities. Three DMC-ODSs received a rating of Partially Met, primarily because they have not started improvement activities based on their findings.

Timeliness measurement starts with the initial contact from a potential member, usually a service request made by phone or in person at a service site. The average time from the first request to the first offered non-urgent appointment was 5.20 days. This represents a 19.75 percent decrease from the 6.48 days reported in FY 2022-23.

The first offered appointment is crucial as it indicates how promptly the system can provide necessary services. Across the Plans, the average wait time ranged from less than 1 day to 11 days, with a median wait time of 2 days.

The data in Table 5-3 shows the average wait time in business days and the percentage of services that met the 10 business-day standard for the first non-urgent service offered.

Table 5-3: Wait Time (Business Days) to Initial Non-Urgent Outpatient Service Offered, Reported in ATA in FY 2023-24

DMC-ODS	First Non-Urgent Service Offered						Validated by CalEQRO
	Overall		Adult		Youth		Yes/No
	Avg Wait	% Met Standard	Avg Wait	% Met Standard	Avg Wait	% Met Standard	
Alameda	3.3	94%	3.2	94%	4.3	94%	Yes
Contra Costa	5.4	90%	5.4	90%	N/A	N/A	Yes
El Dorado	Not Reported						
Fresno	1.9	98%	1.9	98%	1.0	99%	Yes
Imperial	6.0	99%	7.0	99%	0.0	100%	No
Kern	7.1	87%	7.2	87%	6.2	89%	Yes
Los Angeles	6.0	82%	6.0	83%	12.0	19%	No
Marin	1.9	98%	1.9	98%	6.3	71%	Yes
Merced	11.0	51%	11.0	48%	9.0	73%	Yes
Monterey	7.2	86%	7.0	86%	6.0	79%	No
Napa	9.2	81%	10.3	82%	8.0	80%	No
Nevada	5.4	85%	4.4	85%	1.8	100%	No
Orange	3.4	97%	3.3	97%	6.5	81%	No
PHC	2.7	93%	2.7	93%	1.2	98%	No
Placer	Not Reported						
Riverside	Not Reported						
Sacramento	9.9	78%	10.3	77%	1.4	96%	No
San Benito	3.6	99%	3.7	99%	2.0	100%	Yes
San Bernardino	4.0	86%	4.0	87%	13.0	35%	No
San Diego	3.2	95%	3.3	95%	2.1	97%	Yes
San Francisco	1.7	99%	1.6	99%	3.1	100%	Yes
San Joaquin	7.2	79%	7.2	79%	6.7	79%	Yes
San Luis Obispo	0.0	99%	0.0	99%	3.0	97%	Yes
San Mateo	2.4	91%	2.0	91%	4.0	91%	Yes
Santa Barbara	3.7	89%	3.9	87%	2.3	97%	Yes
Santa Clara	8.2	72%	8.2	72%	8.3	72%	No
Santa Cruz	4.4	88%	4.1	89%	106.0	67%	Yes
Stanislaus	10.0	62%	10.0	64%	13.0	45%	No
Tulare	6.0	80%	7.0	79%	1.0	100%	Yes
Ventura	5.6	89%	5.7	89%	4.7	94%	Yes
Yolo	Not Reported						

Among the 27 Plans reporting, 89,267 service requests were made. Of these, 89.93 percent received a timely appointment within the state's 10-business day standard. Compared to last

year, the percentage of timely appointments substantially increased from 57 percent. Performance ranged from 51 percent to 99 percent, with a median of 89 percent. However, 11 of the 27 Plans (40.74 percent) did not provide sufficient source data for validation, including large counties such as Orange, Sacramento, San Bernardino, and Santa Clara, which introduces some uncertainty to the overall results; this is listed in the last column in Table 5-3 above.

Of the 27 DMC-ODS Plans reporting on the measure of first non-urgent service offered, 22 Plans achieved an 80 percent or higher compliance rate with the 10-business day standard. This represents a 16 percent increase from the previous year when 19 Plans met the standard for 80 percent of services. All Plans except Merced reported an overall average wait of 10 business days or less; Merced's wait time was slightly longer than the prior year (10.3 days) and slightly fewer members' appointments met the standard (51 percent) compared to last year (55 percent). Most Plans showed shorter wait times compared to the prior year. The most marked improvement was **San Bernardino's** improvement from an average of 32 business days to 4 business days.

Many Plans improved their timeliness for non-urgent appointments, either meeting or exceeding timeliness standards, or moving in that direction. This improvement may be attributed to various factors, including changes in tracking methods, enhanced access line responses, increased bilingual staff, expanded service capacity, and better interagency collaboration. For instance:

- **El Dorado** reallocated staff and created more intake slots, improving access for all demographics.
- **Kern** established a call center facilitating inter-county transfers, boosting access and timeliness.
- **Monterey** integrated activities with its MCP, local hospitals, and primary care, improving care coordination and efficiency.
- **Contra Costa** expanded bilingual staff to better serve its Hispanic/Latino community.

Additional efforts include:

- **Orange** implemented cross-training of assessment staff in SUD and MH clinics and adopted a policy for treating co-occurring disorders.
- **Santa Clara** developed two data analytics teams to identify and address needs, producing regular reports to inform leadership and improve system performance.

These initiatives reflect a broader trend toward more effective and data-driven approaches to improving timely access to care.

Time to Initial Service Delivered

Timeliness tracking from the first request to the initial face-to-face contact is crucial for assessing the actual initiation of treatment, following a screening or intake process. This measure is vital for engaging individuals in SUD treatment, as many members may be ambivalent about seeking care. The time between the first request and the initial contact often represents a critical window for successfully starting treatment.

The data in Table 5-4 shows the average wait time in business days and the percentage of services that met a local standard for the first non-urgent service delivered.

Table 5-4: Wait Time (Business Days) First Non-Urgent Service Delivered, Reported in ATA in FY 2023-24

DMC-ODS	First Non-Urgent Service Delivered						Validated by CalEQRO
	Overall		Adult		Youth		Yes/No
	Avg Wait	% Met Standard	Avg Wait	% Met Standard	Avg Wait	% Met Standard	
Alameda	7.7	77%	8.4	77%	6.0	88%	Yes
Contra Costa	6.7	80%	6.7	80%	N/A	N/A	Yes
El Dorado	9.8	82%	9.8	81%	7.0	100%	No
Fresno	3.1	95%	4.0	93%	0	99%	Yes
Imperial	13.0	N/A	16.0	N/A	6.0	N/A	No
Kern	20.2	75%	20.6	75%	8.5	83%	Yes
Los Angeles	8.0	74%	8.0	74%	12.0	58%	No
Marin	3.0	95%	2.9	96%	6.3	71%	Yes
Merced	17.0	55%	19.0	50%	10.0	81%	Yes
Monterey	0.1	99%	0	99%	0	95%	Yes
Napa	12.0	70%	20.0	68%	4.0	93%	No
Nevada	9.1	73%	6.67	73%	2.8	100%	No
Orange	4.0	86%	3.8	86%	7.9	72%	No
PHC	2.7	93%	2.7	93%	1.2	98%	No
Placer	3.8	87%	3.8	87%	2.5	100%	No
Riverside	1.7	96%	1.69	97%	1.7	94%	Yes
Sacramento	63.9	27%	65.6	25%	43.9	43%	No
San Benito	4.9	90%	5.1	89%	1.5	100%	Yes
San Bernardino	8.0	69%	8.0	70%	15	21%	No
San Diego	4.2	93%	4.2	94%	3.8	91%	Yes
San Francisco	3.1	93%	3.0	93%	12.2	50%	Yes
San Joaquin	12.2	52%	12.2	52%	5.0	100%	Yes
San Luis Obispo	10.0	87%	10.0	88%	12	71%	No
San Mateo	4.0	84%	4.0	84%	11.0	64%	Yes
Santa Barbara	4.5	49%	4.9	46%	2.0	65%	Yes
Santa Clara	11.3	63%	11.3	63%	10.4	62%	No
Santa Cruz	9.8	72%	9.7	72%	12.2	64%	Yes
Stanislaus	7.0	76%	6.0	80%	14.0	43%	No
Tulare	9.0	80%	4.0	69%	1.0	100%	Yes
Ventura	8.8	79%	8.8	80%	9.2	74%	Yes
Yolo	25.0	65%	25.0	65%	N/A	N/A	Yes

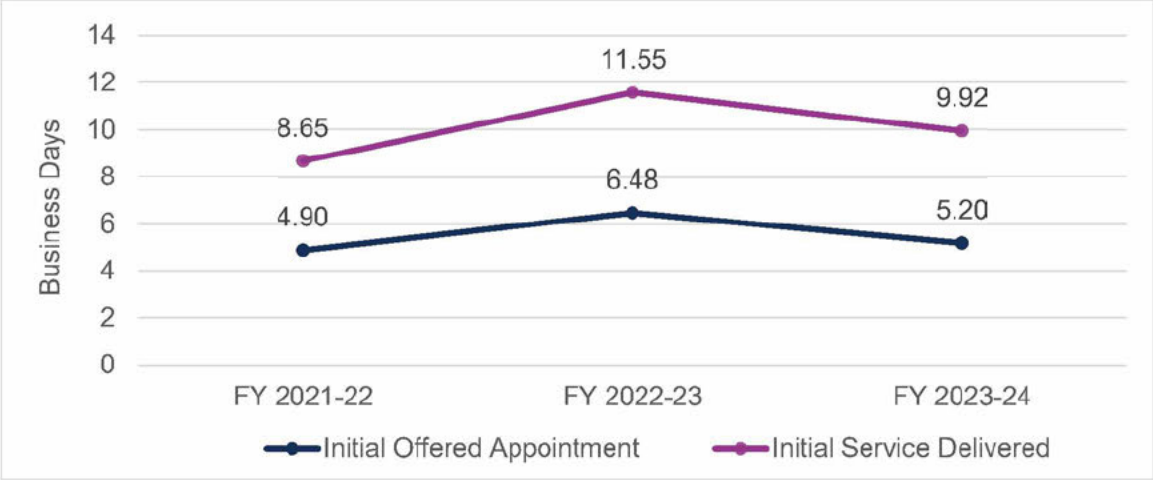
All 31 Plans reported data for the first billed service metric. However, Imperial did not define a standard and thus did not determine compliance percentages. The statewide average wait time for the first billed service was 9.92 days, a 14.11 percent decrease from 11.55 days in FY 2022-23. The range of average wait times varied from 0.1 days (Monterey) to 63.9 days (Sacramento), with a median of 8.0 days.

Nearly 40 percent of the Plans had average wait times of less than 5 days, while one-quarter had wait times exceeding 10 days. Out of the 30 Plans that defined a standard, 52,574 services were delivered, with 84 percent (44,026) meeting the standard. This represents an 18 percent increase from the 71 percent compliance reported in FY 2022-23. Additionally, 15 Plans reported meeting their standards 80 percent of the time or more. The percentage of services meeting standards ranged from 27 percent to 99 percent, with a median of 80 percent.

Strong performers in this metric included **Monterey** (99 percent), **Fresno** (95 percent), **Marin** (95 percent), **Riverside** (96 percent), and **PHC** (93 percent). Showing marked improvement, **Contra Costa**'s timeliness on this metric 15.8 business days last year and 51 percent compliance, and this year showed an average of 6.7 business days and 80 percent compliance. **San Bernardino** also improved from 67.0 business days to 8.0 business days. Alternatively, this year Sacramento's wait of 63.9 business days was longer than last year at 46.2 business days.

Figure 5-2 shows the 3-year trend for the average wait time for both the offered and delivered first non-urgent service.

Figure 5-2: DMC-ODS ATA Timeliness, Comparison over Review Years, FY 2021-22 to FY 2023-24



Both measures show improvement (decreased wait) from what was reported last year, but not quite to the stronger numbers shown in FY 2021-22.

Time to First MAT NTP/OTP Service

Timeliness in tracking MAT services is crucial for effective substance use treatment. MAT combines prescription medications with counseling and behavioral therapies to address SUDs comprehensively. This is especially vital when individuals transfer from another county or have begun MAT during incarceration, as maintaining continuous medication is essential. Crucial in the opioid overdose crisis, MAT is most effective when provided promptly. It significantly enhances treatment success by alleviating physical discomfort and cravings, which supports recovery skill development. Delays in MAT can disrupt treatment and impede recovery.

The data in Table 5-5 shows the average wait time (in business days) and percentage of services meeting the standard for the first NTP/OTP appointment offered.

Table 5-5: Wait Time (Business Days) First NTP/OTP Appointment Offered, Reported in ATA in FY 2023-24

DMC-ODS	First NTP/OTP Appointment Offered						Validated by CalEQRO
	Overall		Adult		Youth		Yes/No
	Avg Wait	% Met Standard	Avg Wait	% Met Standard	Avg Wait	% Met Standard	
Alameda	2.3	82%	2.3	82%	N/A	N/A	Yes
Contra Costa	Not Reported						
El Dorado	Not Reported						
Fresno	1.0	99%	1.0	99%	N/A	N/A	Yes
Imperial	1.0	100%	1.0	100%	N/A	N/A	No
Kern	0.4	99%	0.4	99%	N/A	N/A	Yes
Los Angeles	3.0	80%	3.0	80%	N/A	N/A	No
Marin	0.1	100%	0.1	100%	N/A	N/A	Yes
Merced	6.9	28%	6.9	28%	N/A	N/A	No
Monterey	5.0	56%	5.0	56%	N/A	N/A	Yes
Napa	0.0	100%	0.0	100%	N/A	N/A	No
Nevada	1.4	94%	1.4	94%	N/A	N/A	No
Orange	0.1	99%	0.1	99%	0.0	100%	No
PHC	1.9	93%	1.9	93%	N/A	N/A	No
Placer	6.0	21%	6.0	21%	N/A	N/A	Yes
Riverside	Not Reported						
Sacramento	Not Reported						
San Benito	2.0	75%	2.0	75%	N/A	N/A	Yes
San Bernardino	1.0	99%	1.0	99%	N/A	N/A	No
San Diego	0.1	99%	0.1	99%	N/A	N/A	Yes
San Francisco	0.3	99%	0.3	99%	0.0	100%	Yes
San Joaquin	0.9	93%	0.9	93%	N/A	N/A	Yes
San Luis Obispo	0.0	100%	0.0	100%	N/A	N/A	No
San Mateo	2.0	100%	2.0	100%	N/A	N/A	No
Santa Barbara	2.5	76%	2.5	76%	4.0	N/A	Yes
Santa Clara	4.8	64%	4.5	67%	10.0	0%	Yes
Santa Cruz	4.3	43%	4.3	43%	N/A	N/A	Yes
Stanislaus	5.0	50%	5.0	50%	N/A	N/A	No
Tulare	1.0	97%	1.0	97%	N/A	N/A	No
Ventura	0.4	95%	0.4	95%	N/A	N/A	No
Yolo	Not Reported						

Table 5-5 shows that 26 DMC-ODS Plans (84 percent) reported data for time to first NTP/OTP appointment offered. Additionally, 13 Plans either failed to submit complete data or provided incomplete materials, which prevented validation of their wait times.

For the reporting Plans, the average wait time for the first MAT appointment was 2.10 business days, with a median of 1.0 day. Eighteen plans met the standard at least 80 percent of the time, and 13 had wait times of 1 day or less. Additionally, 23 Plans (74 percent) were rated as "Met" for this measure as a Key Component, reflecting a 28 percent increase from last year.

Alameda reported a significantly improved wait time from 6.2 business days last year to 2.3 business days this year. Similarly, **San Benito** improved on this metric from 15.3 business days to 2.0 business days. Of the plans with longer wait times, Placer and Merced averaged 6.0 and 6.9 business days, respectively, with the lowest percentages meeting the 3 business-day standard.

Timeliness to Urgent Appointments

Within the DMC-ODS framework, Plans must operationally define urgent member needs. Though Plans can create their own guidelines for urgent appointments, services must be offered within 48 hours.[55]

Definitions vary across Plans; some narrowly define urgent conditions to include only pregnant opioid users, while others have broader definitions encompassing all WM/NTP or member self-reported urgency. Some rely on federal priority populations (e.g., pregnant, human immunodeficiency virus positive, and intravenous drug users), others on ASAM severity criteria, or locally developed criteria like hospital and criminal justice referrals.

Plans continue to develop and revise definitions of urgent appointments to better track the provision of urgent services. While several Plans have the tools within their EHRs or external devices like spreadsheets to capture, monitor, and evaluate urgent services in hours, others lack these mechanisms. These Plans often report urgent wait times in business days, making it difficult to precisely assess improvements in meeting the 48-hour service threshold. Due to the variability in reporting methods, CalEQRO converts findings reported in days to hours (by multiplying total days by 24) in Table 5-6; and later this is shown in year-over-year comparisons in Figure 5-3.

For this metric, Key Component 2C, 15 DMC-ODSs were rated Met, 12 Partially Met, and 4 Not Met.

The data in Table 5-6 show the average wait time (in hours) and percentage of services meeting the standard for urgent services offered.

[55] Department of Managed Health Care. (n.d.). *Timely access to non-emergency health care services.* https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/ta2nehcs.pdf

Table 5-6: Wait Time (Hours) to Urgent Service Offered, Reported in ATA in FY 2023-24

DMC-ODS	First Urgent Service Offered						Validated by CalEQRO
	Overall		Adult		Youth		Yes/No
	Avg Wait (Hours)	% Met Standard	Avg Wait (Hours)	% Met Standard	Avg Wait (Hours)	% Met Standard	
Alameda	48.0	84%	48.0	84%	0.0	100%	No
Contra Costa	Not Reported	N/A	Not Reported	N/A	N/A	N/A	No
El Dorado	32.6	84%	32.6	84%	N/A	N/A	No
Fresno	56.4	58%	50.6	57%	144.0	50%	Yes
Imperial	68.75	50%	68.75	50%	N/A	N/A	Yes
Kern	35.0	90%	35	89%	30.0	100%	Yes
Los Angeles	24.0	92%	24	92%	N/A	N/A	No
Marin	2.4	98%	2.4	98%	N/A	N/A	Yes
Merced	112.5	67%	112.51	67%	N/A	N/A	No
Monterey	48.0	99%	48.0	99%	0.0	100%	No
Napa	21.8	88%	21.8	88%	N/A	N/A	Yes
Nevada	112.3	54%	112.3	54%	N/A	N/A	Yes
Orange	7.2	99%	7.2	99%	N/A	N/A	No
PHC	60.0	86%	60.0	86%	N/A	N/A	No
Placer	Not Reported						
Riverside	Not Reported						
Sacramento	Not Reported						
San Benito	Not Reported						
San Bernardino	47.5	85%	47.5	85%	N/A	N/A	No
San Diego	58.6	70%	58.7	70%	22.7	100%	No
San Francisco	4.8	97%	4.8	97%	0.0	100%	Yes
San Joaquin	43.2	76%	43..2	76%	43.2	83%	Yes
San Luis Obispo	49.4	100%	49.4	100%	48.0	100%	No
San Mateo	15.4	99%	15.5	99%	12.0	100%	Yes
Santa Barbara	96.0	71%	88.8	72%	187.2	60%	No
Santa Clara	Not Reported						
Santa Cruz	5.9	99%	5.9	99%	16.0	100%	Yes
Stanislaus	96.0	63%	96.0	63%	N/A	N/A	No
Tulare	1.0	88%	1.0	88%	N/A	N/A	Yes
Ventura	61.0	64%	61.0	64%	66.0	63%	Yes
Yolo	Not Reported						

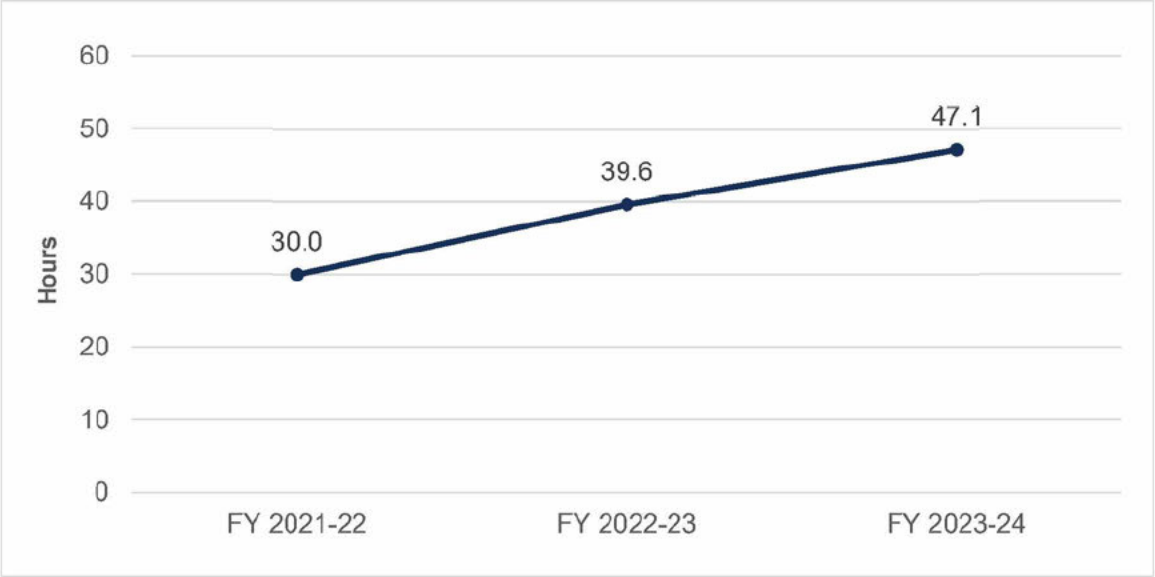
For urgent service requests, 25 DMC-ODSs (81 percent) reported on this metric.

Plans marked as N/A for youth services had no urgent needs for youth. Wait times that were provided for youth varied tremendously by Plan and tended to be longer than the corresponding adult wait times. Ten Plans had average wait times that exceeded 48 hours.

Only 12 of the reporting Plans (48 percent) provided source data that could be used to validate their submission, while the remaining 13 Plans either offered only summary reports or incomplete data sets.

Figure 5-3 shows wait times for timely access for urgent services as reported across the last 3 review years.

Figure 5-3: DMC-ODS Average Wait Times for Urgent Services, Reported in the ATA: Comparison over Review Years FY 2021-22 through FY 2023-24



Overall wait times for urgent appointments increased by 57 percent from FY 2021-22 (30.0 hours) to FY 2023-24 (47.1 hours) yet remained under 48 hours each year. Some Plans did not report annually, and others had few urgent service requests, possibly inflating wait times. Figure 5-3 may not fully represent trends over time due to these inconsistencies as well as the mathematical conversion to hours from days reported. As Plans refine their strategies, fluctuations are expected, especially with the small service numbers. Clear and consistent definitions of clinical urgency are essential to ensure timely responses and maintain member engagement and clinical outcomes.

Follow-up from Residential Treatment

Timely transition from residential to outpatient care is crucial for continuity and treatment success. Tracking both the transition speed and attrition rate during this process is important, as moving from structured residential settings to community outpatient treatment is challenging for those in early recovery.

Table 5-7 shows the overall average wait for follow-up and the percentage that received a follow-up within 7 and 30 days. In addition, this table shows whether the Plan submitted data that could be used to validate their findings (only 13 Plans did so).

Table 5-7: Follow-up After Residential Treatment at 7 and 30 Days, Reported in the ATA in FY 2023-24

DMC-ODS	Follow-up After Residential			Validated by CalEQRO
	Overall Avg Days to Service	Percent at 7 Days	Percent at 30 Days	Yes/No
Alameda	3.4	69%	82%	Yes
Contra Costa	18.5	19%	29%	Yes
El Dorado	Not Reported			
Fresno	36.0	41%	70%	Yes
Imperial	5.0	51%	62%	No
Kern	11.6	26%	47%	Yes
Los Angeles	7.0	24%	30%	No
Marin	9.1	27%	42%	No
Merced	11.0	16%	32%	Yes
Monterey	5.0	62%	77%	No
Napa	16.8	12%	13%	No
Nevada	15.1	52%	73%	No
Orange	14.9	22%	43%	No
PHC	8.8	59%	66%	No
Placer	10.2	34%	53%	No
Riverside	14.1	65%	92%	Yes
Sacramento	41.6	87%	Not Reported	No
San Benito	4.3	83%	100%	Yes
San Bernardino	32.0	6%	13%	No
San Diego	26.4	34%	40%	Yes
San Francisco	23.0	27%	32%	No
San Joaquin	5.0	31%	39%	Yes
San Luis Obispo	3.0	82%	93%	No
San Mateo	5.6	44%	58%	Yes
Santa Barbara	7.4	23%	36%	No
Santa Clara	18.8	15%	30%	Yes
Santa Cruz	29.8	30%	39%	Yes
Stanislaus	10.0	52%	68%	No
Tulare	38.0	9%	17%	No
Ventura	32.6	13%	28%	Yes
Yolo	16.0	65%	86%	No

Consistent with last year's review, 22 of the 31 Plans (71 percent) rated Met for the follow-up Key Component, while 9 Plans were rated Partially Met. Overall, CalEQRO sessions confirm

ongoing evaluation and strategy development to improve the transition time from residential to outpatient care.

This metric is the only timeliness measure where all but one Plan reported data, indicating a strong commitment to tracking post-residential follow-up. This is an improvement from last year when three Plans did not report this metric; while El Dorado did not supply this metric this year, they did so last year.

At 35.72 percent for follow-up outpatient services within 7 days, this year showed an increase from last year's 28.82 percent. Additionally, 53.43 percent received services within 30 days, up from 41.86 percent last year. These improvements suggest that Plans are adopting more effective strategies to accelerate transitions from residential to outpatient care.

Table 5-8 shows the Plan-submitted data for follow-up after residential treatment, indicating the average wait time and the percentage of services that occurred in 7 and 30 days, for both adults and youth.

Table 5-8: Follow-up after Residential Treatment, Adult vs Youth, Reported in the ATA in FY 2023-24

DMC-ODS	Follow-up After Residential: Breakdown of Adult and Youth					
	Avg Days to Service for Adults	Percent at 7 Days for Adults	Percent at 30 Days for Adults	Avg Days to Service for Youth	Percent at 7 Days for Youth	Percent at 30 Days for Youth
Alameda	3.4	69%	82%	N/A	N/A	N/A
Contra Costa	18.5	19%	29%	N/A	N/A	N/A
El Dorado	Not Reported					
Fresno	36	41%	70%	N/A	N/A	N/A
Imperial	5	51%	62%	2.0	50%	50%
Kern	11.6	26%	47%	10.5	0%	22%
Los Angeles	7.0	24%	29%	15.0	14%	42%
Marin	9.1	27%	43%	5.0	33%	33%
Merced	11	16%	32%	N/A	N/A	N/A
Monterey	5	62%	77%	N/A	N/A	N/A
Napa	16.75	12%	13%	N/A	N/A	N/A
Nevada	15.2	52%	73%	2.0	100%	100%
Orange	14.9	22%	44%	12.0	0%	17%
PHC	8.81	59%	66%	14.0	50%	100%
Placer	10.2	35%	53%	9.5	0%	50%
Riverside	13.98	65%	92%	20.76	58%	79%
Sacramento	41.6	87%	N/A	N/A	N/A	N/A
San Benito	4.3	83%	100%	N/A	N/A	N/A
San Bernardino	32	6%	13%	18	10%	19%
San Diego	26.2	34%	40%	44.1	13%	18%
San Francisco	23	27%	32%	N/A	N/A	N/A

DMC-ODS	Follow-up After Residential: Breakdown of Adult and Youth					
	Avg Days to Service for Adults	Percent at 7 Days for Adults	Percent at 30 Days for Adults	Avg Days to Service for Youth	Percent at 7 Days for Youth	Percent at 30 Days for Youth
San Joaquin	5	31%	39%	N/A	N/A	N/A
San Luis Obispo	3	82%	93%	N/A	N/A	N/A
San Mateo	5.63	44%	58%	N/A	N/A	N/A
Santa Barbara	7.5	23%	36%	3.7	43%	57%
Santa Clara	18.7	16%	30%	19.3	12%	26%
Santa Cruz	29.8	30%	39%	N/A	N/A	N/A
Stanislaus	10	52%	68%	N/A	N/A	N/A
Tulare	38	9%	17%	N/A	N/A	N/A
Ventura	30	13%	29%	117	8%	8%
Yolo	14	66%	87%	128	0%	0%

In most Plans that reported follow-up data for youth versus adults, the average wait times differed for the two age groups. Sometimes it was exceptionally longer for youth to receive a follow-up appointment, up to 128 days. Youth in four Plans (Imperial, Marin, Nevada, Santa Barbara) were reported to receive a follow-up appointment less than 5 business days after residential discharge.

Of all residential discharges reported, 98.89 percent were adults and 1.13 percent were youth. Youth follow-ups within 7 days dropped to 21.20 percent and within 30 days dropped to 35.16 percent. Compared to the prior year, the adult transition rate improved by 28.11 percent, while the youth rate decreased by 8.20 percent. Despite progress for adults, youth transitions need further improvement.

Further analysis on follow-up after residential treatment using CalEQRO approved claims data, as opposed to the Plan-submitted data displayed above, is available in the Quality chapter of this report.

Readmission to Withdrawal Management

Tracking admissions, discharges, and 30-day readmissions to WM helps assess system coordination and LOC transitions. At the program and provider levels, this data helps DMC-ODS Plans identify members needing ongoing care and ensures effective LOC coordination for continuity of care.

Table 5-9 shows the total count of WM discharges, the percentage that had readmissions, and whether CalEQRO was able to validate the results or not for each Plan.

Table 5-9: Readmission to WM within 30 Days, Reported in the ATA in FY 2023-24

DMC-ODS	Readmission to WM within 30 Days of Discharge		Validated by CalEQRO
	# WM Discharges	% Readmissions	Yes/No
Alameda	1,096	10%	Yes
Contra Costa	898	9%	No

DMC-ODS	Readmission to WM within 30 Days of Discharge		Validated by CalEQRO
	# WM Discharges	% Readmissions	Yes/No
El Dorado	26	0%	No
Fresno	134	13%	Yes
Imperial	12	[redacted]	No
Kern	101	[redacted]	Yes
Los Angeles	4,578	8%	No
Marin	593	13%	Yes
Merced	Not Reported		
Monterey	236	[redacted]	No
Napa	180	17%	No
Nevada	106	[redacted]	No
Orange	968	6%	No
PHC	940	6%	No
Placer	53	0%	No
Riverside	1,222	5%	Yes
Sacramento	132	[redacted]	No
San Benito	Not Reported		
San Bernardino	459	3%	No
San Diego	2,063	9%	Yes
San Francisco	1,325	12%	No
San Joaquin	[redacted]	[redacted]	Yes
San Luis Obispo	0	N/A	Yes
San Mateo	473	19%	Yes
Santa Barbara	232	[redacted]	Yes
Santa Clara	322	7%	No
Santa Cruz	496	13%	Yes
Stanislaus	294	7%	No
Tulare	0	N/A	Yes
Ventura	372	[redacted]	Yes
Yolo	17	[redacted]	No

Table 5-9 (above) indicates that 29 Plans (94 percent) reported readmissions to WM, while two did not track this metric. Of the 29 reporting Plans, 28 were rated as Met and one as Partially Met. The two non-reporting Plans received a Not Met rating. Among the reporting Plans, 13 (45 percent) provided validated source material, while 16 (55 percent) either did not provide detailed information or submitted incomplete data.

Based on the 17,338 WM discharges reported by Plans for FY 2023-24, 8.23 percent resulted in readmission within 30 days, a 1.42 percentage point increase from FY 2022-23. This increase occurred alongside a 21.25 percent rise in total discharges, and the involvement of data from

two additional reporting Plans. Feedback from CalEQRO reviews highlights that member reluctance to engage in continued care, despite Plans' increased efforts, influences readmission rates. Successful reduction of readmissions often involves setting clear expectations for WM admissions, integrating residential or outpatient LOCs within programs, and employing system navigation and motivational interviewing techniques to enhance member engagement with treatment services.

Performance on WM readmissions, based upon approved claims analysis, is detailed in the Quality chapter of this report.

No-Show Tracking

The performance of DMC-ODSs in tracking no-show rates varied significantly. As shown in Table 5-10 below, findings for FY 2023-24 are consistent with previous review cycles (FYs 2021-22 and 2022-23), with eight Plans reporting no tracking of this metric.

Table 5-10: No-Shows, Reported in the ATA in FY 2023-24

DMC-ODS	Average Monthly No-Shows			Validated by CalEQRO
	Total Across Programs	Outpatient Services	NTP Services	Yes/No
Alameda	26%	9%	10%	Yes
Contra Costa	26%	27%	N/A	No
El Dorado	51%	41%	30%	No
Fresno	14%	10%	30%	Yes
Imperial	36%	38%	31%	No
Kern	55%	55%	21%	Yes
Los Angeles	Not Reported			
Marin	8%	12%	[redacted]	Yes
Merced	35%	35%	N/A	Yes
Monterey	48%	48%	0%	Yes
Napa	10%	10%	N/A	No
Nevada	14%	25%	8%	No
Orange	52%	55%	39%	Yes
PHC	16%	24%	1%	Yes
Placer	Not Reported			
Riverside	Not Reported			
Sacramento	Not Reported			
San Benito	28%	31%	0%	No
San Bernardino	Not Reported			
San Diego	38%	47%	20%	No
San Francisco	1%	0%	4%	Yes
San Joaquin	Not Reported			

DMC-ODS	Average Monthly No-Shows			Validated by CalEQRO
	Total Across Programs	Outpatient Services	NTP Services	Yes/No
San Luis Obispo	12%	11%	N/A	No
San Mateo	8%	Not Reported	8%	No
Santa Barbara	36%	20%	0%	Yes
Santa Clara	16%	19%	16%	No
Santa Cruz	2%	24%	[redacted]	No
Stanislaus	18%	16%	48%	No
Tulare	Not Reported			
Ventura	25%	24%	N/A	Yes
Yolo	Not Reported			

Of the 23 Plans reporting counts for this metric, 15 were rated as Met, 7 as Partially Met, and 1 as Not Met. Approaches to tracking no-shows varied; some Plans tracked initial service no-shows only, while others monitored all appointments. Additionally, some Plans tracked only outpatient no-shows, while others received NTP no-show data from contractors. Of the submitted materials, 11 Plans provided data that CalEQRO could validate, whereas 12 Plans either did not provide sufficient information or submitted incomplete data.

The 23 Plans reported a total of 33,368 no-show events in FY 2023-24, reflecting a 23.74 percent increase from FY 2022-23 (26,966 events). Despite this increase, the overall no-show rate across all programs decreased to 9.60 percent, a 1.32 percentage point reduction from the previous year's 10.92 percent. The average no-show rate for outpatient services dropped by 1.52 percentage points to 27.61 percent from 29.13 percent. Notably, no-show rates for NTP services saw a substantial decrease from 31.21 percent in FY 2022-23 to 14.97 percent in FY 2023-24, representing a reduction of over 52 percent.

Despite challenges and varying tracking methods among reporting Plans, there is evidence that efforts are being made to reduce no-show events and improve treatment engagement. However, data collection and assessment processes need significant improvement across all DMC-ODSs, including the eight Plans that have shown no progress since the previous review cycle. Given the reliance on non-county contracts, CalEQRO observed that no-show tracking often depends on individual treatment providers. An example of improvement is **Riverside**, which secured a grant for an artificial intelligence server to track and analyze no-show factors. Plans should foster data-driven environments with effective feedback loops to regularly review and use this information to drive improvements in the systems of care.

NETWORK ADEQUACY VALIDATION

CalEQRO attempted to validate the timeliness of the next visit that occurred after the initial outpatient and the initial MAT visit as submitted by Plans to DHCS in the 2023 TADT. The reporting period for both elements was July 1, 2022, to March 31, 2023. Due to deficiencies in initial Plan data submissions, DHCS ultimately did not use this data to assess DMC-ODS compliance with timely access standards. Instead, Plans were required to submit updated timely access reports in June 2024 for the period of April 1, 2023, to June 30, 2023. This updated data set was not available to CalEQRO for analysis in time for inclusion in this report. Consequently,

the report does not include Plan data validation for network adequacy as indicated by Protocol 4. Additionally, the timeliness data in this report is distinct from the data analyzed by DHCS for Plan compliance purposes

SUMMARY OF TIMELINESS

Most Plans reported on most timeliness metrics, though 48 percent of Plans did not report on at least one metric.

Table 5-11 displays the average wait (e.g., business days, hours) for each measure across the DMC-ODS Plans as reported in the ATA for FY 2023-24.

Table 5-11: DMC-ODS Summary Assessment of Timely Access, Reported in FY 2023-24

Timeliness Measure	Average/Rate	Standard	% Appointments Met Standard
First Non-Urgent Appointment Offered	5.20 Business Days	10 Business Days*	90%
First Non-Urgent Service Rendered	9.92 Business Days	10 Business Days**	58%
Non-Urgent MAT Request to First MAT NTP/OTP Appointment	2.10 Business Days	3 Business Days*	81%
Urgent Services Offered	47.10 Hours	48 hours**	75%
Follow-up Services Post-Residential Treatment	16.00 Days	7 Days	36%
WM Readmission Rates Within 30 Days	8.27%	N/A	N/A

* DHCS-defined timeliness standards per BHIN 23-041

** DMC-ODS-defined timeliness standards

*** The DHCS standard for urgent care is 48 hours if the service does not require pre-authorization and 96 hours for a service that requires pre-authorization. Plans did not track these services separately and reported all based upon a 48-hour standard.

In summary, 90 percent of initial non-urgent appointments reported met the 10 business-day standard, with an average offer time of 5.20 business days. However, the delivery of these services occurred 4.72 business days later, on average, than the initially offered service, with only 58 percent reported to have been provided within 10 business days. The first MAT service was typically offered in 2.10 business days, with 81 percent of appointments within the 3 business-day standard. These results are based on data from DMC-ODSs that reported these metrics, including Plans that did not submit source data to be used for validation.

Overall performance on timeliness is affected by incomplete and inconsistent reporting from DMC-ODS Plans, coupled with a lack of adequate data analytics staff and EHR tools for supporting data collection and analysis. Without comprehensive data sets and sufficient data analytic staffing, Plans cannot accurately assess how well their strategies facilitate timely access to care. Improvements in timeliness are likely due to the presence of robust data analytics, effective tracking mechanisms, and quality feedback loops that enable regular review and informed decision-making.

Due to incomplete reporting by some Plans, especially regarding urgent services and no-shows, and the lack of source data validation, generating comprehensive statewide perspectives is

challenging. Further, Plans in which contract providers deliver most services also face difficulties due to system interoperability issues. However, given the available data, it appears that the majority of Plans met the DHCS expectation of at least 80 percent of initial services meeting timeliness standards.

INTRODUCTION

CMS defines quality as the extent to which the PIHP increases the likelihood of desired member outcomes through its structure, operations, evidence-based services, and performance improvement interventions. The DMC-ODS operates on a quality of care framework that guides and holds entities jointly accountable for enhancing SUD care and outcomes.

Quality is the cornerstone of the EQR process, reflecting the DMC-ODS's ability to oversee the system using data and best practices to promote optimal outcomes. While Plans recognize QM and improvement as priorities, fulfilling this commitment often proves challenging. With a smaller and strained workforce, Plans have struggled to allocate staff to QM and QI issues as they are needed for service delivery. More specifically, some QM staff have been diverted from ongoing quality and compliance efforts to support CalAIM reforms and other initiatives.

This chapter outlines the structural elements and quality-related activities crucial for effective SUD treatment:

- Providing member-centered treatment across a continuum of care.
- Establishing care coordination and recovery support, treatment adhering to best practices and standards of equitable, culturally competent care.
- Building an infrastructure dedicated to continuous QI, with a focus on data and measurable outcomes management.

Various sources document changes related to quality care elements, including ASAM LOC referral data, TPS data, CalOMS results, Medi-Cal Claims, and stakeholder and member feedback. CalEQRO evaluates quality of care in a DMC-ODS Plan using these data sources along with program and member focus group interviews.

CalEQRO identifies eight essential components of SUD service quality that are crucial for achieving high-quality care and improving outcomes for members. Each subcomponent of the Quality Key Component includes specific criteria that together determine the overall Key Component rating: Met, Partially Met, or Not Met.

Table 6-1 outlines the eight Key Components and provides a summary of the rating results for the 31 Plans reviewed in FY 2023-24.[56]

[56] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

QUALITY KEY COMPONENTS

Table 6-1: Key Components: Summary of Oversight of Quality– Statewide FY 2023-24

KC #	Key Components – Quality	Met	Partially Met	Not Met
3A	Quality Assessment and Performance Improvement are Organizational Priorities	28	3	0
3B	Data is Used to Inform Management and Guide Decisions	24	7	0
3C	Communication from DMC-ODS Administration and Stakeholder Input and Involvement in System Planning and Implementation	16	14	1
3D	Evidence of an ASAM Continuum of Care	20	10	1
3E	MAT Services (both NTP and non-NTP) Exist to Enhance Wellness and Recovery	25	6	0
3F	ASAM Training and Fidelity to Core Principles are evident in Programs within the Continuum of Care	28	3	0
3G	Measures Clinical and/or Functional Outcomes of Members Served	25	5	1
3H	Utilizes Information from Member Perception of Care Surveys to Improve Care	17	11	3

In Table 6-2 the Plan-level results for each of the Quality Key Components are displayed.*

Table 6-2: Quality Key Components by Plan, FY 2023-24

DMC-ODS	3A	3B	3C	3D	3E	3F	3G	3H
Alameda	M	M	M	M	M	M	M	NM
Contra Costa	M	PM	PM	M	M	M	PM	M
El Dorado	M	PM	M	M	M	M	PM	M
Fresno	M	M	PM	M	PM	M	M	PM
Imperial	M	M	M	M	M	M	PM	PM
Kern	M	PM	M	M	M	M	PM	M
Los Angeles	M	M	PM	M	PM	M	M	M
Marin	M	M	PM	M	M	M	M	M
Merced	M	M	M	PM	PM	M	M	M
Monterey	M	PM	M	M	M	M	M	M
Napa	M	M	PM	PM	M	M	M	M
Nevada	M	PM	PM	M	M	M	M	PM
Orange	M	M	M	M	M	M	M	M
Partnership	M	M	PM	PM	M	PM	M	M
Placer	M	M	PM	PM	M	M	M	NM
Riverside	PM	PM	M	M	M	M	M	M
Sacramento	M	M	NM	NM	PM	M	NM	PM

DMC-ODS	3A	3B	3C	3D	3E	3F	3G	3H
San Benito	PM	PM	M	M	PM	M	M	NM
San Bernardino	M	M	PM	M	M	M	M	M
San Diego	M	M	PM	M	M	PM	M	M
San Francisco	M	M	PM	M	M	PM	M	M
San Joaquin	M	M	PM	PM	M	M	M	PM
San Luis Obispo	M	M	M	PM	M	M	PM	PM
San Mateo	M	M	M	M	M	M	M	M
Santa Barbara	M	M	M	PM	M	M	M	PM
Santa Clara	PM	M	PM	M	M	M	M	PM
Santa Cruz	M	M	M	PM	M	M	M	PM
Stanislaus	M	M	PM	M	M	M	M	M
Tulare	M	M	M	PM	PM	M	M	PM
Ventura	M	M	M	M	M	M	M	M
Yolo	M	M	M	PM	M	M	M	PM

*Note: M = Met, PM = Partially Met, NM = Not Met

Quality Key Component Summary of Findings

Quality Key Component 3A focuses on the QI efforts and achievements of DMC-ODS Plans in developing a systematic, organization-wide approach to monitoring and enhancing the quality of care. Overall, most reviewed Plans have well-defined QI structures with clear lines of responsibility and authority for their quality assurance and QI activities. QIC membership varied based on the inclusion of members and their families, as well as the consistency of other attendees' participation. With few exceptions, QAPI WPs were integrated MH/SUD Plans. WPs were updated annually, and most DMC-ODSs also conducted evaluations of their prior years' WPs, assessing whether goals were met or carried over to the following year.

In this review cycle, 28 Plans (90 percent) met the 3A objective, compared to 26 Plans (84 percent) that Met these criteria the previous year. Additionally, three Plans (10 percent) were rated as Partially Met for this item. This rating indicates these Plans either failed to link their WPs to improvement activities, did not monitor the impact of interventions, did not set improvement goals for clear problem areas, or lacked representative participation in QI activities from persons with lived experience.

Key Component 3B assesses how each DMC-ODS Plan collects, analyzes, and utilizes reliable and valid data to identify strengths and areas for improvement. Plans differed in the amount and depth of data and analytic resources they employed. As in the previous year, challenges have persisted, with 24 Plans (77 percent) fully meeting the data elements and 7 Plans (23 percent) rated as Partially Met for this component. However, this marked an improvement over the prior year, which saw 21 Plans (68 percent) rated as Met, 6 Plans (19 percent) rated as Partially Met, and 4 Plans (13 percent) rated as Not Met. The DMC-ODS Plans rated as Met for this Key Component had set benchmarks and quantitative goals for their quality initiatives and action plans.

Many DMC-ODS Plans faced data infrastructure challenges this year due to significant IT system changes, including payment reform and new EHR implementations, as well as delays in the rollout of the multi-county SmartCare system through California Mental Health Services Authority (CalMHSA). This was further complicated by challenges at the provider level, where

many legal entities lacked fully functional or compatible EHR systems and did not have access to the county's EHR. These issues are explored in greater detail in the Information Systems chapter of this report.

Key Component 3C addresses the effectiveness of bi-directional communication between DMC-ODS administration and stakeholder groups, particularly concerning system planning and quality of care. Most Plans facilitated information sharing and planning activities through QICs and in monthly meetings with providers. Of the 31 Plans, 16 (52 percent) fully Met this component this year, compared to 12 Plans (39 percent) the previous year. Partially Met indicates concerns raised by one or more significant stakeholder groups about communication and inclusion or issues with the effectiveness of essential communications. There were 14 Plans (45 percent) with Partially Met findings and only one rated as Not Met. COVID-19 concerns persisted through FY 2023-24, reducing the frequency of in-person meetings and events, as well as the relative ease that many staff have come to embrace. Plans used online video conferencing and expanded email and web communications, but many stakeholders and providers reported that these methods felt inadequate for the complexity of CalAIM planning. Most providers and stakeholders requested direct engagement in more comprehensive exchanges of ideas and concerns, particularly in areas that affect their processes and programs. Improving communications with providers and other stakeholders was recommended in 17 of the 31 Plans (55 percent) in this year's EQR reports.

Key Component 3D evaluates the evidence of a sufficient and well-functioning continuum of care based on the ASAM paradigm. There were 20 DMC-ODS Plans (65 percent) that Met this requirement, one more than in the previous year. However, 10 Plans (32 percent) were rated as Partially Met, and one Plan (3 percent) did not meet this component. This component issues with insufficient access at key LOCs, as evidenced by waiting periods for services or members declining necessary care due to the distance from their communities. Many Plans were actively working on expanding services to address identified needs for specific LOCs or to rectify deficits highlighted by NA findings. MAT expansion efforts were noted in most Plans, achieved through collaboration with NTPs, local primary care and hospital entities.

Some Plans also expanded prevention and services to at-risk populations to reduce overdose events. Some Plans do not have in-county residential WM or treatment facilities (or have inadequate local capacity) and rely on contracted out-of-county residential WM or residential treatment. As a result, many members declined the LOC deemed most appropriate by the ASAM screenings and assessments, resulting in unusually low utilization. Examples of this include San Benito, where adult male residential WM, residential, and all MAT are in other counties and have very low utilization despite higher overdose rates.[57]

Napa has a similar issue with methadone and lower utilization for the NTP out-of-county programs. Imperial, like San Benito, has very remote residential WM and treatment locations, and use by members is low despite screenings on ASAM. PHC has several counties with no residential that reported impacts on perinatal and other members refusing to be far from local family members. CalEQRO compares normal NTP levels for similar counties using PM data and investigates these low-use patterns in client and stakeholder groups to identify the reasons. Distance barriers are especially noted by members and staff related to MAT and residential LOCs when they are not in the county, particularly with transportation challenges. Access to sufficient youth services at all LOCs remained challenging, especially at residential LOCs. Most Plans were recruiting new providers, sometimes continuously, to address these needs, and 29

[57] California Department of Public Health. (n.d.) *California overdose surveillance dashboard.* https://skylab.cdph.ca.gov/ODdash/?tab=Home

identified workforce issues in stakeholder sessions. Plans also offered incentives to expand capacity in needed LOCs and add additional LOCs with existing providers. Notably, **Fresno** and **Stanislaus** more than doubled the number of youth they served in CY 2022 through their school and after-school programs.

Key Component 3E evaluates the availability of MAT services and the quality monitoring put in place. Twenty-five Plans (81 percent) met this component, while 6 Plans (19 percent) partially met it. There was evidence of increased access to MAT services for both methadone and non-methadone medications through new sites and expanded clinic hours. Additionally, several Plans increased their focus and efforts on MAT access for members with AUDs. This included additional hospital and clinic-based telehealth locations with kiosks for prescriber access, extended hours, and pharmacy delivery options. All Plans provide access to or facilitate the distribution of naloxone or Narcan to members, staff, their local communities. Several Plans have started integrating MAT services into MH and SUD outpatient clinics, while others have set these expansions as quality goals for FY 2023-24. Many expansions in MAT access sites and coordinated care were linked to FUA and POD PIPs, totaling 25 FUA and 18 POD. These efforts enhance coordination with EDs and MCP providers.

Key Component 3F outlines QM functions related to member experiences within the SUD continuum of care. Twenty-eight DMC-ODS Plans (90 percent) Met this requirement, up from 22 Plans (71 percent) the previous year, with a decrease in Plans that Partially Met the requirement from nine to three. The overall use of the ASAM Criteria for assessing member needs and determining appropriate LOC placement was improving, as evidenced by training events and staff interviews. Many Plans were preparing to update their ASAM tools to comply with the new DHCS documentation requirements outlined in BHIN 23-068.[58] With DHCS oversight of approved tools, ASAM screening and assessment will be standardized to better identify the most suitable treatment options for members. DMC-ODS Plans had systems for contract monitoring, with QI teams supporting clinical areas and improvement goals. Common focus areas included adherence to member-centered care principles, application of best practices, and implementation of CalAIM-related quality goals and requirements. Many Plans had DHCS CAPs and updates for measures that did not meet required or designated levels. Some Plans improved quality by introducing new measures or requirements for provider contracts or chose to cancel contract agreements when serious issues persisted.

Key Component 3G evaluates the DMC-ODS's capability to track and analyze data related to member outcomes and other key quality requirements. Twenty-five Plans (81 percent) met this requirement, up from 20 Plans (65 percent) in the previous review cycle. Additionally, five Plans (16 percent) partially met the requirement, a decrease from ten Plans (32 percent) the prior year. Only one DMC-ODS did not meet this requirement. Due to major data system changes during this review cycle, many Plans lacked current CalOMS and service utilization data and were working with vendors to resolve these issues. Most Plans conducted extensive training for core staff and providers related to data system changes. Data submissions were monitored, but full analysis was not always available. There was an increased focus on equitable access and quality for ethnic demographic groups, with Plans using this information to drive QI efforts and health equity. These limitations, plus workforce challenges, have made h system-level outcome data and analysis more challenging to implement. Additionally, there was an increased focus beyond submitting complete CalOMS data, with CalOMS being integrated into most of the newer EHRs from paper versions. Most Plans used CalOMS for quality efforts, but the IT

[58] https://www.dhcs.ca.gov/Documents/BHIN-23-068-Documentation-Requirements-for-SMH-DMC-and-DMC-ODS-Services.pdf

workforce faced significant challenges due to new EHR implementations and billing codes for payment reform. Using CalOMS for quality efforts has become more difficult since DHCS no longer provides the data through California's Information Technology Web Service (ITWS). Access to ITWS for on-demand CalOMS system reports was beneficial, as previously described. Further, Plans and providers frequently inquired about when CalOMS would be updated to align with ASAM and DMC-ODS LOCs.

Key Component 3H measures activities related to collecting, analyzing, and using TPS data for targeted improvements. Seventeen DMC-ODS Plans (55 percent) Met this requirement, down from 21 Plans (68 percent) in the previous review cycle. Evelen Plans (35 percent) received Partially Met ratings, compared to nine Plans (29 percent) the previous year, while three (10 percent) had a Not Met rating, up from one Plan (3 percent). Upon review of this trend, many Plans reported that payment reform and CalAIM data changes were their priorities, leaving them with inadequate staffing to focus on TPS utilization for improvements. Response rates varied across individual LOCs and among youth or non-English speakers. Most Plans reported lower online response rates compared to the prior year and decided to use both paper and online TPS forms for maximum participation. Some Plans demonstrated innovative approaches to improving quality care by using TPS data to drive system changes and sharing the data with providers. Several Plans, including **Los Angeles**, **San Diego**, **Contra Costa**, and **Riverside**, administered the TPS more frequently than annually and provided additional transportation and support to boost participation. The Member Perceptions of Care chapter covers the TPS in more detail.

QUALITY IMPROVEMENT INFRASTRUCTURE

Quality Improvement Monitoring and Activities

The contract between DHCS and the counties' DMC-ODS Plans requires the implementation of a comprehensive QAPI program that clearly defines its structure, assigns responsibility, adopts quantitative measures to assess performance, and identifies areas for improvement. The basic structure of the various DMC-ODS QAPI programs remained consistent with previous years. However, the level of integration and collaborative approaches to health improvements expanded significantly, now including MCP providers and detention medical services. Convenience, efficiency, and a general push toward integration have prompted Plans to develop BH QI programs organized under the leadership of both MH and DMC-ODS executives. Most Plans also monitored processes and goals through a combined QIC, a shared MH-SUD QAPI WP, and an annual evaluation of the QAPI WP. However, the DMC-ODS sometimes received less attention than the MHP.

Membership in QICs generally includes representatives from a diverse group of MHP and DMC-ODS stakeholders. These QICs typically include clinical leadership, analytic support staff, clinical and contract provider staff, members and families, and community partners. Engaging general community members and those with lived experience as QIC members were featured in 28 of the QAPI programs (90 percent). To ensure a more comprehensive approach and enhance focus on specialized areas like cultural competence and health equity, 29 Plans' QAPIs (94 percent) organized multiple teams or committees that report to the QIC, up from 26 Plans (84 percent) in the previous review.

QIC subcommittees have continued to broaden and diversify participation by inviting additional stakeholders, providers, and members, effectively increasing community input to the QIC. The standard practice is to hold meetings with subcommittees on a more frequent basis. During this review cycle, QIC meetings were held monthly for 15 Plans, every 2 months for 6 Plans, and

quarterly for 10 Plans. Attendance at QIC meetings varied, with more meetings held in person or in hybrid formats compared to prior years when COVID-19 outbreaks were more common. The increased in-person format was welcomed by participants, particularly providers and community members, who reported greater satisfaction with the enhanced interactive, two-way communication during these sessions.

Overall, improvements were being made with expanded QI programs, influenced by the EQR process and input, the experience of developing their own QAPI programs, and responses to CalAIM initiatives. The FY 2023-24 WPs were advancing toward a standardized QI process and structure, incorporating proactive tracking of key performance indicators and implementing actionable recommendations to improve clinical care and address associated challenges. The QAPI WP generally includes leadership, and 94 percent (29 out of 31) of QAPI programs include QI, compliance, and utilization management functions.

In the FY 2023-24 reviews, more Plans added medication monitoring or MAT committees with medical leadership participation. They also coordinated with public health leadership and MCP pharmacy committees on issues affecting service delivery. This expansion of committee membership and activities was supported by enhanced data and information sharing, ensuring that decisions about one area do not conflict with other interests and prioritize member needs.

QI goals were initially heavily weighted toward MH objectives during the formation of the integrated MH/SUD QAPI WPs. The SUD side of most WPs was limited, focusing primarily on essential compliance monitoring and required PIPs. EQR recommendations and TA have consistently urged Plans to expand their QAPI WPs beyond compliance, become more data-driven, and address identified clinical and operational QI issues. Reviews demonstrated an increase in goals and objectives that addressed specialty needs and best practices, as well as cultural competency and health equity – all also important to DHCS's CQS.

Monitoring compliance activities, such as timeliness requirements, also remained central to the goals and objectives of the QAPI WPs. Some Plans used advanced action language, including measurable thresholds that would trigger corrective actions from the QIC or providers under its guidance. During FY 2023-24 reviews, there was an increase in site-specific and LOC-specific timeliness monitoring, which enhanced intervention improvement strategies.

Throughout FY 2023-24, CalEQRO observed expanded use of data to drive actionable steps for care improvements by QI, along with the implementation of new dashboard tools for real-time monitoring of improvement strategies applied. For example, noting the decline in member access to SUD treatment locally during the COVID-19 pandemic, several Plans developed QI goals and objectives to increase PRs for underrepresented populations and meet pre-pandemic service levels. Over 74 percent of the reviewed WPs had clear, measurable goals and objectives. However, only a few QIC meeting records included descriptions of change-focused QI action steps when measurable goals were not being met. Too often, continued monitoring was the documented response to unmet goals during the year. It was noted, however, that these goals were updated in the annual QI work plan with new interventions and often refined goals.

Tools and processes for monitoring and taking action on QI goals varied depending on the focus area. Many Plans use PRs or national prevalence rates, which are often calculated using data from DHCS NA analysis or the methods shared by CalEQRO. Other tools used for QI include timeliness data, call center data, length of stay in treatment overall and at specific LOCs, and the percentage of members with opioid diagnoses on MAT or at least tried on some forms of MAT. TPS surveys in some Plans have been used more frequently than annually as a helpful tool, and some have targeted these frequent TPS events for programs with low ratings to work

on interventions. The approaches to intervention effectiveness involves comparisons to research literature, other counties, and consultations, particularly with CalEQRO for PIPs and DHCS for NA issues.

Some of the larger Plans with research-trained staff use federally generated National Survey on Drug Use and Health (NSDUH) data on prevalence.[59] They analyzed this data to focus on the Medi-Cal population and different age groups, such as young members. **Riverside**, for example, in the initial three years of the DMC-ODS implementation, focused on youth prevalence for the Medi-Cal population using NSDUH data; they set goals with interventions related to access, timeliness, and service capacity for youth throughout their large region. This resulted in adding two youth residential treatment programs of six beds, with one facility for girls and one for boys. Each year, the number of youth served increased. In addition, they added 12 MOUs with school districts for access on campus and after school, as well as MOUs with Juvenile Probation and Child Welfare. They created new referral and at-risk systems to increase referrals, and drop-in centers with art and cultural activities for TAY youth with BH needs. These enhanced access strategies were typical across many Plans, though few used NSDUH data due to its complexity and analytic staffing.

Orange, in alignment with CalAIM policies, established a comprehensive "No Wrong Door" policy with measurable goals and tracking of improvements in initiation and engagement. This was enhanced by a reorganization that added more SUD clinical and program expertise to the QIC, the QAPI WP, and the SUD continuum of programs.

Fresno has developed a QAPI WP and evaluation with National Committee for Quality Assurance (NCQA) standards in mind. It includes trended performance metrics, barriers to change, recommended interventions, an outline of intervention activities and measurable objectives, and an evaluation of results. The format is clear and concise, aligning well with Lean Six Sigma management principles.[60]

San Francisco QAPI WP set goals with strategies and monitoring of overdose rates for opioid disorders. With extensive community prevention efforts, including Narcan distribution and mobile crisis teams responding to SUD events, they were able to reduce the rate from the prior year. These mobile teams also assisted with overdose reversals.

Ventura developed goals and objectives for its data-driven decision-making initiative, aligning with the QAPI WP. This initiative included developing key outcomes and reporting related to Ventura Plan Behavioral Health's Five-Year Strategic Plan.[61] The WP included measurable outcomes and continuous improvements to their BH public-facing dashboard.[62]

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[59] Substance Abuse and Mental Health Services Administration. (January 5, 2024). *National survey on drug use and health (NSDUH).* https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

[60] American Society for Quality. (2024). *What is six sigma?* https://asq.org/quality-resources/six-sigma

[61] Ventura County Behavioral Health. (August 2021). *2021-2026 Strategic Plan.* https://assets-global.website-files.com/62e9972ac69f44f2d5f7aa52/64d45efa441f42eaddd0ef35_Ventura_County_Behavioral_Health_2021-2026_Strategic_Plan.pdf

[62] Conduent Healthy Communities Institute. (2024). *Community health dashboards.* Health matters in Ventura County. https://www.healthmattersinvc.org/indicators

Information Systems and Data Analytic Tools

DMC-ODS Plans depend on various quality-linked managed care functions that require IS staff and data analytic support, including providing and coordinating clinical care, and processing and transmitting claims and invoices. To ensure accountability for the quality of these functions, Plans must monitor data collection, storage, reporting, and analysis, and implement changes when improvement is needed. Many Plans lack sufficient staff with the subject matter and technical expertise needed to extract data and conduct analyses from EHRs and provider networks. This level of staffing is crucial for effective QM and ensures the capacity to extract and monitor key metrics endorsed by the National Quality Forum (NQF), NCQA, SAMHSA, ASAM, and/or the Veterans Administration. Such capacity also enables the extraction and review of new measures linked to latest scientific advancements in the field, which can be used to promote and enhance treatment experiences and outcomes for Plan members. Refer to the Information Systems chapter for more details on these data-related efforts.

Two QI-related trends observed in Plans are expected to enhance their QM capacity. One positive trend was the increase in Plans joining health information exchanges (HIEs) to enhance data exchange and care coordination. Successful data sharing is a central goal running across care coordination and all interactions between patients, providers, and payers. Another significant improvement in QI was the adoption of data visualization software, enhances the sharing of key information with a wide range of audiences, including clinical staff, Plan members, advisory boards, and other stakeholders.

Several Plans demonstrated effective QI work due to their robust IT infrastructure and specialized staffing:

Los Angeles, with its strong research and analytics capacity, utilized a Treatment Effectiveness Assessment (TEA) both at admission and discharge to evaluate treatment outcomes. In addition to CalOMS, TPS, and ASAM Continuum software for assessments, Los Angeles implemented the TEA as a QI tool. The TEA tool is utilized to gauge recovery progress from the members' perspective at the time of discharge. The FY 2022-23 evaluation indicated improved functioning compared to members' status at the beginning of treatment. Results indicated that 32 percent of members reported improvements in personal responsibility, such as paying bills and following through on commitments. Additionally, 38 percent reported experienced better management of drug and alcohol use, including reduced frequency, lower spending, and improved handling of cravings. Improvements in physical health were reported by 32 percent of members, encompassing better sleep, eating habits, and dental care. Likewise, 32 percent experienced enhanced MH, feeling more positive about themselves. Lastly, 31 percent of members felt they had become better community members, showing improved law-abiding behavior, responsibility, and positive impacts on others.

PHC expanded QI activities and analytics related to members' health and BH profiles, tracking utilization across the service array, from acute care to care coordination across the MHP, DMC-ODS, and physical healthcare. Based on profiles widely shared with clinical and program leadership, goals and initiatives were developed to improve wellness and address barriers to treatment for members facing multiple health challenges.

PERSON-CENTERED TREATMENT CONTINUUM

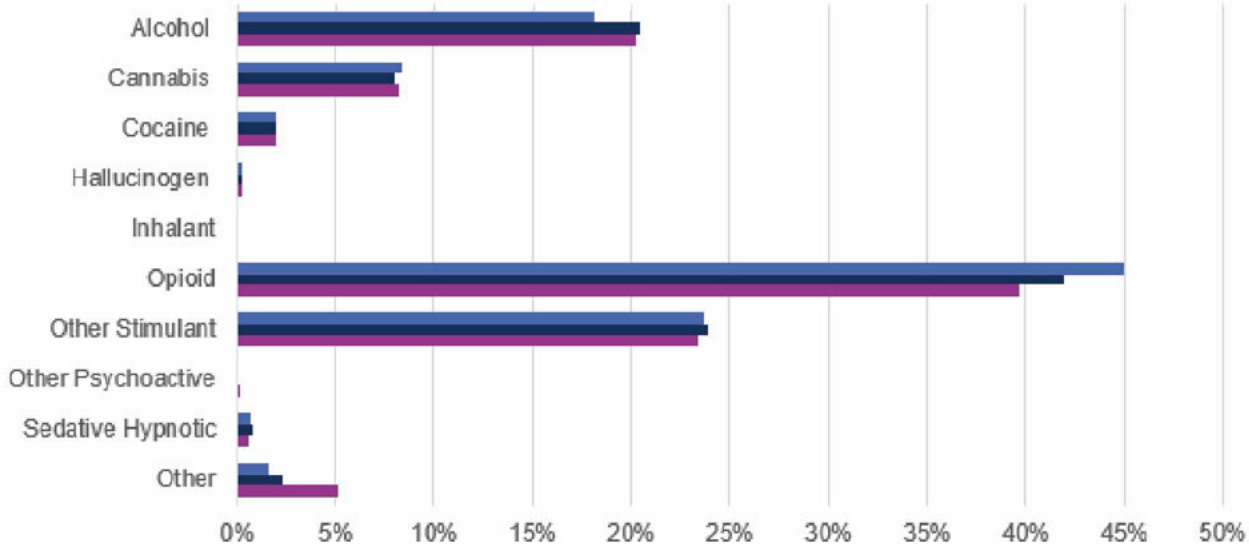
Diagnosis and Drug Use Trends

Developing a diagnosis, including levels of functioning and other psychosocial factors, is fundamental to delivering appropriate treatment. While not required under CalAIM for a claim submission, developing a diagnosis early in care helps to focus treatment goals effectively. Additionally, DMC-ODS policymakers, service planners, practitioners, and others working in the BH system need information that documents changes in drug use within the community and among the members served.

Figure 6-1 displays the percentage of DMC-ODS members within each diagnostic category in comparison to statewide figures. Each year, the total of all diagnostic categories sums up to 100 percent, representing the full spectrum of diagnoses associated with members' claims. A member may be represented in multiple diagnostic categories but will only be counted once within each category.

The diagnostic groupings are outlined in Appendix 1. It should be noted that all diagnosis data represented presents only the primary SUD diagnosis reported and does not include secondary or tertiary diagnoses. For example, members with a primary diagnosis of "other stimulant" (typically methamphetamine) may also have a secondary addiction to opioids, which is not reflected in what appears to be the declining prevalence of OUD seen in the figures below.

Figure 6-1: Statewide Members Served by Diagnoses, CY 2020-22



	Other	Sedative Hypnotic	Other Psychoactive	Other Stimulant	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
CY 2020	1.57%	0.68%	0.14%	23.66%	44.98%	0.05%	0.28%	2.03%	8.43%	18.17%
CY 2021	2.34%	0.81%	0.06%	23.93%	41.95%	0.07%	0.30%	2.05%	7.98%	20.50%
CY 2022	5.21%	0.65%	0.17%	23.38%	39.76%	0.08%	0.32%	1.98%	8.16%	20.29%

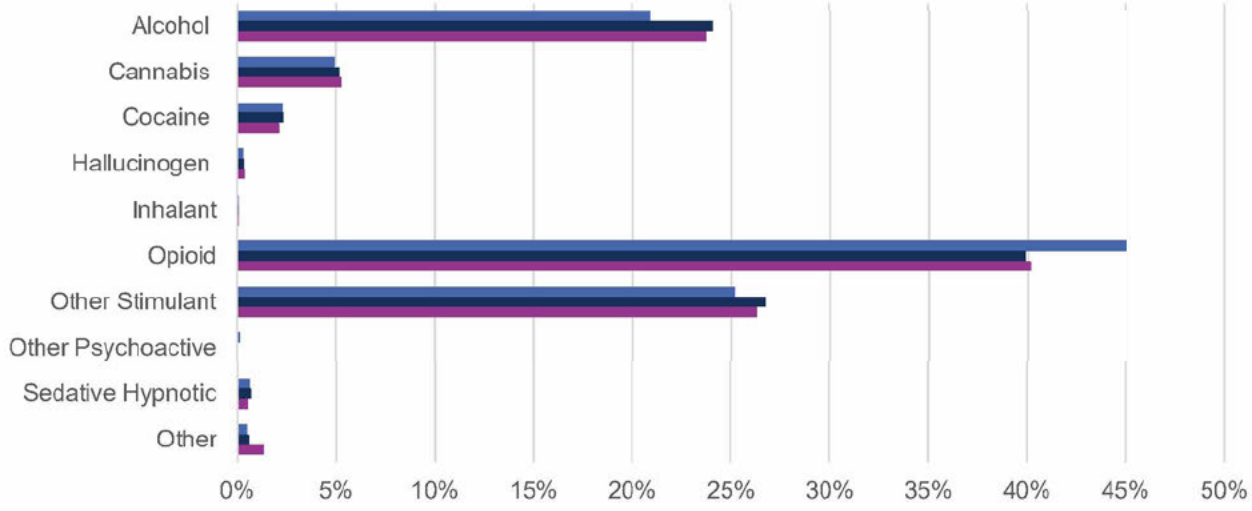
Figure 6-1 reflects statewide diagnoses, showing that among members served by the DMC-ODS systems, the most prevalent primary SUD diagnoses for CY 2022 were opioids (39.76 percent), other stimulants including methamphetamine (23.38 percent), and alcohol (20.29 percent).

The diagnostic categories with the greatest shifts over the past three CYs are opioid, which has decreased, and the "Other" category, which has increased. The "Other" category encompasses a variety of less frequently seen diagnoses, including Z codes and MH conditions. Alcohol also increased between CY 2020 and CY 2021, remaining relatively stable in CY 2022.

The decrease in the proportion of members with opioid-related diagnoses, reflecting an 11.7 percent drop over the displayed period, correlates with the previously noted reductions in the utilization of NTP/OTP services, as discussed in the Access chapter. The relative decline in OUD diagnoses does not fully reflect the severity of the opioid crisis, including the growing impact of fentanyl and other opioid-related overdoses impacting individuals, families, and communities. It also does not reflect any OUD diagnoses reflected as a secondary or tertiary diagnosis.

Figure 6-2 shows the relative proportions of claims associated with the DMC-ODS diagnostic categories, where each year adds to 100 percent.

Figure 6-2: Statewide Approved Claims by Diagnoses, CY 2020-22



	Other	Sedative Hypnotic	Other Psychoactive	Other Stimulant	Opioid	Inhalant	Hallucinogen	Cocaine	Cannabis	Alcohol
CY 2020	0.51%	0.68%	0.14%	25.17%	44.99%	0.07%	0.29%	2.30%	4.93%	20.92%
CY 2021	0.62%	0.73%	0.04%	26.73%	39.89%	0.09%	0.34%	2.32%	5.16%	24.08%
CY 2022	1.35%	0.58%	0.06%	26.30%	40.17%	0.08%	0.36%	2.11%	5.28%	23.71%

Expenditures by diagnostic category largely correspond to the diagnostic patterns of members shown in Figure 6-1.

The decrease in opioid claims corresponds to the relative decrease in members with OUD shown in Figure 6-1. Cannabis diagnoses utilize comparatively fewer financial resources, with 8.16 percent of members and 5.28 percent of claims.

Well-Coordinated Clinical Continuum of Care

Member-centered care is a priority for the CQS and essential to SUD treatment; it emphasizes respect for and responsiveness to individual preferences and values. Members are treated as equal partners in planning, developing, and monitoring their health care, ensuring it aligns with their preferences and needs. This approach acknowledges that an individual's needs evolve throughout treatment, necessitating adjustments in LOC and treatment strategies to match their progress. Individualized, member-centered care also recognizes that members may require multiple services simultaneously, necessitating effective referrals, linkage to additional services, and coordinated care. Modeled after the ASAM Criteria for SUD treatment services, the DMC-ODS continuum of care adopts a member-centered approach, incorporating quality measures and utilization monitoring to ensure effective and responsive care. These measures are designed to continuously improve quality, support the efficient use of resources, utilize EBPs, and provide timely access to services.

The DMC-ODS continuum encompasses five ASAM-designated LOCs. These include Level 0.5 Early Intervention, Level 1 Outpatient, Level 2 Intensive Outpatient – which comprises Levels 2.1 Intensive Outpatient and 2.5 Partial Hospitalization – Level 3 Residential/Inpatient, covering Levels 3.1, 3.3, and 3.5 for clinically managed residential and Level 3.7 for medically managed inpatient, and Level 4 medically managed, intensive inpatient. The DMC-ODS continuum of care also incorporates outpatient MAT, including both NTP/OTP services, as well as outpatient non-methadone MAT services. Additionally, it features five levels of WM. The LOCs differ in their intensity and the types of interventions provided, each tailored to address a specific range of clinical needs and symptom severity. The Fourth Edition of the ASAM Criteria introduced some refinements to the LOCs.[63]

Member needs are assessed and rated on an acuity scale using the latest ASAM Criteria, which includes six-dimensions. A best-fit LOC placement is made based on the six-dimension assessment results, while also considering member preferences.[64] The use of the ASAM Criteria and LOC placement, combined with a member-centered approach, has demonstrated increased member satisfaction, improved treatment retention, and greater utilization of new LOC.[65] True to its member-centered philosophy, DMC-ODS services are designed to include a flexible system that allows members with an SUD initially engage in the LOCs most suitable to their needs and, when appropriate or necessary, to transition smoothly up or down in treatment intensity. Additionally, this allows members, if indicated, to overlap treatments, such as residential treatment and NTP MAT services.

LOCs and transitions between them have been impacted by workforce shortages, particularly in licensed practitioner and certified counselor positions, which continue to be a major challenge for DMC-ODS Plans. In the FY 2023-24 report, specific recommendations were made for 22 Plans (71 percent) based on evidence of workforce issues. The challenges in maintaining or retaining staff are influenced by local factors such as the high cost of living and difficulty obtaining housing. These issues have been further exacerbated by post-COVID-19 reluctance

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[63] American Society of Addiction Medicine. (2024). *About the ASAM criteria.* https://www.asam.org/asam-criteria/about-the-asam-criteria

[64] Ibid.

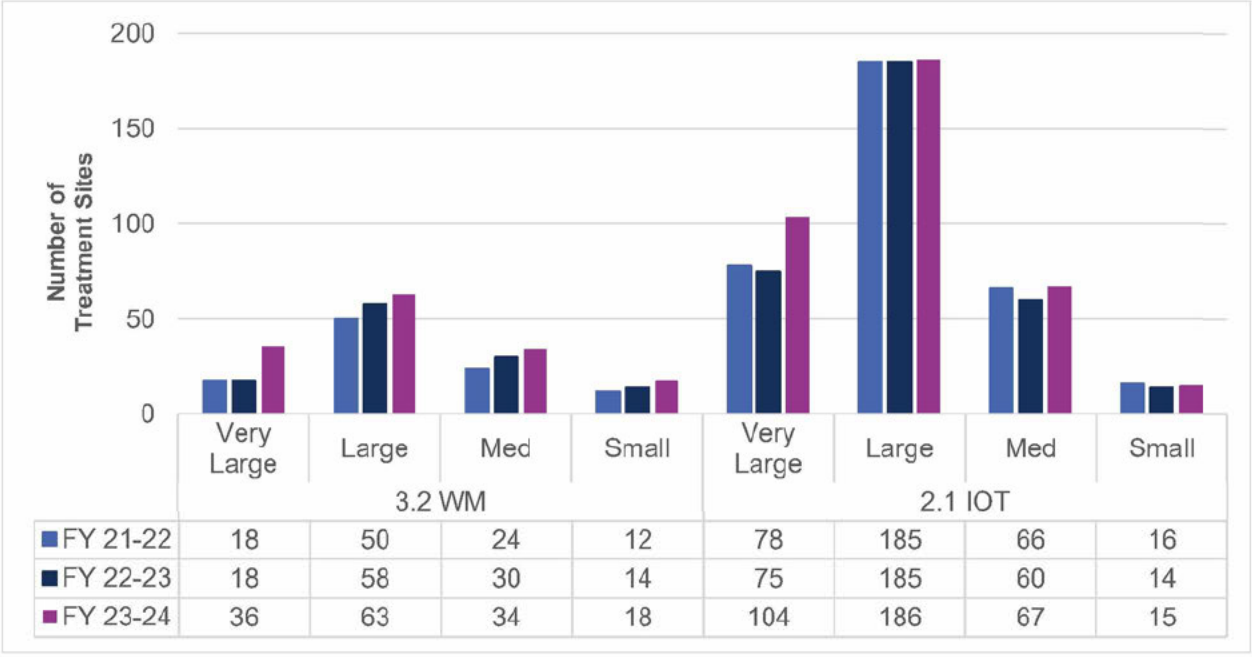
[65] Deck, D., Gabriel, R., Knudsen, J., & Grams, G. (2003). Impact of patient placement criteria on substance abuse treatment under the Oregon Health Plan. *Journal of Addictive Diseases, 22*(Supplement 1), 27-44. https://doi.org/10.1300/j069v22s01_03

among some individuals to return to full-time, on-site employment. Counties that offered higher wages, flexible work schedules, and more comprehensive benefits than contract providers have generally been more successful in recruiting and retaining qualified staff. This is a challenge for DMC-ODS systems that primarily deliver services through contract providers. Staff at community-based agencies often face the need to commute from more affordable housing areas and frequently leave contract providers for positions in neighboring counties' DMC-ODS or the private sector, where salaries are higher and telework is dominant. Contract providers often, however, provide degrees of flexibility that few counties offer, and many staff are retained in contract agencies for this reason.

Although the more restrictive COVID-19 requirements were lifted during FY 2023-24, Plans reported that challenges similar to those of the previous 2 pandemic years persisted, though to a lesser degree. Challenges included maintaining fiscally productive census levels in some LOCs and dealing with severe, and at times catastrophic, workforce shortages due to outbreaks across the DMC-ODS care system and its administrative supports.

Figure 6-3 below illustrates a 3-year comparison of the numbers of WM (Level 3.2) and IOT (Level 2.1) treatment sites by county size. The treatment sites counted include both county-operated and contract provider sites, as reported in the annual EQR Continuum of Care form. The total number of treatment sites serves as a broad measure of service capacity and indicates a Plan's ability to maintain or expand its LOCs as needed.

Figure 6-3: LOC Comparison – Levels 3.2 and 2.1 Number of Treatment Sites, FY 2021-24



	3.2 WM				2.1 IOT			
	Very Large	Large	Med	Small	Very Large	Large	Med	Small
FY 21-22	18	50	24	12	78	185	66	16
FY 22-23	18	58	30	14	75	185	60	14
FY 23-24	36	63	34	18	104	186	67	15

Residential WM Level 3.2 Sites

Residential WM has increased for each of the three FYs as Plans attempt to meet the demand for this urgent service. Los Angeles doubled its sites and had more WM than all medium Plans together, and over half the number in all of the large Plans together.

In FY 2023-24, the number of Level 3.2 WM sites increased modestly across all sizes of Plans. Residential programs exhibited some fluctuation in numbers among small Plans, an increase in

Level 3.5 residential services among medium-sized Plans, and an increase in Level 3.1 residential services in large Plans.

The increase in Level 3.2 WM was a positive development, addressing consistent concerns from the previous years' member focus groups and feedback from care coordination staff regarding the need for prompt access to WM services. In most Plans, members in active withdrawal seeking care are categorized as urgent requests. **Los Angeles** experienced the most significant expansion in Level 3.2 WM sites, having doubled from last year to this year. **San Bernardino** also expanded its Level 3.2 WM sites, increasing from four to seven in FY 2023-24.

In the small and medium-sized Plans, **Napa** increased its Level 3.2 WM sites from one to four in FY 2023-24. **PHC** increased its Level 3.2 WM sites from five to six, and **Nevada** increased its sites from four to five during the same period. San Benito increased its Level 3.2 WM sites from one to three. Merced and Tulare reported having no Level 3.2 WM sites in their networks for the past two FYs.

Intensive Outpatient Treatment Level 2.1 Sites

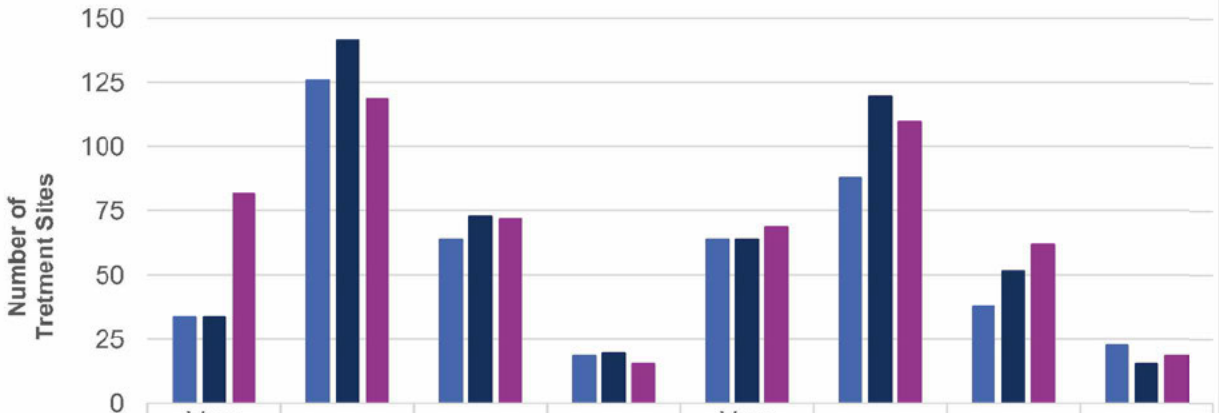
The number of IOT Level 2.1 sites increased in Los Angeles by 38.7 percent and in medium Plans, while there was no change in small Plans.

The number of IOT treatment sites has been fairly stable except for significant growth in Los Angeles, expanding by 38.7 percent this year compared to last year. For medium Plans, after a drop in FY 2022-23 due to program closures, the number of IOT sites were restored. There was a modest change in the small Plans, increasing from 14 to 15, but still not as high as the 16 sites reported in FY 2021-22.

IOT Level 2.1 census numbers were particularly impacted by COVID-19 in 2020 and 2021. Members reported difficulty attending the 3-hour Level 2.1 virtual sessions. Plans worked to increase participation in IOT as COVID-19 infections decreased, but some programs had a hard time building their caseloads again. Additionally, many programs reported greater success retaining members in care when IOT is linked to recovery housing options that support treatment goals and skills building.

Figure 6-4 below illustrates a 3-year comparison of the numbers of residential treatment sites for Levels 3.1 and 3.5 by county size. The treatment sites counted include both county-operated and contract provider sites, as reported in the annual EQR Continuum of Care form.

Figure 6-4: LOC Comparison – Levels 3.1 and 3.5 Number of Treatment Sites, FY 2021-24



	3.1 Res				3.5 Res			
	Very Large	Large	Med	Small	Very Large	Large	Med	Small
FY 21-22	34	126	64	19	64	88	38	23
FY 22-23	34	142	73	20	64	120	52	16
FY 23-24	82	119	72	16	69	110	62	19

Residential Treatment Level 3.1 Sites

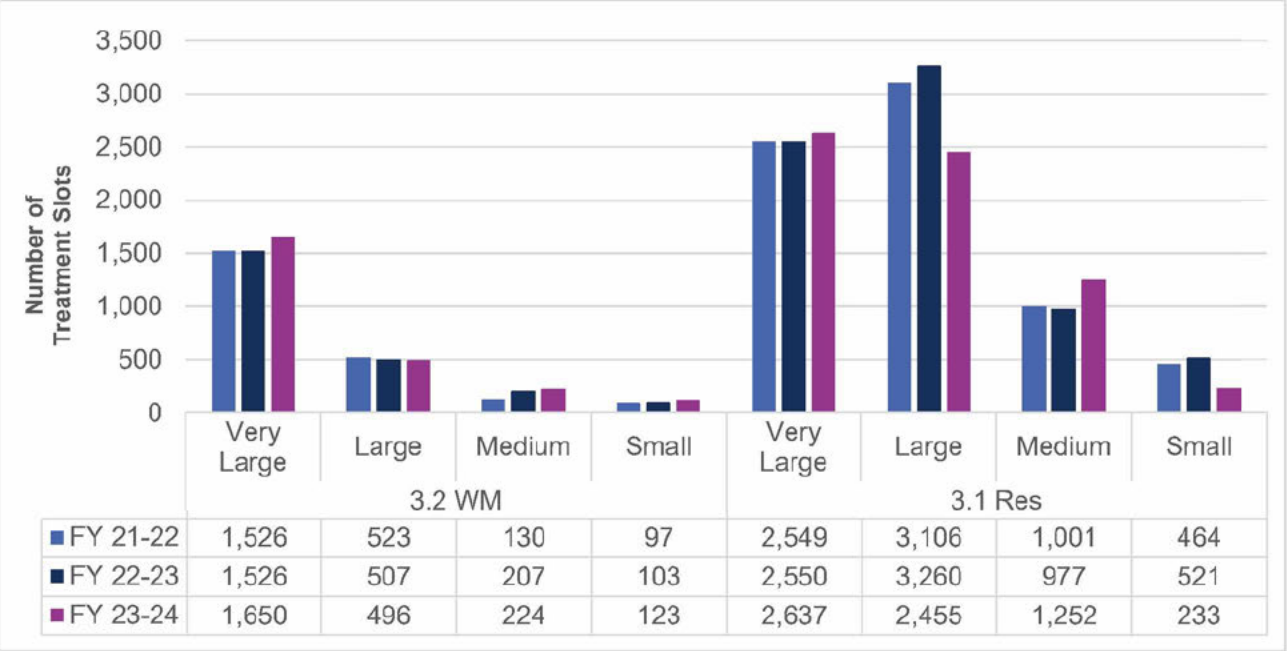
For residential treatment Levels 3.1 and 3.5, large Plans showed a decrease in treatment sites while Los Angeles showed a 41.2 percent increase in Level 3.1 and a modest five additional sites representing a 7.8 percent increase in Level 3.5. Large Plans experienced a reduction in both levels of residential care, with a total of 33 fewer sites. Small Plans showed a decrease in residential 3.1 but a commensurate increase in Level 3.5. Medium Plans had one fewer Level 3.1 but an increase of ten Level 3.5 program sites.

Some of the new Level 3.1 sites were designated to handle multiple LOCs, allowing them to adjust bed availability as needed to meet members' treatment requirements. Thus, there were both new sites and existing sites with shifting designations for bed usage. Similarly, some existing Level 3.1 residential sites added Level 3.3 services, nearly doubling the number of Level 3.3 sites in DMC-ODS Plans. Thus, the increase in certified sites does not necessarily reflect a commensurate increase in the number of available beds. Plans have adjusted their capacity based on evolving demands for access in various county areas and for specific populations, such as perinatal members and non-English speakers.

Many Plans set specific goals for expanding residential treatment to address timely access issues, meet the specialized needs of perinatal populations and members with co-occurring conditions, and provide culturally focused treatment, especially for non-English-speaking members. Additionally, some Plans had no residential access within the county or nearby, often creating barriers for members due to the distance they needed to travel to receive these services.

While the two prior figures displayed the number of program sites, Figure 6-5 below displays the change in treatment capacity, measured by the number of treatment beds within Level 3.2 WM and Level 3.1 residential programs, as reported by the Plans.

Figure 6-5: Residential Treatment Bed Capacity, FY 2021-24



	3.2 WM				3.1 Res			
	Very Large	Large	Medium	Small	Very Large	Large	Medium	Small
FY 21-22	1,526	523	130	97	2,549	3,106	1,001	464
FY 22-23	1,526	507	207	103	2,550	3,260	977	521
FY 23-24	1,650	496	224	123	2,637	2,455	1,252	233

Residential WM Level 3.2 Client Capacity

As shown earlier, the number of residential WM Level 3.2 slots increased across all Plan sizes. However, there was a less significant impact on the number of available beds. Los Angeles added 124 beds, an 8.1 percent increase. Despite five more program sites, large Plans experienced a decrease in capacity by 11 beds. Medium and small Plans increased by 17 and 20 beds, respectively.

The combined **PHC** Plan, represented in the medium Plans, increased its Level 3.2 WM capacity from 8 available beds in CY 2021 to 44 beds in CY 2022, and then to 80 beds in CY 2023. In the medium-sized and small Plans, there were modest increases in beds for services. Clinically managed Level 3.2 WM serves as a crucial entry point or return to treatment for members experiencing moderate to severe SUD withdrawal. It is also frequently used for members who have relapsed and require stabilization to continue their treatment. It remains a critical treatment for urgent services and deserves every opportunity to expand, especially in Plans lacking local WM residential capacity, which often leads to member refusals to enter treatment. Similarly, feedback from members and provider staff during EQR sessions indicated that a lack of WM residential options often results in the de-facto detoxification of members admitted to residential treatment. It should be noted that the number of WM beds can accommodate multiple members over the course of a month, as Plans reported an overall average LOS of 5.5 to 8.0 days in Level 3.2 WM sites and beds.

Several Plans – Merced, San Luis Obispo, Tulare, and Imperial – rely on hospital or out-of-county residential providers for Level 3.2 WM services. San Luis Obispo and Imperial also rely on out-of-county providers for their Level 3 residential treatment services. Reliance on out-of-county providers may be due to the proximity of major population centers in adjacent Plans, which can make local deployment of the same services economically unfeasible. In other Plans, the lack of local treatment options leads to underutilization of certain LOCs, as members may be unwilling to travel outside their communities to access care.

Local options for youth residential treatment at all LOCs were extremely limited statewide for DMC-ODS Plans. Due to the shortage of youth-specific residential treatment providers, nearly all DMC-ODS Plans contract with the Tarzana Treatment Center in Los Angeles to provide WM and Level 3 residential treatment for their youth members. Many Plans, members, and families expressed a need for these services to be closer and more accessible for assessment, consultation, and urgent treatment. Some Plans are entering into special contracts with co-occurring MH/SUD residential facilities. However, these facilities are not certified for DMC-ODS claiming and are limited in number.

Youth DMC-ODS services are enhanced by claim-eligible Level 0.5 Early Intervention Treatment and the resumption of school-based services as schools transitioned back to in-person learning. Many Plans have not yet provided Level 0.5 services to youth, but others have resumed school-based prevention services connected to community treatment, aiming to incorporate early intervention treatment. **Fresno**, **Stanislaus**, and **Imperial** each more than doubled the number of youth members served in FY 2023-24 compared to the previous year. Fourteen Plans reported a youth PR below the statewide rate of 0.25 percent, and four Plans served ten or fewer youth members. **Santa Clara** increased PRs for youth by having programs at ten schools and conducting special outreach and through engagement activities with Asian/Pacific Islander and Latino youth. Santa Clara also established a hospital pediatric unit for youth needing WM from fentanyl and other drugs and integrated aftercare with both MH and DMC-ODS services.

Residential Treatment Level 3.1 Client Capacity

Despite some fairly significant increases in the number of treatment sites, the number of available beds was not significantly improved, and there was a net decrease across the state. Increases were seen with 124 (8.1 percent) more slots in Los Angeles and 275 (28.1 percent) more slots in medium Plans. However, large Plans, with reportedly 23 fewer sites, showed a significant decrease of 805 slots (24.7 percent) and small Plans showed a decrease of 288 beds (55.3 percent). Statewide there was a net loss of 694 residential Level 3.1 beds per Plans.

Care Coordination

Case management, now referred to as care coordination, is a required service in all DMC-ODS Plans. Approaches to care coordination service delivery vary among Plans. The most basic and common approach is a decentralized model, where each SUD provider is responsible for delivering coordination services to members under their care. This approach is present in every DMC-ODS Plan and is a billable care component across all DMC-ODS LOCs. Having counselors provide care coordination for their program members is critical due to the fragmentation that can occur as members transition across various LOCs. However, as members transition between treatment settings to a different LOC, their care coordination plan, and the specific nuances developed may not always be carried over to their new treatment setting. Such transitions have been reported to contribute to issues with Medi-Cal, such as changes in benefits or enrollment, which can take up to 90 days to resolve.

Plan leadership reported that many SUD counselors in provider programs are not always trained to effectively provide care coordination, particularly when it involves field-based follow-up assistance. Some Plans have begun training case management skills based on the MH Assertive Community Treatment model. This was highlighted as a goal by executive managers in BHPs to achieve flexible, field-based care coordination, particularly for members with complex, multiple disorders. Some have also expanded coordination efforts by partnering with enhanced care management providers and local MCPs.

Most Plans achieved greater success in engagement and retention in treatment by employing a combination of centralized case management staff or community teams for care coordination, alongside the efforts of decentralized, agency-bound counselors. Some of these centralized teams focus on specific member populations, such as those identified by demographics, language, common access needs, or special challenges, including transitions from incarceration to treatment, or from hospitals after childbirth. The continuum of care data provided by each Plan enables CalEQRO to document these care coordination models, and members often emphasize the importance of these services for achieving their goals and supporting their recovery.

San Mateo DMC-ODS's integrated MAT team includes care coordinators embedded in the ED to assist with managing psychiatric and SUD services referrals and to connect members with community providers for MAT initiation and management, as well as housing, and co-occurring needs. Other Plans, such as **San Benito** and **Orange**, have found that assigning a care coordinator to members at intake and maintaining that relationship throughout the care continuum offers the most structured and scalable approach to chronic care management. **Riverside** and **Los Angeles** have established wellness centers on healthcare campuses, facilitating easy coordination and access to care. Both have enhanced care coordination models connected to community sites, treatment sites, and mobile teams.

The expansion of care coordination has been emphasized in some Plans' PIPs and other objectives effectively link members to essential support services and their initial face-to-face appointments. In FY 2023-24, care coordination was a key intervention in both FUA and POD PIPs, focusing on improving transitions in care and follow-up treatment after ED visits. This approach was integral to 25 FUA PIPs and 18 POD PIPs. Additionally, the CQS strongly advocated for enhanced care coordination, communication across health sectors, and data exchange to improve care quality and outcomes.

MAT Treatment

Plans continue to face a public health crisis within their communities due to ongoing patterns of opioid misuse, overdoses, and fatalities. The California Department of Public Health monitors overdoses and provides this information through its California Overdose Surveillance Dashboard.[66] The number of overdose deaths in California rose from 5,502 in CY 2020 to 7,385 in CY 2022.[67] Fentanyl-related overdose deaths in California have skyrocketed from 239 in CY 2016 to 6,095 in CY 2022, marking a more than 25-fold increase in 6 years. Overdose death rates were higher among males than females, with Native American/Alaska Natives and Black/African Americans experiencing the highest rates. In CY 2021, Native Americans had an overdose death rate of 59.33 per 100,000, which increased to 60.60 per 100,000 in CY 2022. The dashboard shows that the overdose death rate among African Americans remained relatively stable at around 36 deaths per 100,000, while the rate among the White population decreased to approximately 25 deaths per 100,000.

Although other drugs are still involved in overdose fatalities, the vast majority of these deaths were due to fentanyl and other opioids, underscoring the critical need for rapid access to treatment services.[68] Medications used to treat OUDs include methadone, buprenorphine,

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[66] California Department of Public Health. (n.d.) *California overdose surveillance dashboard.* https://skylab.cdph.ca.gov/ODdash/?tab=Home

[67] Ibid.

[68] Ibid.

buprenorphine extended release, and naltrexone. MAT medications for AUD include naltrexone, disulfiram, naltrexone extended release, and acamprosate. Treatment plans for OUD and AUD should be patient-specific and developed collaboratively with input from the patient, the prescriber, and other health care team members, consistent with the approach used for other chronic diseases.[69]

MAT is a key evidence-based practice that requires further development for treating opioid and alcohol use disorders. The significance of these services has been a key- priority for DHCS and DMC-ODS Plans. DHCS supports various opioid response projects to improve access and quality, with many Plans and their providers participating.[70] In addition to the significant rise in opioid overdose events and deaths, AUD and related fatalities also increased during the COVID-19 pandemic. The number of deaths involving alcohol increased nationwide from 78,927 in CY 2019 to 99,017 in CY 2020.[71] California had 1,069 deaths from alcohol poisoning in 2023, the second-highest state in the nation, and was 14th of the 50 states with 9.9 deaths per million, according to the National Center for Drug Abuse Statistics.[72] Thus, it is crucial to capitalize on opportunities for effective AUD treatment through MAT and counseling, as well as efforts on opioid use disorders.

EQR reviews indicated that Plans have made efforts to expand MAT sites, increase program capacity, extend hours of operation, and enhance prescriber skills. During the year, many Plans explored mobile methadone treatment options in conjunction with DHCS pilot opportunities. There was also evidence of MAT being implemented in more detention settings, often accompanied by SUD counseling, and was integrated with CalAIM re-entry protocols to ensure follow-up upon release. Additionally, several Plans have made significant progress by collaborating with local jail facilities, Sheriff Departments' and medical providers to continue MAT for individuals and identify new candidates for initiation within inmate facilities. Many DMC-ODS Plans have maintained coordination of member access to MAT by expanding partnerships with FQHC primary care clinics.

As the opioid epidemic evolves, prioritizing the expansion and strengthening of MAT services throughout the entire healthcare system is crucial. Plans have intensified their focus on outreach and education as essential strategies for enhancing treatment engagement. An example of these efforts is the **Los Angeles** DMC-ODS, which developed websites to provide current MAT information and created four educational videos on methamphetamine, cannabis, opioids, and access to SUD care, available on both the Los Angeles Health and DMC-ODS Public Health

[69] Coulter, A., Entwistle, V. A., Eccles, A., Ryan, S., Shepperd, S., & Perera, R. (2015). Personalized care planning for adults with chronic or long-term health conditions. *Cochrane Database of Systematic Reviews*, (3), 1-130. https://doi.org//10.1002/14651858.CD010523.pub2

[70] California Department of Public Health. (2024). *Substance and Addiction Prevention Branch.* https://www.cdph.ca.gov/Programs/CCDPHP/sapb/Pages/default.aspx

[71] White, A. M., Castle, I. P., & Powell, P. A. (March 18, 2022). Alcohol-related deaths during the COVID-19 pandemic. *Journal of the American Medical Association, 327*(17), 1704-1706. https://doi.org//10.1001/jama.2022.4308

[72] National Center for Drug Abuse Statistics. (2024). *Alcohol related deaths.* https://drugabusestatistics.org/alcohol-related-deaths/

sites.[73] [74] Other Plans are also creating similar public-facing resources focused on fentanyl, other dangerous drugs, and treatment access options. **Santa Clara** supported the distribution of "Fentanyl High," a video documentary created by a local high school student in response to several tragic deaths in the community.[75] This video was presented at the CBHDA SUD leadership meeting, where the student who created it shared the impact of the deaths at his high school on students, families, and the community. His goal was to create a tool to help prevent further deaths.

For those DMC-ODS Plans that reported effective delivery of MATs, their practices include:

- Screening and referral to MAT starts at first contact, regardless of the site in the provider network or local health system.
- Referrals for alcohol MAT include client identification outside of Plan clinics, such as during ED admissions, within driving under the influence (DUI) episodes, or DUI program participation, alongside enhanced SUD screening in primary care settings.
- County-operated inmate facilities have incorporated MAT both prior to and upon release from custody. Approximately half of the Plans have collaborated with justice partners to ensure seamless, uninterrupted re-entry from in-custody to Plan-linked MAT services for treatment needs.
- The DMC-ODS Plans supported stigma reduction through community education and vocal advocacy for MAT services. Public Health frequently partners with DMC-ODS Plans, for education and prevention activities, including the distribution of overdose prevention medications. Many communities have opioid safety coalitions with broad membership that support prevention and education events, including Narcan distribution.

DHCS has developed and supported community engagement and expansion plans for various MAT projects. These efforts are part of the CQS, and information about them is available on the DHCS California Opioid Response website.[76] Members and Plans report that these programs and policy initiatives, especially the ED Bridge projects, criminal justice collaboration efforts, and expanded services, have been immensely helpful.

In FY 2023-24, **PHC,** in collaboration with MCP hospitals and the primary care system, provided MAT treatment support to 1,107 members, including those who received services as a result of or in conjunction with ED events. PHC, in collaboration with DHCS, is developing a funding model for community health workers linked to hospitals and other settings to enhance access to MAT and SUD treatment. PHC has also offered incentives to its network for successful transitions from acute care into SUD and MH treatment.

San Francisco, in collaboration with MCP hospitals and FQHC clinics, supports innovative MAT approaches aimed at reducing opioid overdoses. Some of their standout programs include

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[73] Los Angeles County Department of Health Services. (n.d.) *Medications for addiction treatment Los Angeles community clinic directory.* www.losangelesmat.org

[74] County of Los Angeles Public Health Substance Abuse Prevention and Control. (n.d.) *MAT works.* https://www.matworks.org/

[75] County of Santa Clara. (2024). *Fentanyl High documentary film screening.* https://d5.santaclaracounty.gov/fentanyl-high-documentary-film-screening

[76] California Department of Healthcare Services. (2023-2024). *Projects.* Opioid response. www.californiaopioidresponse.org/projects

evening NTP services with transportation, reminder calls, and food incentives. They also offer mobile street medicine teams that perform overdose reversals and link members to treatment. Additionally, there is an office-based buprenorphine induction clinic partnered with a county-operated pharmacy offering extended hours and medication delivery services. An extensive overdose prevention program features a low-barrier, medication-first approach. [77] San Francisco's initiative is notably strengthened by its access to public health and epidemiological expertise, as well as a long-standing population health philosophy that permeates nearly all its efforts. It has improved access and coordination of care, as reflected on their website.[78]

San Luis Obispo maintains a strong county-operated non-methadone MAT program, which also provides naloxone and fentanyl test strips to all members receiving OUD treatment. Alongside MAT services, the DMC-ODS integrates this care with traditional SUD services, including individual and group sessions, enabling members to address their recovery needs comprehensively. A key strength of this Plan's approach is the involvement of medical staff, including psychiatric technicians, licensed vocational nurses, and nurse practitioners, who bring medical management expertise that is typically absent in traditional BH clinicians.

Recovery Support Services

RSS is designed to assist in recovery and prevent relapse, with the goal of helping members achieve their highest possible level of functioning within the community. Similar to care coordination, Plans have adopted various formats for implementing RSS, with many utilizing the traditional SUD provider-organized aftercare support group model.

RSS has primarily served as the mechanism for delivering peer-led services. Since the launch of the peer support service benefit in July 2022, DMC-ODS Plans have reported an expanded workforce and increased flexibility in services involving peers, although there are still challenging areas for expanding this model of care. Plan managers often report that that staffing for DMC-ODS residential and MAT treatment services is already stretched thin, leading to a prioritization of acute treatment needs over the more extensive implementation of recovery supports. As a result, expanding RSS remains a challenge.

Napa has maintained a highly successful recovery support model that integrates with outpatient treatments and is closely linked to discharge planning. This success was evident in the number of members served, particularly in PRs compared to other Plans. They maintain contact with all discharged members and conduct active outreach every 6 months to assess their need for RSS, even if they initially declined it after discharging from a treatment program. This ongoing effort to support members and connect recovery support to prosocial events and activities has been important for retaining members in the care system.

Contra Costa improved access to RSS across many LOCs, receiving positive feedback from focus group members who referred to their support as "recovery coaches." Members told CalEQRO that these staff were a valued resource for support across multiple LOCs and for addressing ongoing challenges and needs that threaten their recovery.

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[77] City and County of San Francisco (October 16, 2024). San Francisco has continued decline in fatal overdoses, expands on-demand treatment program for people who use fentanyl. https://www.sf.gov/news/san-francisco-has-continued-decline-fatal-overdoses-expands-demand-treatment-program-people

[78] City and County of San Francisco. (n.d.). *Department of Public Health.* https://www.sf.gov/departments/department-public-health

Although RR housing is not a DMC-ODS service, a supportive recovery environment anchored in stable, clean, and sober housing is particularly important for treatment success. For some members, recovery-oriented housing support is crucial for maintaining successful participation in outpatient treatment. This is due to factors such as income or interpersonal issues in their current living situation, as well as the presence of family members or roommates who may be actively using substances. Efforts to expand RR resources are hindered across nearly every Plan by rising housing costs, limited housing supply, and the increasing number of unhoused individuals.

This is particularly true in areas such as Los Angeles, San Francisco, Sacramento, San Diego, and other costly coastal communities. Plans have resourcefully utilized Substance Use Services Block Grants and formed partnerships with criminal justice programs and other allied agencies to expand RR capacity. Implementation of Proposition 1, Behavioral Health Services Transformation, is also expected to address critical treatment gaps and provide housing for those with MH or SUD.[79] [80]

Current capacity markers show that RR remains a focus for Plans, with data from FY 2023-24 reporting 403 housing sites and 4,405 beds, some of which are dedicated to members with children. This represents a decrease from the prior year when data showed more sites and beds (427 sites and 4,606 beds). Inadequate RR housing capacity was a common issue in nearly every Plan reviewed, as highlighted by members and providers during EQR sessions. Plans noted that lack of funding, limited available housing, and significant local resistance to establishing RRs in their neighborhoods were impacting their efforts. Nevertheless, many Plans aimed to expand RR capacity, particularly with the support of opioid settlement funds.

Implementing ASAM Assessment Criteria

The DMC-ODS continuum of care offers a framework for members to start treatment at a level suited to their needs and then transition to different services as their conditions and needs evolve. Consistent and accurate assessment, along with ASAM dimension severity scoring by trained clinicians and counselors, ensures placement in the LOC most likely to achieve success, from early intervention to medically managed hospital inpatient therapy. Placing members into the most appropriate LOC should improve cost-effectiveness by avoiding ineffective under-treatment and resource-wasting overtreatment. Many DMC-ODS providers offer on-demand training for employees, and some Plans have sponsored staff training with nationally recognized ASAM subject matter experts. As previously mentioned, starting January 2025, DHCS will require Plans to use ASAM-developed tools for screenings or assessments, or to use tools approved by DHCS.

EQR reviews the ASAM training process and the tools used for training. Most Plans processes to train new staff on conducting ASAM assessments with fidelity to the member-centered process, scoring, and placement decision-making. Annual ASAM training or booster sessions are offered to enhance skills and ensure staff stay current with ASAM Criteria and its connection to optimal treatment services.

Table 6-3 presents ASAM findings for CY 2022, detailing reasons for discrepancies between the ASAM-determined LOC and the referral made by the practitioner at three points in care.

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[79] Legislative Analyst's Office. (March 5, 2024). *Proposition 1.* https://lao.ca.gov/BallotAnalysis/Proposition?number=1&year=2024

[80] https://www.dhcs.ca.gov/BHT/Pages/home.aspx

Table 6-3: Congruence of LOC Referrals with ASAM-Based Findings – Screenings, Assessments and Follow-up Assessments, CY 2022

Category	Brief Screening		Initial Assessment		Follow-up Assessment	
	# of Members	% of ASAM Results	# of Members	% of ASAM Results	# of Members	% of ASAM Results
Placement Decision Match	37,152	79.45%	70,344	80.56%	36,856	80.85%
Reasons for Placement Decision Mismatch						
Patient Preference	2,667	5.70%	5,931	6.79%	2,389	5.24%
Level of Care Not Available	112	0.24%	283	0.32%	123	0.27%
Clinical Judgment	1,069	2.29%	5,066	5.80%	3,091	6.78%
Geographic Accessibility	27	0.06%	88	0.10%	44	0.10%
Family Responsibilities*	41	0.09%	127	0.15%	32	0.07%
Legal Issues	435	0.93%	213	0.24%	135	0.30%
Lack of Insurance/Payment**	27	0.06%	38	0.04%	36	0.08%
Other	5,127	10.96%	4,806	5.50%	2,544	5.58%
Actual LOC Missing	107	0.23%	423	0.48%	333	0.73%
Total Non-Congruence	**9,505**	**20.33%**	**16,975**	**19.44%**	**8,727**	**19.15%**

* Family Responsibilities: Conflicts with obligations associated with providing care to family

** Lack of insurance may refer to those individuals who are uninsured, privately insured, or have a cost-prohibitive share of the cost associated with their Medi-Cal coverage.

Introduced and discussed also in the Access chapter in terms of initial referral and brief screening, Table 6-3 shows congruence in "placement decision match" ratings across three ASAM service events – screening, assessment, and follow-up assessments – with similar rates of congruence at each point in care. The rate reflects the percentage of ASAM referrals that matched the optimal ASAM recommendation. Overall, across all ASAM points of use, the largest reason for non-congruence was Other (n=12, 477), followed by patient preference (n=10,987) and clinical judgement (n=9,226). The "Other" category comprises many situation-specific reasons.

In many Plans, the first event is screening using ASAM parameters, followed by referrals to a with previous review cycles at 80.56 percent, while follow-up assessment congruence decreased from 88.69 percent in CY 2021 to 80.85 percent. The changes in this rating category were due to increases across all reason categories, except for the unavailability of the LOC, with patient preference and clinical judgement being the most frequently cited reasons.

The follow-up assessment reflects updates to a member's ASAM, generally done when transitioning through LOCs. Still, the non-congruence was similar to other phases of ASAM use.

Feedback from multiple Plans indicated issues with obtaining complete data during the implementation of new EHRs, especially in those Plans that were more reliant on contract providers. More Plans are incorporating ASAM assessment software into their new EHRs, which could potentially impact these ratings, particularly those related to clinical judgment. Noting that

the variance from the recommended placement is often due to patient preference can indicate adherence to member-centered care principles, showing respect and responsiveness to member preferences. Retention in the treatment process is important for new members seeking SUD treatment. Staff and members indicated that the two most common reasons for refusing program referrals were distance from their communities and child/family issues.

Los Angeles uses ASAM Triage and Continuum software integrated with its EHR, which is accessible system-wide for contract providers. The data captured from these screenings and assessments is more extensive compared to other DMC-ODS Plans. The ASAM software is linked to thousands of research-based algorithms that guide referral recommendations and diagnoses. Los Angeles DMC-ODS collaborates directly with ASAM Continuum developers to enhance the assessment and matching of treatment services for members with diverse SUD conditions and functioning. They also identify and provide feedback on areas needing software enhancements. The database offers valuable quality information to the Plan and helps identify trends in member profiles, SUD history, and needs.

San Diego regularly monitors the congruence between their ASAM screening and assessment findings for the congruence and the treatment referrals made. QI uses that data to guide supervision on reliability and consistency and to inform training decisions.

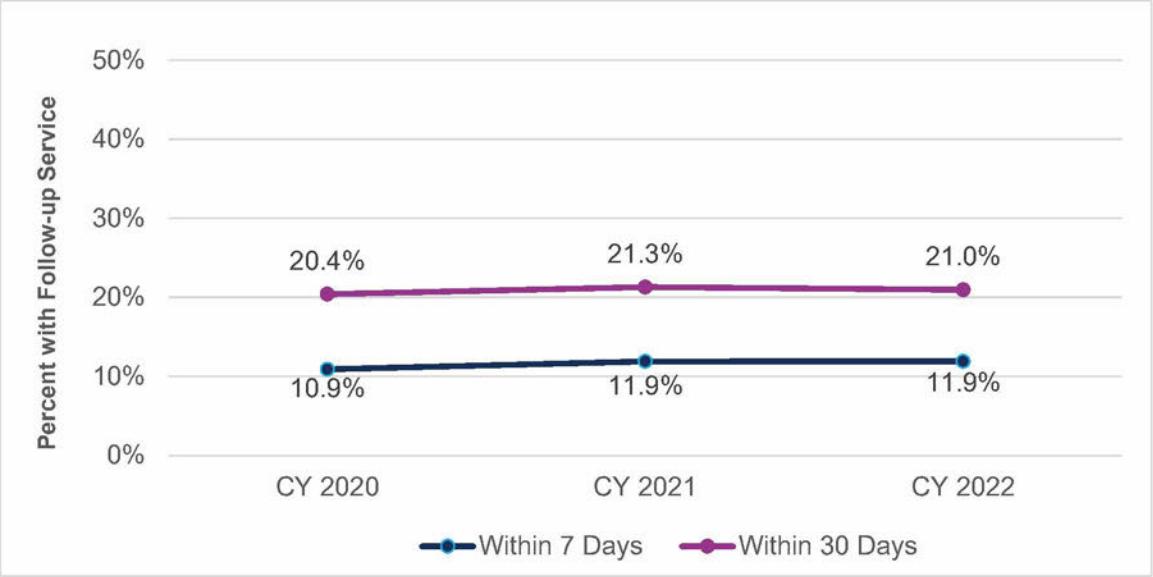
Monitoring and Improving Care Transitions

During a member's ASAM-based assessment, specific presenting problems and clinical priorities are identified to justify admission to a particular DMC-ODS LOC. Over time, the member is expected to transition to a less intensive LOC and receive RSS. Unlike program-driven treatment, where success is defined as completing a standardized, time-determined LOS and program curriculum, DMC-ODS is member-centered and clinically driven. This model of care defines success and LOC based on each member's progress toward individualized clinical goals throughout treatment and supportive services.

Figure 6-6 displays DMC-ODS claims data on the percentage of members discharged from residential treatment who received a follow-up treatment session at a step-down non-residential LOC, along with the timeliness of that transition, whether within 7 days or 30 days. Follow-up services may include partial hospitalization, IOT, outpatient, NTP, and RSS. The follow-up services in this measure do not include transfers to another residential treatment program or to a residential WM facility.

Again, it should be noted that CalEQRO does not have access to MCP Medi-Cal claims data, which would include member treatment transitions to MAT in primary care or other medical settings. Similarly, any DMC-ODS services not billed to Medi-Cal would not be included in this metric.

Figure 6-6: Timely Transitions Following Residential Treatment Discharge, CY 2020-22



Timely transitions in care following a residential treatment episode remained stable in CY 2022 compared to CY 2021, with both time frames showing higher follow-up rates than CY 2020. Overall, 11.9 percent of members received follow-up care within 7 days and 21.0 percent received it within 30 days.

While this data appears to suggest that improvement is needed in connecting members to outpatient care after residential discharge, with nearly four-fifths of members not transitioning within 30 days, it is important to remember that services provided but not billed or not billable to Medi-Cal are not reflected in this data. In systems with delayed entry into outpatient care, the transition may have occurred at 31 days later. CalEQRO requests Plans to provide this same data based on their own tracking of all follow-up activities in their ATA submission (discussed further in the Timeliness chapter) which universally shows a much higher level of post-residential service and linkage.

Plans with higher rates of timely transitions often emphasize early discharge planning within residential treatment programs, along with close collaboration with outpatient programs, recovery housing, and the members' individual needs and goals. With many Plans providing data showing significant post-residential activities not reflected in this figure due to those services not being billed, CalEQRO continues to encourage them to review billing practices to ensure reimbursement when possible. However, many Plans are still working on expanding overall treatment capacity, which often affects their ability to transition members seamlessly and in a timely manner from residential treatment. This was a new focus for many Plans, which included providing incentives to providers to add other LOCs within their organizations to facilitate smoother transitions. These expansions within an organization often included the ability to maintain therapeutic relationships with primary staff across different LOCs. Members and program staff identified these primary counselor relationships as critical to treatment success and key to effective transitions across LOCs.

Predictive factors for unsuccessful transitions in care include having significant unmet basic needs (e.g., homelessness, lack of childcare or stable transportation), reluctance to switch to new counselors and treatment programs, and insufficient social support to sustain treatment after being away from home for residential care. Staff and members identified several program

barriers, including poor communication and coordination across LOCs, cumbersome and repetitive paperwork during transitions, inconvenient service times or locations, and wait times exacerbated by staffing shortages. Programs with more successful transitions of care used analytics to develop a more effective referral system. This included enhanced use of telehealth, overlaps in services (rather than summary exits) to help members feel comfortable with the new LOC, and actively prioritizing engagement with members, providers, family members, peers, and key support systems.[81]

Napa provided care coordination support to 79 percent of its members during the last review year, with this support billed via DMC-ODS to facilitate access and transitions. It also provided an additional seven percent of members with special care coordination visits to connect them with primary care clinics for physical examinations. The medical visits were not billed to Medi-Cal through DMC-ODS but were an important QI goal that reflects the integrated approach endorsed in the CQS.

Placer and **Santa Cruz** DMC-ODS have a continuum of care with many providers offering multiple LOCs within a single organization. They found that provider organizations designed to offer multiple LOCs make member transitions across LOCs easier and more effective. **Los Angeles** was also working toward this model by offering incentives for providers to diversify their programs, expanding treatment options to include a variety of LOCs and MAT.

Riverside found that a centralized case management program, which included professional and peer support services for care coordination across all LOCs, improved support for member transitions. Additionally, teams that prioritize discharge planning are assigned to members while they are in residential settings. They also provide support to those in RR, facilitate transitions to outpatient care and MAT, and identify any unique medical issues for the member.

ENGAGEMENT AND RETENTION

While the primary goal of treatment is to address the negative effects of substance use, the broader aim is to help members achieve wellness and effective functioning in their family, workplace, and community. Research tracking individuals in treatment over extended periods shows that most people who in treatment stop using drugs, reduce criminal activity, and improve their occupational, social, and psychological functioning.[82] The duration of treatment needed varies for each individual. However, several studies have confirmed LOS as a predictor of better outcomes.[83] Therefore, the ability to engage and retain members for a sufficient LOS to support ongoing recovery is an indicator of quality care and a vital component of effective SUD treatment.

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[81] Timko, C., Schultz, N. R., Britt, J., & Cucciare, M. A. (2016). Transitioning from detoxification to substance use disorder treatment: Facilitators and barriers. *Journal of Substance Abuse Treatment, 70,* 64-72. https://doi.org/10.1016/j.jsat.2016.07.010.010

[82] Gerstein, D. R. & Harwood, H. J. (Eds.). (1990). *Treating drug problems: Volume 1: A study of the evolution, effectiveness, and financing of public and private drug treatment systems.* National Academy Press. https://nap.nationalacademies.org/read/1551/chapter/1

[83] Turner, B. & Deane, F. P. (2016). Length of stay as a predictor of reliable change in psychological recovery and wellbeing following residential substance abuse treatment. *Therapeutic Communities: The International Journal of Therapeutic Communities*, *37*(3), 112-120. https://doi.org/10.1108/TC-09-2015-0022

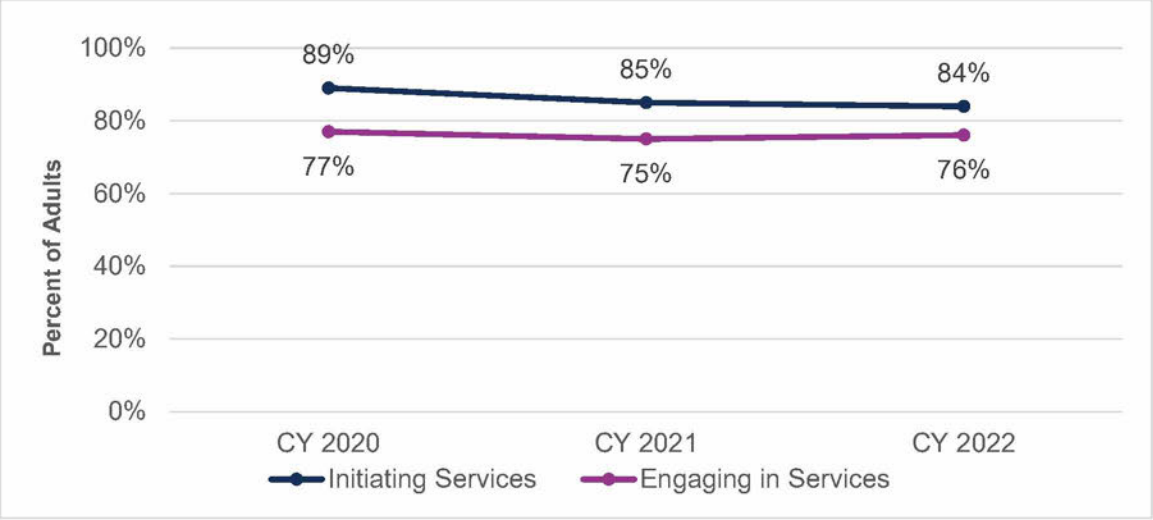
Research indicates that both individual and provider factors influence the initiation, engagement, and retention of SUD treatment. Individual factors include attitude and beliefs about the need for and efficacy of SUD treatment, the type of SUD, age, and the presence of co-occurring mental and physical health conditions. System and provider factors include wait times, stigma, accessibility of services (both in terms of time and proximity), availability of care coordination, and the efficacy of treatment.[84] Additionally, the quality of services – such as employing EBPs and establishing a strong therapeutic alliance with members in the early stages of treatment – positively influences member satisfaction and engagement during the first 30 days.[85]

Initiating and Engaging in Treatment

CalEQRO's contract includes two DHCS-approved measures to evaluate the extent to which members remain engaged during the preliminary stages of treatment. The measures were adapted from nationally recognized sources, including the NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) quality data measures and the National Quality Forum. One of these indicators, called "initiation into treatment," measures the percentage of members who have at least one visit or 1 day in treatment within 14 days of their first billed visit (numerator), typically, the assessment or initial event. The second measure, "engagement in treatment," tracks the percentage of members who have at least two additional visits or days in treatment between the 14th and 30th days following their initiation into treatment (numerator). The first claimed clinical service as the denominator for both measures.

Figure 6-7 compares the rates of initiation into treatment and engagement in treatment for adults for CY 2020-22.

Figure 6-7: Initiating and Engaging Adults in Treatment, CY 2020-22



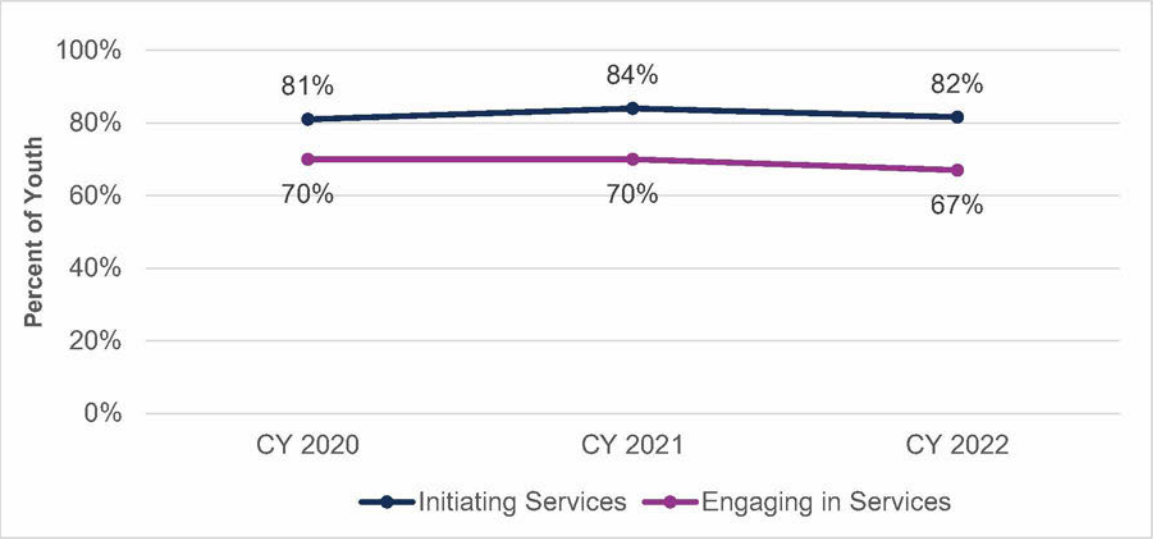
[84] Hser, Y. I., Evans, E., Teruya, C., Ettner, S., Hardy, M., Urada, D., Huang, Y. C., Picazo, R., Shen, H., Hsieh, J., & Anglin, M. D. (2003). *The California treatment outcome project (CalTOP) final report*. University of California, Los Angeles Integrated Substance Abuse Programs & California Department of Alcohol and Drug Programs. https://www.researchgate.net/publication/275950310_The_California_Treatment_Outcome_Project_CalTOP_Final_Report

[85] Simpson, D. D. (2001). Modeling treatment process and outcomes. *Addiction, 96*(2), 207–211. http://dx.doi.org/10.1080/09652140020020937

In CY 2022, 84 percent of adult members who received an initial intake appointment obtained a second DMC-ODS service within 2 weeks. This initiation rate is slightly lower than in CY 2021, continuing a downward trend from CY 2020. However, adult engagement rates remained high, with a slight increase to 76 percent of members continuing to receive two or more services between days 14 and 30 in CY 2022. This high rate of engagement demonstrates that Plans were effectively employing member-centered care practices, which positively motivate and sustain treatment engagement.

Figure 6-8 compares the rates of initiation into treatment and engagement in treatment for youth from CY 2020 to CY 2022.

Figure 6-8: Initiating and Engaging Youth in Treatment, CY 2020-22



In CY 2022, 82 percent of youth members receiving an intake appointment obtained a second DMC-ODS service within 2 weeks. That initiation rate is slightly lower than for CY 2021 (84 percent), though it remains slightly higher than in CY 2020 (81 percent).

Youth engagement rates fell to 67 percent, indicating that a smaller proportion of youth members continued to receive two or more services between days 14 and 30. This is the first shift in the youth engagement rate over the prior three CYs. Many Plans are just beginning to utilize and redevelop on-site school services and link youth to treatment services post-pandemic. Additionally, in several Plans, school officials reported that they now have their own funds and counselors to conduct SUD screening and treatment (up to a certain level of acuity), reducing the need for the DMC-ODS for services for school-based care in many cases. These Plans had recorded low numbers of youth services, highlighting an area for review recommendations to increase access to care for youth.

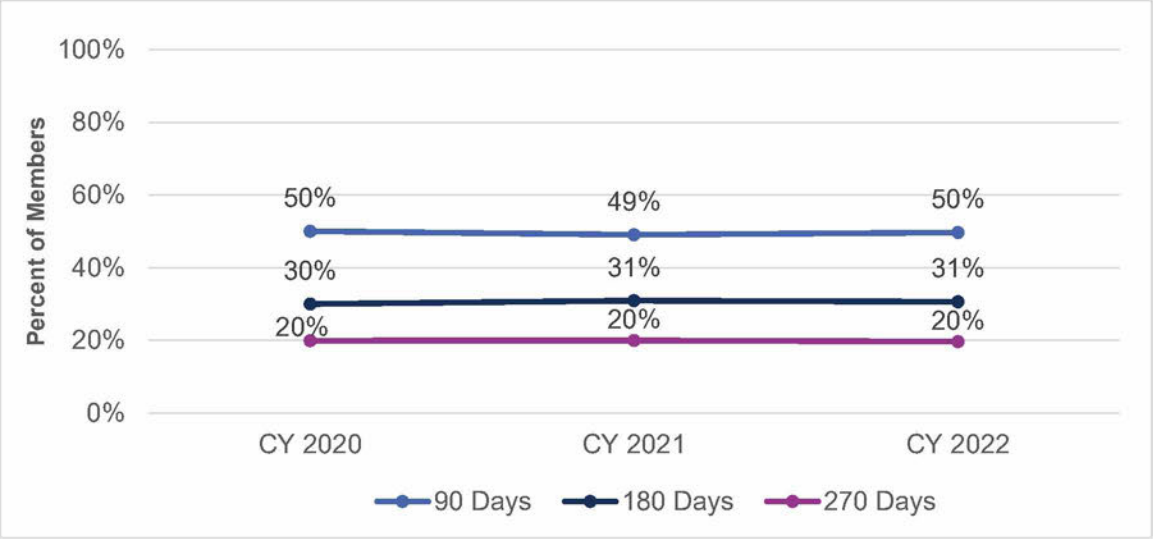
Several DMC-ODS Plans (*e.g.,* **Santa Barbara**, **Los Angeles**, **Marin,** and **Riverside**) evaluated their programs' effectiveness in part by using their adult and youth member data to measure initiation and engagement overall and by each program and LOC. They have used this data to identify opportunities for QI initiatives at specific programs or LOCs. Several are also providing Level 0.5 at-risk prevention services to youth.

Retention in Treatment

To measure retention in treatment, CalEQRO uses Medi-Cal claims data to demonstrate continuous treatment within the DMC-ODS continuum, with no interruption in care exceeding 30 days. Length of time in treatment has consistently been the most important predictor of favorable outcomes in SUD treatment. Improved outcomes reduce relapses, enhance overall well-being, and ultimately lower overall healthcare costs.[86]

Figure 6-9 displays how long the DMC-ODS provider system retains members in its treatment continuum, measured by services claimed to DMC-ODS Medi-Cal. The PM tracks cumulative time in care based on services delivered across any LOC. A service interruption exceeding 30 days is considered a treatment discharge, and LOS is calculated from this point. This does not include members who remained in care at the end of CY 2022.

Figure 6-9: Member Length of Stay in Treatment – All Age Members, CY 2020-22



The proportions of all members remaining in treatment for 90, 180, and 270 days have been stable over the last three CYs. Annually, half of the members served were retained for at least 90 days. By 180 days (6 months), just under one-third of members are retained, and one-fifth are retained for 270 days.

Given the strong research linking LOS with better outcomes in SUD treatment, these retention rates are promising. As an adjunct to tracking engagement, many Plans reported a goal to monitor non-billable services such as RR, peer support, and alumni groups. This aims to document continued participation in wellness and relapse prevention activities, regardless of billability.

Seventeen Plans reported that over 50 percent of those served remained in treatment for a 90-day LOS or longer. In four Plans – Modoc (within the PHC Plan), San Francisco, Ventura, and Stanislaus – more than 55 percent of members remained in care for 90 days or longer.

[86] McLellan, A. T., Alterman, A. I., Cacciola, J., Metzger, D., & O'Brien, C. P. (1992). A new measure of substance abuse treatment: Initial studies of the treatment services review. *Journal of Nervous and Mental Disease, 180*(2), 101–110. https://doi.org/10.1097/00005053-199202000-00007

Fresno expanded NTP service hours to include nights and weekends for sites near their hospital EDs and implemented additional support, such as transportation, to address common barriers to persistent care.

PHC collaborated with leadership across the seven regional counties to enhance transitions into RR and other housing options, and to provide care coordination, outpatient, and RSS. This approach has reportedly led to longer LOS across various LOCs.

EVIDENCE-BASED PRACTICES

While the importance and benefit of MAT in addiction treatment and recovery is increasingly recognized, most SUD treatment is still delivered through traditional behavioral treatment modalities and interventions. The DMC-ODS Waiver Special Terms and Conditions required that providers receive training in at least two of the following EBPs: motivational interviewing, cognitive behavioral therapy, relapse prevention therapy/treatment, trauma-informed treatment, and/or psychoeducation. Other curriculum-based EBPs, such as Seeking Safety and the Matrix Model, remain prevalent in the DMC-ODS system. These curricula integrate multiple EBPs to address diverse aspects of treatment. Additionally, some Plans use these models alongside Dialectical Behavioral Therapy, Moral Reconation Therapy, and other Multisystemic Family Therapy approaches. In most cases, Plans have worked diligently to identify specific needs of various sub-populations they serve, using EBPs as clinically appropriate to address factors unique to those members. There is also an expanding use of incentive models, including contingency management, which launched as a pilot in CY 2023 to target the needs of individuals with stimulant use disorders. Nineteen DMC-ODS Plans reported participation in the Recovery Incentives Program, is DHCS' Medicaid contingency management initiative," which rolled out in 2023.[87] California is the first state in the country to receive federal approval for contingency management as a Medicaid benefit. DHCS's leadership, in partnership with UCLA-ISAP and the DMC-ODS Plans, continues to enhance this benefit. DHCS has noted that more than 2,700 members are enrolled in the project statewide and 24 counties are participating.[88]

CalEQRO found that Plans incorporated adherence to EBPs into their contract monitoring activities, including assessing fidelity in the provision of ongoing EBP training. There is ongoing training among DMC-ODS providers, as SUD clinicians adopt a more science-based approach to recovery and incorporate new research on SUDs. Reviews of each Plan's training calendars and documents confirm that EBP-related training is ongoing, ensuring that new staff are trained and experienced staff have their skills reinforced. This review year's training for staff at all levels emphasized the use of new EHRs and data to track and improve quality. As new models and curricula are introduced, it is important that Plans provide opportunities for clinical and counseling staff to engage in continuous learning and clinical collaboratives.

Alameda regularly trains and holds case conferences with Dr. David Mee Lee, a well-regarded ASAM leader and ASAM Criteria contributor, to enhance clinical skills and strategies for improved care. Alameda offers a broad range of EBP training opportunities both online and

[87] https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspx

[88] Hart, A. (May 20, 2024). *California pays meth users to get sober.* California Healthline. https://californiahealthline.org/news/article/california-pays-meth-users-sober-contingency-management-calaim/

in-person. These sessions are available to provider staff in both MH and the DMC-ODS, including peer navigators.

San Bernardino implemented a 16-week diagnostic cross-training program to improve assessment and diagnostic skills among SUD contract providers. Updates on ASAM and other EBPs were also included.

Fresno maintained its ongoing education for system providers on EBPs. The Plan also requires that monitoring staff "sit in" on and observe clinical sessions and use a standardized scoring system to detect fidelity drift and identify future training needs.

OUTCOMES OF CARE

A key and challenging question for DMC-ODS Plans is whether the services they provide are effective and result in favorable clinical outcomes. SUDs are recognized as chronic conditions, where recovery often involves a lifelong process with intermittent setbacks, including relapses. Given the chronic nature of SUD, treatment programs should view outcomes as progress rather than final "cures," focusing on both short-term and long-term improvements. SUDs, being more complex than some other chronic conditions, impact various aspects of a person's life and of those around them. Therefore, progress must be measured across multiple areas beyond just immediate symptoms. As described in the Methods chapter, CalEQRO uses DMC-ODS approved claims, CalOMS reports, ASAM results, and TPS data.

Plans welcomed the sharing of outcome data during their annual EQRs, particularly TPS, ASAM, CalOMS, and the PMs derived from Medi-Cal claims. One challenge for Plans is developing the data and analytic capacity needed to use national outcome measures endorsed by NCQA, CMS, and NQF measures, which require advanced knowledge and expertise. This will be a factor for Plans submitting their own rates for the CalAIM quality measures.

Key Data Sources for Measuring Outcomes

Member Focus Groups

CalEQRO collaborates with Plans to conduct member focus groups, providing an in-depth understanding of member perspectives on care accessibility, timeliness, quality, and effectiveness. The group facilitator, a staff member with personal lived experience, asks about the impact of treatment on members' lives and gathers insights into their perceptions of treatment experiences and outcomes.

2022 CQS Behavioral Health Accountability Sets

The 2022 CQS introduced four CalAIM SUD quality measures, also known as the BHAS, which drive the intended outcomes of CalAIM implementation, were validated by CalEQRO.[89] These measures are anticipated to be incorporated into routine tracking and reporting by Plans. BHC's report of analysis of these results, MY 2022 Quality Measure Report, is available on DHCS's website.[90]

For the first year of reporting, measurement year (MY) 2022, DHCS calculated the rates to allow Plans additional time to develop the necessary infrastructure for direct collection and reporting

[89] https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf

[90] https://www.dhcs.ca.gov/services/MH

of these measures. Accurate measurement requires data exchange with MCPs to ensure reliable results for metrics such as ED visits, prescribed OUD medications, and other data elements. DHCS promoted data exchange via the BHQIP, Milestone 3d, which offered financial incentives for Plans to focus on FUA and POD measures. Many DMC-ODSs chose to engage in this project using the DHCS-provided templates and have submitted them to CalEQRO to meet one or both PIP requirements. This past year, 25 Plans implemented the FUA PIP, and 18 Plans implemented the POD PIP as part of their reviews. The final BHQIP submission to DHCS occurred in September 2023, but the projects were reviewed throughout the year.

BHIN 2024-004, issued in January 2024, outlined expectations for future years, including time frames for data submissions, review, validation, and publication.[91] MY 2022 was set as the baseline year, with the expectation that DMC-ODS Plans will aim to reach the 50th percentile nationally, and increase performance by 5 percent annually if below this target, for the four SUD measures:

1. Follow-up after ED visit for alcohol and other drug abuse or dependence (FUA) – HEDIS measure
2. Pharmacotherapy of opioid use disorder (POD) – HEDIS measure
3. Use of pharmacotherapy for opioid use disorder (OUD) – CMS measure
4. Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET) – HEDIS measure

California Outcomes Measurement System

SAMHSA developed a National Outcomes Measurement System (NOMS) to standardize the tracking of measures across states. All states receiving SAMHSA federal block grant funds for SUD treatment programs must develop and implement a state-specific version of the NOMS for all treatment services. California's version, CalOMS, includes forms for an Admissions Summary, Discharge Summary, and Annual Treatment Summary for members who continue in a single, uninterrupted treatment episode for an entire year. All treatment providers must complete these forms for their members, ideally in consultation with the member.

CalOMS is a data collection system that provides valuable information on members at the time of admission into treatment and offers comparative data when they are discharged from services. This approach allows for the collection, analysis, and utilization of outcome data to assess treatment efficacy and benefits, helping to identify what works well for SUD service recipients and areas that need improvement. However, the current CalOMS was developed prior to the DMC-ODS and does not align with the ASAM LOCs. This misalignment hampers the current treatment model's analysis. Aligning CalOMS with the ASAM LOC would enable outcome data analysis based upon LOC, strengthening opportunities to evaluate and identify opportunities to improve the system of care.

Treatment discharge status measures successful progress and serves as a potent indicator of positive outcomes for members and program effectiveness. Research indicates that dropping out of a treatment program strongly predicts relapse, while treatment completion is linked to

[91] https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-24-004-Quality-Measures-and-Performance-Improvement-Requirements.pdf

improved clinical outcomes. Treatment completion is also associated with reduced criminal justice involvement, higher wages, and fewer readmissions.[92]

Following the shut-down of ITWS, DHCS moved the CalOMS data into the Behavioral Health Information System; and when compared to information previously accessible from ITWS, it remains substantially limited. Although DHCS intends to make CalOMS reports more readily available, Plans are currently challenged in this area. The ITWS portal previously provided a means for Plans and providers to monitor the data submissions, receive data submission status and error reports, and access the various outcomes reports available through the CalOMS system. No fewer than 16 reports existed where a Plan or provider could access CalOMS data input at the system or program level. Authorized users could set specific report parameters within the core set of service utilization, assess service referrals and demographics, and examine client characteristics. The latter category included both clinical and functional changes within categories such as medical, housing, employment, education, and criminal justice, as well as use patterns of their SUD. Many large counties and some medium counties have used the CalOMS data with additional analytic data tools and added numerous staff to achieve the prior ITWS capacity system-wide and assist their provider organizations. **Los Angeles**, **Fresno, San Diego**, **PHC**, and **Marin** help in this way. It allows focused TA when data shows a negative pattern of low progress, high dropouts, and lack of program completion. Small and medium Plans often do not have the staffing to do this extensive database work, limiting their use of CalOMS for outcomes. Further, the current data gap also does not allow many contractor providers to function as full partners in the managed care system with the other programs, despite a general desire by counties' administrations to embrace that partnership. Because of the enormous cost/resources to establish a unified EHR, DMC-ODS Plans have yet to optimize the use of CalOMS, ASAM, TPS, or other quality tools available to track electronically and targeted outcome improvement.

CalOMS Status Discharge Ratings

The CalOMS Discharge Summary requires providers to assess a member's progress at discharge using eight rating options, shown with statewide data for three years in Table 6-4 – four indicating positive progress and four indicating a lack of progress.[93] [94]

CalEQRO analyzed and provided each Plan with a comparison of their aggregated results against the statewide average for each of the eight discharge rating options. Details are available in each Plan report.

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[92] Lappan, S. N., Brown, A. W., & Hendricks, P. S. (2020). Dropout rates of in-person psychosocial substance use disorder treatments: A systematic review and meta-analysis. *Addiction, 115*(2), 201-217. https://doi.org/10.1111/add.14793

[93] https://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

[94] https://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

Table 6-4: CalOMS Discharge Status Ratings, CY 2020-22

Discharge Status	CY 2020		CY 2021		CY 2022	
	#	%	#	%	#	%
Completed Treatment – Referred	20,601	18.0%	22,078	20.1%	19,232	21.6%
Completed Treatment – Not Referred	7,911	6.9%	8,619	7.8%	5,687	6.4%
Left Before Completion with Satisfactory Progress – Standard Questions	15,348	13.4%	15,417	14.0%	12,302	13.8%
Left Before Completion with Satisfactory Progress – Administrative Questions	9,626	8.4%	8,822	8.0%	7,046	7.9%
Satisfactory Progress Subtotal	*53,486*	*46.7%*	*54,936*	*49.9%*	*44,267*	*49.8%*
Left Before Completion with Unsatisfactory Progress – Standard Questions	16,728	14.6%	18,573	16.9%	15,497	17.4%
Left Before Completion with Unsatisfactory Progress – Administrative	42,384	37.0%	33,999	30.9%	28,288	31.8%
Death	918	0.8%	1,653	1.5%	166	0.2%
Incarceration	880	0.8%	878	0.8%	740	0.8%
Unsatisfactory Progress Subtotal	*60,910*	*53.2%*	*55,103*	*50.1%*	*44,691*	*50.2%*
Total CalOMS Discharge Status	**114,396**	**100%**	**110,039**	**100%**	**88,958**	**100%**

Table 6-4 shows 28 percent of members completing treatment (top two rows), comparable to CY 2021 (27.9 percent), but a 12.4 percent increase over CY 2020 (24.9 percent). **Marin** had the highest rate of treatment completions at 47.85 percent, followed closely by **El Dorado** at 46.90 percent.

Conversely, this indicates that in CY 2022, 72 percent of members did not complete treatment before discharging from services. However, when considering whether members left early but made satisfactory progress, the total of 49.8 percent making satisfactory progress was similar to CY 2021 but an increase over CY 2020 (4.67 percent). Overall, the lack of completion highlights an area needing QI improvement efforts. Additionally, when members leave treatment, gathering exit information can offer valuable feedback for program improvements.

CalOMS data also reflects an annual increase in the proportion of members completing treatment at one LOC and being referred to aftercare or another LOC, "completed treatment, referred," at 21.6 percent in CY 2022 compared to 20.1 percent in CY 2021 and 18.0 percent in CY 2020. This suggests some improvement in engaging members in the necessary LOC and then working to coordinate transfer when appropriate. **Marin** had the highest rate in this category at 42.03 percent. This is followed by six Plans (**Nevada**, **El Dorado**, **San Bernardino**, **Riverside**, **San Mateo**, and **Contra Costa**) with completion rates greater than 30 percent.

In CY 2022, the proportion of members discharged due to death notably decreased, marking a positive improvement. This decline may be linked to stabilization and fewer relapse events exposing members to lethal drug levels, particularly fentanyl. Examining this in more detail could

further understand the causes behind the reduction in fatalities. However, the percentage of members discharged due to incarceration remained stable at 0.8 percent.

Santa Clara (24.97 percent) and **Contra Costa** (19.35 percent) were among the plans that kept their unsatisfactory discharge rates well below the statewide average of 50 percent. **Marin**, **Alameda**, and **San Mateo** also had unsatisfactory discharge rates below 40 percent. On the other end, eight Plans had unsatisfactory discharge rates exceeding 60 percent, with one reaching as high as 80 percent. Successful plans were noted for early, extensive discharge planning and having relatively more RR beds to facilitate smoother transitions from residential treatment. Plans also provided staff training on using CalOMS to reduce administrative discharges, enhance care coordination, address relapses and relapse prevention, and tackle barriers to care by adding evening hours and ensuring convenient access to transportation and childcare. EQR review staff have encouraged Plans to actively engage in QI efforts, suggesting that program-level analysis may be necessary to identify specific clinics, practices, or staff contributing to higher levels of unfavorable outcomes and understand the reasons behind them.

An administrative discharge designation is selected when a member exits treatment without planned completion and does not participate in an exit interview, typically aligning with the bottom four categories listed above in Table 6-4. Such exits provide limited clinical or functional status information and occur when a member leaves treatment, whether with satisfactory or unsatisfactory progress. CalEQRO review teams have encouraged Plans to examine and address common factors at the provider or program levels that lead to summary exits with minimal information, indicating potential issues with member engagement. CalEQRO has also continued to review the process and accuracy of CalOMS reporting with Plans. Reviews found that service providers improved data accuracy and discharge rating assignments in CalOMS when TA and training from local QI staff, along with locally developed tracking systems, were provided.

The overall number of discharges in CY 2022 decreased by over 19 percent from CY 2021 and 22 percent from CY 2020. Standard discharges are associated with more favorable outcomes, as they typically involve members completing their treatment episode and participating in the exit assessment. Improvements in the proportion of standard adult discharges (50.1 percent compared to 43.9 percent in CY 2020) were largely sustained in CY 2021, though the rate slightly decreased to 49.8 percent in CY 2022. It is important to note that the percentage of detox discharges and the proportion of youth in the treatment population affect both the total number of discharges and the ratio of standard to administrative discharges.

Administrative adult discharges (the two administrative categories, plus death and incarceration in Table 6-4) slightly decreased to 40.7 in CY 2022 from 41.2 percent in CY 2021, and were notably higher at 47.1 percent in CY 2020. The range of administrative discharges varied widely across Plans and across all CYs. In CY 2022, the range of administrative discharges across Plans varied from a low of 10 percent to a high of 80.6 percent. Administrative discharges were under 12 percent in **San Francisco**, **Alameda**, and **San Bernardino**. Additionally, **Placer, Marin, San Mateo,** and **Napa**) had administrative discharge rates below 30 percent. Plans with lower administrative discharge rates have encouraged staff to address erratic attendance promptly and focus early on member-specific goals, including housing, family, and employment needs. If a member terminates, it is important to make every effort to contact them and complete a CalOMS discharge interview as soon as possible after termination. This approach demonstrates engagement with members throughout their treatment episodes, even if they choose not to complete treatment.

Two Plans (Imperial and Kern) had administrative discharge rates exceeding 65 percent. Higher administrative discharge rates reduce the quality and reliability of data for understanding

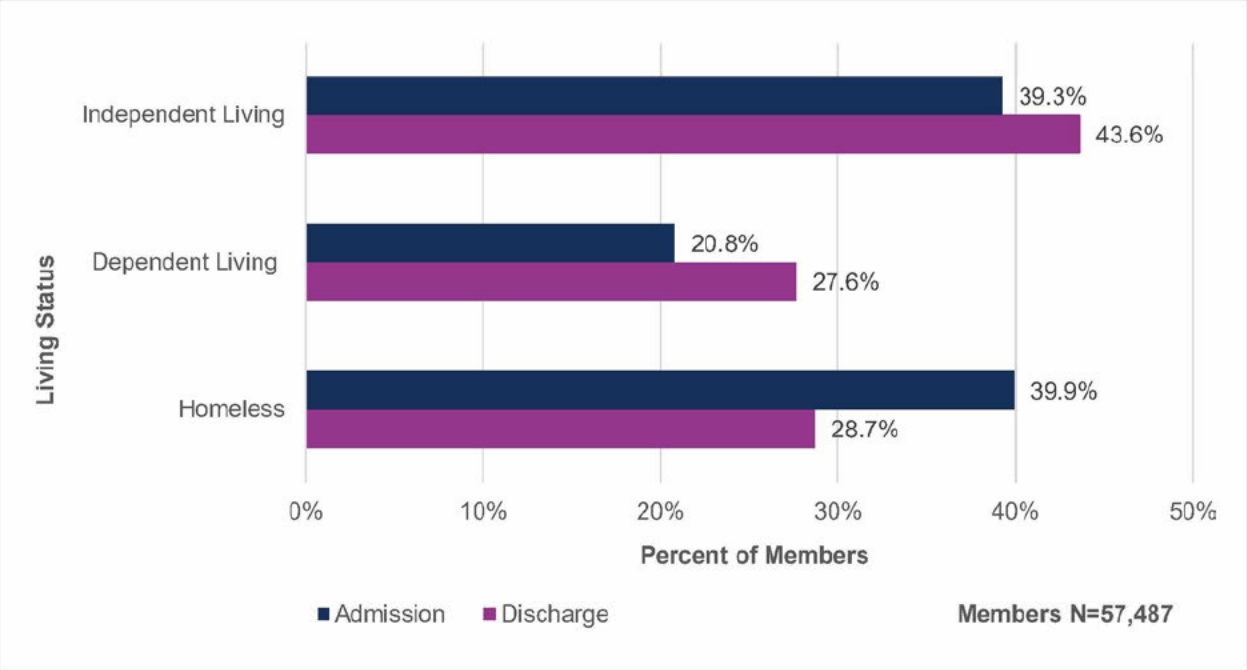
needed improvements in care or barriers to treatment completion. This is a key factor for maintaining CalOMS integrity as an outcome tool. As noted earlier, a high administrative discharge rate results in minimal data for standard exit analysis, causing a program to lose valuable information needed for initiating QI activities and understanding its impact on members. Administrative discharges are more common when members are not progressing, may have relapsed, or frequently miss visits. Dropouts can signal the need for a program to focus more on the clinical appropriateness of services, address individual psychosocial barriers (such as transportation or housing), introduce MAT when indicated, and enhance member engagement with relevant, individualized treatment goals.

Some Plans have integrated and many plan to integrate CalOMS into new EHR systems to facilitate timely and accurate submissions from clinicians and counselors, helping the Plan oversee implementation and consistency. This action can also enable a more comprehensive analysis of members' progress and any barriers to success.

CalOMS Living and Employment Statuses as Outcomes

Figure 6-10 evaluates housing, a key indicator of successful progress in SUD treatment, for members with housing status recorded at both admission and discharge.

Figure 6-10: CalOMS Living Status at Admission versus Discharge, CY 2022



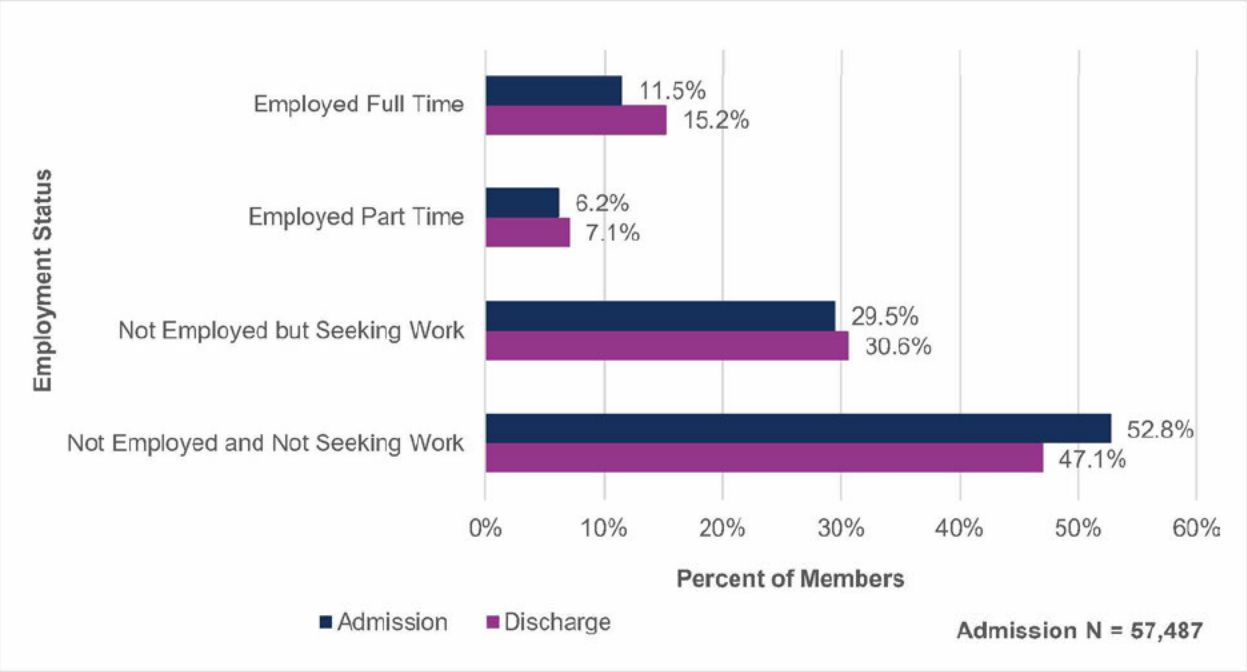
In CY 2022, nearly 40 percent of members experienced homelessness at admission, making this the most common living status category, followed by independent living. The proportion of members identified as unhoused at discharge decreased to 28.7 percent, reflecting a 28.1 percent improvement for those who were unhoused at admission. This likely reflects many Plans' efforts to connect members with housing resources while they receive ongoing outpatient, RSS, and MAT services. Additionally, if members were in RR housing and received rental support, Plans required continued treatment at some LOC.

More members transitioned to dependent living situations, including RR, as well as independent living. Noting that 39 percent of members reported living independently at admission, this rate

improved to 44 percent at discharge. Members in dependent living situations made up 21 percent of the population at admission and increased to 28 percent at discharge.

Figure 6-11 reflects members' work experiences at admission and discharge.

Figure 6-11: Employment Status at Admission versus Discharge CY 2022



In CY 2022, the proportion of members who were unemployed and not seeking work decreased from 52.8 percent to 47.1 percent, representing a 10.8 percent improvement. The rates of members being employed part-time or full-time, or seeking employment, all increased between admission and discharge. In fact, full-time employment improved by 32.2 percent.

RECOMMENDATIONS FOR QUALITY

- Continue expanding Plans' DMC-ODS services and provider networks based on the most recent ASAM recommended service levels and reasonable distances for members, aiming to reduce wait times and admission delays, especially for more acute LOCs such as WM and residential.
- Increase outreach and systemwide SUD services for youth to better align with their needs and prevalence. Align service levels and PRs more closely with the 2023 National Survey on Drug Use and Health data on SUD prevalence.[95]
- Encourage Plans to prioritize the establishment of more RR housing linked to care coordination, outpatient, and MAT services, as recommended by members in many reviews to prevent relapse after discharge from residential treatment. While not a component of the DMC-ODS, RR housing plays a key role in enabling treatment success.

[95] Valentine, A. & Brassil, M. (January 27, 2022). *2022 edition – substance use in California.* California Healthcare Foundation. https://www.chcf.org/publication/2022-edition-substance-use-california/

- Strengthen care coordination between DMC-ODS, MH, and physical health programs, as these key treatment programs are crucial for successful access to care, support for LOC transitions, and treatment retention. Care coordination tailored to members' specific needs is also essential for advancing CQS goals, including engaging members in their health, integrating BH and wellness, and eliminating health disparities.
- Continue MAT expansion projects, including mobile NTP and primary care partnerships, with clinical leadership to enhance and integrate NTP and non-methadone MAT services at all LOCs, including MAT for AUD. Provide TA on incentive models and legal issues related to land use zoning and other barriers used to block new treatment sites and RR housing.
- Set Plan and QI performance standards, establish targets, and initiate improvement strategies for member engagement, transitions, and overall care retention when programs fall below the threshold. Review and apply the lessons learned from SUD treatment research and successful PIPs to improve care transitions and retention, thereby enhancing treatment outcomes.
- Provide incentives to enhance DMC-ODS Plan and provider network data infrastructure and expertise, building on CalAIM initiatives. Plans need the capacity to use clinical and program data to assess system needs, evaluate the success of improvement strategies in measures such as HEDIS, and support leadership in making key decisions.
- Refine QAPI WPs by setting standards to establish measurable goals and objectives for improving members' experiences with low-barrier access, timeliness, quality, and effective treatments. To support these efforts, they should increase their use of technology with data analytic software to make useful measures (including HEDIS and NQF) and reports readily available for QI purposes.
- Improve NOMS standards for California by updating CalOMS to align with ASAM and state-required LOCs, ensuring capacity for useful reports on program completions, early departure (administrative discharges), and treatment progress, in collaboration with stakeholders.
- Continue expanding and strengthening workforce capacity by including additional disciplines such as occupational therapists in the DMC-ODS, expanding loan forgiveness and training options, requiring new training for EBPs through continuing education units and continuing medical education requirements, and fostering integrated career tracks for SUD treatment and MH.
- Leverage new workforce opportunities, such as peer certification, recovery navigators, and community health workers, to broaden workforce options in partnership with Plans and network providers, including those offering prevention services linked to treatment referrals.
- Continue efforts to increase response rates to TPS during annual administrations at all LOCs, seeking broad inclusion of demographics, languages, and age groups.

SUMMARY OF QUALITY

As Plans adjust to national quality measures, embrace CalAIM, and expand their QI efforts, there is growing demand for data analytics to support QM and skilled QI staff who must monitor and interpret these analyses. Additionally, executive leadership must value and invest in these processes, integrating member feedback and involvement as fundamental to the system.

Similarly, improving communication with providers and stakeholders, enhancing data systems, and strengthening staffing to support quality were key areas for improvement.

Those Plans that changed their EHRs expressed both hope and anxiety that their new systems would enhance QI efforts rather than just compliance, especially for aggregate calculations and HEDIS measure collection. For many Plans, measures are still a mix of manual entry and electronic tracking, resulting in data that is not always readily available, sufficiently accurate, or adequately displayed to inform the system. CalMHSA also supports these efforts by reporting BHAS measures for the Plans that contract for this service.

QAPI WPs included more goals for addressing system quality issues rather than just compliance, with some expansion of the continuum of care services noted and many expansion goals set for FY 2024-25. DMC-ODS Plans continued to review their continuum of care. While adding various LOC settings remains an ongoing need, they were also working to reduce barriers by offering low-barrier opportunities to reach individuals with SUD but who may not yet be ready to engage in treatment. Practice models are also reassessing the limitations of traditional “completion” outcome paradigms, while strengthening workforce training and ensuring fidelity to EBPs.

In addition to addressing barriers related to the stage of readiness at intake, Plans have made considerable progress in providing support for members once they are engaged in services. This support has included care coordination, system navigation, peer support and case management, very often in collaboration with ancillary services, physical and MH partners, criminal justice, child welfare and other social service entities. Care continues to be refined as increased access to MAT, including non-methadone forms, and overdose prevention are recognized as critical components of the SUD care delivery system.

Along with encouraging adherence to treatment parameters through innovative models such as contingency management, persistence in care has been bolstered by providing necessary resources to address ancillary needs, such as housing. This, in turn, helps members navigate the treatment continuum, adjusting their LOC as clinical needs change, and is fostered by ongoing efforts to ensure seamless transitions between treatment levels. In most Plans, there appears to be a correlation between the levels of support provided from intake through discharge and SUD treatment outcomes. This is further evidenced by improvements in housing and employment statuses reported in CalOMS discharges. Additionally, expanding and strengthening the skillset among the workforce is critical for addressing these quality issues.

Performance Improvement Projects

INTRODUCTION

A PIP is "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner."[96] Each PIP is expected to produce member-focused outcomes. The CMS *Validating Performance Improvement Prcjects* protocol specifies that the EQRO validate two PIPs at each county that have been initiated, are underway, or were completed during the reporting year.[97] Accordingly, for this Annual Report, CalEQRO examined projects that were underway at some time during the 12 months preceding the FY 2023-24 reviews. In each DMC-ODS report, the PIPs are described in detail, along with a summary of the performance based upon the PIP Validation Tool.[98]

Each DMC-ODS is required to conduct two PIPs: one clinical and one non-clinical. The clinical PIP is expected to focus on treatment interventions to improve outcomes and member experiences, while the non-clinical PIP is expected to focus on administrative or operational processes that improve care and the member experience. The goal of both PIPs is to address problems or barriers in care which, if successful, will positively impact member outcomes.

A clinical PIP might target some of the following types of issues:

- Prevention and treatment of a specific SUD condition
- High-risk procedures and services, such as WM with pregnant women
- Transitions in care from 24-hour settings to community settings
- Enhancing treatment for special needs populations

A non-clinical PIP might target some of the following types of issues:

- Coordination of care with pharmacy and ancillary care providers
- Timeliness and convenience of service improvements
- Improvements in customer service and initial engagement in care
- Member services and processes that are barriers to optimal member outcomes and satisfaction
- Improvement in access or authorization processes

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[96] Department of Health and Human Services & Centers for Medicare and Medicaid Services. (February 2023). *CMS external quality review (EQR) protocols.* https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf

[97] Ibid.

[98] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

The CalAIM BHQIP is a DHCS incentive project which allowed each DMC-ODS Plan to earn incentive payments by completing deliverables tied to program milestones.[99] "Leverage improved data exchange capabilities to improve quality and coordination of care, Milestone 3d," produced PIP opportunities to enable Plans to receive incentive funding from DHCS and credit as a PIP, using the DHCS format. There were two options based upon NCQA measures: FUA and POD. Both are worthy PIP topics as they address issues related to high-risk members. As a defined HEDIS measure, POD assesses the percentage of OUD pharmacotherapy treatment events among members that continue for at least 180 days. FUA assesses ED visits for members 13 years of age and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, who had a follow-up visit for SUD. These PIPs could be clinical or non-clinical in nature, depending upon the analysis and subsequent identified interventions. These projects are referred to in this report as BHQIP FUA or POD. The last submission to DHCS was in September 2023, though CalEQRO reviewed these PIPs throughout the year.

METHODS

The PIP Development Tool is a template provided by CalEQRO for the Plans to use when drafting their PIP narratives.[100] Using the tool helps ensure that the DMC-ODS addresses all of the essential PIP components that will be necessary for validation. The Plans are expected to submit both PIPs 4 weeks prior to the EQR, though often times they are submitted the week prior and even the day before the review. The designated CalEQRO Quality Reviewer and the CalEQRO PIP Consultant review all submitted PIPs for clarity, applicability, and relevance to the Plans' population, methodology used, and data findings, among other features included in the PIP Validation Tool.

During the EQR, the assigned review team discusses the documentation provided by the DMC-ODS Plan. During these sessions, the team provides feedback and TA for strengthening the submitted PIPs. Following the review, DMC-ODS staff may resubmit their PIPs with any changes or additions based upon review discussions. CalEQRO reviews and validates, utilizing the PIP Validation Tool, any resubmitted PIPs in accordance with the requirements of CMS Protocol 1.[101]

All PIPs are rated based on their progress, completeness and adherence to the standards found in the CMS protocol. Each of the nine PIP steps include subsections containing standards that are rated according to the PIP Validation Tool; the steps are shown in Table 7-1.

[99] https://www.dhcs.ca.gov/Documents/DHCS-8761-CalAIM-BHQIP-Program-Implementation-Plan-and-Instructions-Enclosure-2.pdf

[100] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

[101] Department of Health and Human Services & Centers for Medicare and Medicaid Services. (February 2023). *CMS external quality review (EQR) protocols.* https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf

Table 7-1: PIP Validation Steps

Step	PIP Section
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method (if applicable)
5	Review the Selected PIP Variables and PMs
6	Review the Data Collection Procedures
7	Review Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

All PIPs are rated based on their completeness and adherence to the standards found in the CMS protocol and are assigned a status and a confidence rating.[102] Validity ratings are based on the degree to which the PIP adheres to acceptable methodology in study design, data collection, analysis, and interpretation of results. Based upon performance as indicated in the PIP Validation Tool, each PIP is subsequently assigned a rating of High, Moderate, Low, or No Confidence, where each rating is described:

- High confidence – Credible, reliable, and valid methods for the PIP were documented.
- Moderate confidence – Credible, reliable, or valid methods were implied or established for part of the PIP.
- Low confidence – Errors in logic were noted or contradictory information was presented or interpreted erroneously; this may include a lack of demonstrated outcome data.
- No confidence – The PIP did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

Table 7-2 defines each of the statuses that are assigned based upon the progress of the PIP.

[102] Ibid.

Table 7-2: PIP Status Definitions

PIP Validation Phase per CMS Protocol Terminology	Definition
PIP Submitted for Approval	The DMC-ODS submitted the PIP concept for review by CalEQRO.
Planning Phase	The DMC-ODS is preparing to implement the PIP.
Implementation Phase	The DMC-ODS has established baseline data on at least some of the indicators, and at least some strategies for improvement have started. Any combination of these is acceptable.
Baseline Year	A strategy for improvement has begun and the DMC-ODS is establishing or refining a baseline measurement.
First Remeasurement	Baseline has been established and one or more strategies are being remeasured for the first year/period.
Second Remeasurement	The success of the strategy(s) is being measured for the second year/measurement period.
Other – Multiple Remeasurements	The strategy is being measured beyond the second remeasurement.
Other – Completed	In the past 12 months (since the prior EQR) the work on the PIP has been completed.
Other – Developed in a Prior Year	Rated last year and not rated this year due to lack of any activities in the past year.

To be considered in the Implementation phase, a PIP must have (1) baseline data on some indicators or PIP variables and (2) some improvement strategies must have started. During the Baseline year, a strategy has begun and refinements in the baseline measurements may be occurring, but there will not yet be a First Measurement. A PIP in the First Remeasurement phase will be measuring the impact of the improvement strategy per the key indicators and then preparing for the Second Remeasurement. Some PIPs have more remeasurement periods, placing them in the other phase. Additionally, PIPs that have been completed at some point since the prior review would also be placed in the Other phase.

PIP SUBMISSIONS

In FY 2023-24, the 31 DMC-ODS Plans submitted a total of 62 of the required 62 PIPs. This is an increase over the 59 (95 percent) of the required 62 PIPs that were submitted for FY 2021-22 and is consistent with the 62 PIPs that were submitted for the FY 2022-23 validation.

Detailed PIP findings across the past 3 years are reflected in Table 7-3.

Table 7-3: PIP Submission Status Summary, FY 2021-24

Submission Status	FY 2021-22		FY 2022-23		FY 2023-24	
	#	%	#	%	#	%
PIP Submitted for Approval	0	0%	0	0%	2	3%
Planning Phase	3	5%	20	32%	11	18%
Implementation Phase	11	18%	9	15%	19	31%
Baseline Year	2	3%	2	3%	7	11%
Remeasurement	28	45%	17	27%	22	35%
Completed	15	24%	14	23%	1	2%
Total PIPs Submitted	**59**	**95%**	**62**	**100%**	**62**	**100%**
No PIP submitted	3	5%	0	0%	0	0%
Total Possible PIPs	**62**	**100%**	**62**	**100%**	**62**	**100%**

Note: *Percentages for Submission Status uses Total Possible PIPs (62) as the denominator. Percentages may not add up to 100% due to rounding of percentages.*

- As in the year prior, all Plans submitted two PIPs, though 2 were submitted for approval and 11 were in the planning phase.
- There was an increase in the number of PIPs submitted in the remeasurement phase for the current validation, improving from 27 percent of all submissions in FY 2022-23 to 35 percent in FY 2023-24. However, this is a decrease from FY 2021-22, which saw 45 percent of all submissions in remeasurement phase. This is generally due to the timing of newly implemented PIPs, but also it may be due to remeasurement activities not occurring as swiftly and frequently as is beneficial and necessary.
- There was a substantial decrease in the number of PIPs submitted that were completed in FY 2023-24. In FY 2022-23, nearly one-fourth of all PIPs submitted were completed for the second review year in a row, compared to just one PIP (2 percent) this year.

Validity ratings are based on the PIP Validation Tool, which evaluates the degree to which the PIP adheres to acceptable methodology in study design, data collection, analysis, and interpretation of results.[103] Each PIP is subsequently assigned a rating of high, moderate, low, or no confidence.[104]

Table 7-4 compares the confidence ratings between the three FYs.

[103] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

[104] Department of Health and Human Services & Centers for Medicare and Medicaid Services. (February 2023). *CMS external quality review (EQR) protocols*. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf

Table 7-4: PIP Validity Ratings Summary, FY 2021-24

Validation Rating	FY 2021-22		FY 2022-23		FY 2023-24	
	#	%	#	%	#	%
High Confidence	7	12%	8	13%	6	10%
Moderate Confidence	24	41%	28	45%	27	44%
Low Confidence	27	45%	24	39%	27	44%
No Confidence	1	2%	2	3%	2	3%
Total PIPs Submitted	**59**	**100%**	**62**	**100%**	**62**	**100%**

***Note**: Percentages for Submission Status uses Total PIPs Submitted (varies per year) as the denominator. Percentages may not add up to 100% due to rounding of percentages.*

- For FY 2023-24, most PIPs were rated Moderate and Low Confidence, each at 44 percent. Low confidence rated PIPs were often found to be in the early stages of development and did not have data to validate the success of the interventions, or the PIPs contained errors in logic or contradictory information that led the CalEQRO to question whether the desired results could be achieved.
- A PIP that receives a validation rating of Moderate Confidence is a PIP that implies credible, reliable, or valid methods for at least part of the PIP and there was a slight decrease noted, with 44 percent of Plans achieving this rating in FY 2023-24 compared to 45 percent during the prior review year.
- Only 10 percent were found to have a High Confidence validity rating, with credible, reliable, valid methods, and results. This is a decrease from its high from FY 2022-23 when 13 percent were rated with high confidence.
- The changes noted above are represented in a decrease in the number of PIPs that were rated as High Confidence in FY 2023-24 over FY 2022-23 and FY 2021-22.
- Each year just one or two PIPs rated No Confidence. A rating of No Confidence is assigned to PIPs that did not contain enough documentation to determine whether credible, reliable, and valid methods were employed, or where documentation demonstrates that those methods were not employed at all.

PIP DOMAINS

In addition to submission and validation statuses, the clinical and non-clinical PIPs can be categorized into four domains: access to care, timeliness of care, quality of care, and outcomes of care. The domains pertain to the DMC-ODS Plans' operation of an effective managed care organization, such as processes for ensuring access to and timeliness of services, as well as processes for improving the quality of care or improvements in functioning or outcomes as the result of care.

Table 7-5 identifies PIPs by one of four domains: access, timeliness, quality, or outcomes for the three FYs.

Table 7-5: PIP Domain by Category and Type, FY 2021-24

Domain	FY 2021-22			FY 2022-23			FY 2023-24		
	% by Domain	# Clinical	# Non-Clinical	% by Domain	# Clinical	# Non-Clinical	% by Domain	# Clinical	# Non-Clinical
Access	34%	7	13	32%	10	10	35%	14	8
Timeliness	12%	1	6	32%	4	16	23%	5	9
Quality	25%	10	5	16%	9	1	32%	8	12
Outcomes	29%	13	4	19%	8	4	10%	4	2

Note: Percentages for Submission Status uses Total PIPs Submitted (varies per year) as the denominator. Percentages may not add up to 100% due to rounding of percentages.

Access to Care

The Access to Care PIPs represent 35 percent of all PIPs submitted, similar to the year prior. These PIPs had a variety of themes, many of which are linked to the initial engagement and screening phase or linkage with the first phase of treatment and access call center functions. Fourteen of these PIPs had a clinical focus while eight had a non-clinical focus.

There were several PIPs developed in response to the CalAIM BHQIP. Many of the POD and FUA PIPs were associated with access to care.

Other access to care PIP topics focused on issues such as continuity of care between residential and lower LOCs, case management or care coordination services and teams, and access to residential treatment.

Timeliness of Care

The number of timeliness of care PIPs, representing 23 percent, was lower than last year. This decrease in the submission of timeliness to care PIPs was also in response to a reclassification of FUA PIPs. The PIPs that are designed to address FUA are focusing on improving tracking and referral systems between the ED and the Plan, and several of these were ultimately classified this year as access or quality PIPs.

The other PIPs in this domain were focused on meeting specific timeliness requirements related to routine first appointments at residential and outpatient, first appointments for assessments, and timely coordination at intake.

Quality of Care

The quality of care topic area had 20 PIP submissions this year, representing 32 percent of all PIPs submitted. This is an increase from the 10 PIPs in this category during FY 2022-23 and the 15 PIP submissions in FY 2021-22. This year, 8 were clinical and 12 were non-clinical.

As mentioned above, the increase in the submission of quality of care PIPs is directly related to the re-classification of BHQIP FUA PIPs. The follow-up care aspect of this HEDIS measure shifted the topic to a quality focus versus the prior year's timeliness focus.

Many other quality related PIPs focused on assessment and services for those with co-occurring MH needs. Several focused on engaging members with care coordination to improve

transitions in care across the system of care. Other PIPs focused on improving integrated care between behavioral and physical health, ensuring services that benefit members beyond SUD treatment.

Outcomes of Care

Outcomes of care represented just 10 percent of PIP projects in FY 2023-24, a drop from the 19 percent in the previous review year and substantially less than the 29 percent presented for review in FY 2021-22.

For the outcomes of care PIP topic area, the six PIPs (10 percent) focused on clinical outcomes, four designed as clinical and two as non-clinical. The clinical PIPs sought to utilize case management to improve individual member outcomes by improving rates of engagement or linkage to ancillary services. The non-clinical PIPs focused on the positive impact on members in engagement and retention resulting from their receiving recovery services, motivational interviewing, and members being provided greater choices within the continuum of care. Each of the designs is supported by research in the field indicating that removing barriers, providing care coordination, and obtaining increased engagement and retention in SUD care will result in a strong likelihood of improved clinical outcomes.

PIP VALIDATION

Table 7-6 below describes the submission status for all 31 Plans. Each Plan's PIP submission status, the title of the PIP, summary of the interventions, domain that the PIP addresses, and the validation status of each PIP are listed below.

Although the Plan may have named the PIP differently, CalEQRO uniformly renamed all BHQIP PIPs as BHQIP FUA or BHQIP POD.

Table 7-6: PIPs, FY 2023-24

PIPs				
DMC-ODS	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating (Confidence)**
Alameda	Clinical	Care Coordination for Residential SUD Services		
		Increased care coordination in residential treatment		
		Quality	Implementation	Low Confidence
	Non-Clinical	BHQIP FUA		
		Leveraged data exchange; clinician alerts; referral tracking system		
		Quality	Implementation	Low Confidence
Contra Costa	Clinical	Decrease the Readmission Rate to Residential WM		
		Created tools for transition management - educational materials, checklists, additional staff		
		Outcomes	Second Remeasurement	Moderate Confidence

PIPs				
DMC-ODS	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating (Confidence)**
Contra Costa	Non-Clinical	BHQIP FUA		
		Navigators stationed in ED to streamline referrals		
		Quality	Planning	High Confidence
El Dorado	Clinical	BHQIP FUA		
		Established an MOU making ED staff capable of assessing members for care		
		Quality	First Remeasurement	Moderate Confidence
	Non-Clinical	BHQIP POD		
		Implemented a social determinants of health screening; wraparound for NTP referrals; thresholds for care coordination referrals		
		Access	First Remeasurement	Low Confidence
Fresno	Clinical	Improving Engagement of Care		
		Strengths-based follow-up for those discharged from outpatient services		
		Outcomes	Second Remeasurement	Low Confidence
	Non-Clinical	BHQIP FUA		
		Real-time referrals and tracking with the ED; alerts for high need referrals		
		Timeliness	First Remeasurement	Low Confidence
Imperial	Clinical	BHQIP FUA		
		Collaborative and coordinated, screening, and referrals from the ED		
		Timeliness	Implementation	Low Confidence
	Non-Clinical	Decreasing Administrative CalOMS Discharges to Improve the Treatment Outcome		
		Staff training on CalOMS; assign supervisors with tracking the discharges		
		Outcomes	Planning	Low Confidence
Kern	Clinical	Recovery Incentives Program		
		A 24-week pilot recovery incentive program		
		Outcomes	Implementation	Low Confidence
	Non-Clinical	Same Day SUD Assessments		
		A daily, walk-in assessment schedule		
		Timeliness	Implementation	Low Confidence
Los Angeles	Clinical	BHQIP POD		
		LPHA trainings; member education materials; monitoring accessibility to medications for opioid use disorder		
		Access	Planning	Moderate Confidence
	Non-Clinical	BHQIP FUA		
		Member education materials; care coordinators and referral tracking system		
		Timeliness	Planning	Low Confidence
Marin	Clinical	BHQIP FUA		
		Bilingual recovery coach in the ED; real-time referral alerts		
		Timeliness	Second Remeasurement	High Confidence

PIPs				
DMC-ODS	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating (Confidence)**
	Non-Clinical	BHQIP POD		
		Increased transportation funding and facilitation; greater collaboration with MCP		
		Access	First Remeasurement	Moderate Confidence
Merced	Clinical	BHQIP POD		
		Application of a medication adherence questionnaire; enhanced care management referrals leveraging an HIE		
		Access	Implementation	Low Confidence
	Non-Clinical	BHQIP FUA		
		Promotional flyers; Standardized referral form; HIE and alert system		
		Timeliness	Implementation	Moderate Confidence
Monterey	Clinical	SUD Clinical PIP Using ASAM Criteria to Place Individuals into Residential Treatment		
		Embedded ASAM in the assessment with closed-loop referrals		
		Quality	Planning	Low Confidence
	Non-Clinical	BHQIP FUA		
		Referral alerts; EHR tracking; and identified staff for linkage from the ED		
		Quality	Implementation	Low Confidence
Napa	Clinical	BHQIP POD		
		A bilingual MH worker to collaborate and coordinate referrals		
		Access	First Remeasurement	Low Confidence
	Non-Clinical	BHQIP FUA		
		Regular stakeholder and team meetings; data tracking; program brochures		
		Timeliness	First Remeasurement	Low Confidence
Nevada	Clinical	BHQIP FUA		
		Use of a tracker for referrals from the ED and navigators for follow-up		
		Quality	Second Remeasurement	Moderate Confidence
	Non-Clinical	BHQIP POD		
		A tracker for members who miss two doses of MAT; care coordinators for follow-up		
		Access	Second Remeasurement	High Confidence
Orange	Clinical	Increase Individual Counseling to Outpatient Members to Improve Satisfactory Progress		
		Reduced length of the intake process; increased appointment reminders		
		Outcomes	PIP Submitted for Approval	Moderate Confidence
	Non-Clinical	Increasing Linkage to Lower Residential LOC Following WM Residential Detox Discharge		
		Bridge services for members awaiting residential placement		
		Outcomes	PIP Submitted for Approval	Moderate Confidence

PIPs				
DMC-ODS	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating (Confidence)**
PHC	Clinical	Enhancing Linkage between Acute Care and SUD Providers with Community Health Workers (CHW) Assisting with Transitions in Care		
		Incentive program for CHWs; billing capabilities for CHWs; referral pathways		
		Timeliness	Planning	Low Confidence
	Non-Clinical	Administrative Support Tools for CHWs Supporting Acute Care and SUD Providers Coordination for Members		
		Roll out of CHWs in hospitals		
		Access	Planning	Low Confidence
Placer	Clinical	Early Engagement with Intensive Outpatient Treatment		
		Case management services to identify and resolve barriers to treatment		
		Quality	Third Remeasurement	No Confidence
	Non-Clinical	BHQIP FUA		
		Warm handoffs; care coordination meetings; data exchange with ED		
		Timeliness	Planning	No Confidence
Riverside	Clinical	Residential Treatment Re-engagement Groups		
		A peer-led group to maintain engagement after members drop out of residential 3.5		
		Quality	Implementation	Moderate Confidence
	Non-Clinical	BHQIP FUA		
		ED navigator dashboards/reports; member follow-ups; hire more Spanish-speaking navigators		
		Quality	Implementation	Moderate Confidence
Sacramento	Clinical	Cross Referrals		
		Enable provider-to-provider referral feature in SmartCare EHR		
		Quality	Baseline Year	Low Confidence
	Non-Clinical	Information Dissemination		
		Updated information dissemination from provider management to line staff		
		Quality	Baseline Year	Low Confidence
San Benito	Clinical	BHQIP FUA		
		HIE and other tracking methods for members noncompliant with MAT		
		Quality	First Remeasurement	Moderate Confidence
	Non-Clinical	BHQIP POD		
		Data exchange with ED and MCP; closed-loop referrals; identified care coordinators		
		Access	First Remeasurement	Low Confidence

PIPs				
DMC-ODS	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating (Confidence)**
San Bernardino	Clinical	BHQIP POD		
		Establish data exchange and alert system for follow-up from the ED		
		Access	Baseline Year	Low Confidence
	Non-Clinical	BHQIP FUA		
		Screen for social determinants of health at intake; provide care coordination		
		Quality	Baseline Year	Low Confidence
San Diego	Clinical	BHQIP POD		
		Developed MAT educational pamphlet and video		
		Access	Implementation	Moderate Confidence
	Non-Clinical	BHQIP FUA		
		Certified peers in EDs; distribute educational resources		
		Quality	Implementation	Low Confidence
San Francisco	Clinical	BHQIP FUA		
		Navigator in ED; use of Epic tools for referral and tracking; assertive outreach to no-shows		
		Timeliness	Second Remeasurement	Low Confidence
	Non-Clinical	BHQIP POD		
		MAT services for those presenting at ED or jail; incentivized visits		
		Access	Completed	Moderate Confidence
San Joaquin	Clinical	BHQIP POD		
		Administration of medication management needs assessment; enhanced referral management		
		Access	Fourth Remeasurement	Moderate Confidence
	Non-Clinical	BHQIP FUA		
		Education and promotion with ED staff; closed-loop referrals; data tracking in SmartCare		
		Quality	Second Remeasurement	High Confidence
San Luis Obispo	Clinical	BHQIP POD		
		Referral tracking mechanism from ED; alert system for high-risk cases		
		Access	First Remeasurement	Moderate Confidence
	Non-Clinical	BHQIP FUA		
		Referral tracking mechanism from ED; alert system for high-risk cases		
		Quality	First Remeasurement	Moderate Confidence

PIPs				
DMC-ODS	**Type**	**PIP Title**		
		Intervention		
		Domain	**Status at Submission**	**Validation Rating (Confidence)**
San Mateo	Clinical	BHQIP POD		
		Establish an alert system when open members have an ED visit		
		Access	Implementation	Moderate Confidence
	Non-Clinical	BHQIP FUA		
		Created standard process for referring to MAT		
		Quality	Planning	Moderate Confidence
Santa Barbara	Clinical	BHQIP POD		
		Design and implement MAT trainings for members, staff, peer promoters		
		Access	Implementation	Moderate Confidence
	Non-Clinical	BHQIP FUA		
		Distribute bilingual Access Line cards to ED; placement of care coordinators; tracking and referral system		
		Quality	Implementation	High Confidence
Santa Clara	Clinical	BHQIP POD		
		Peer navigator program for referrals from the ED		
		Access	Baseline Year	Moderate Confidence
	Non-Clinical	BHQIP FUA		
		Peer mentor as patient liaison in the addiction medicine team		
		Quality	Baseline Year	Moderate Confidence
Santa Cruz	Clinical	BHQIP POD		
		Embedded additional care coordinators in MAT program; data exchange between ED and NTP programs		
		Access	Implementation	Moderate Confidence
	Non-Clinical	BHQIP FUA		
		Bilingual liaisons into the EDs for referrals and screenings; data tracking and exchange		
		Timeliness	Implementation	Moderate Confidence
Stanislaus	Clinical	BHQIP POD		
		Care coordination to high-risk members		
		Access	Implementation	Moderate Confidence
	Non-Clinical	BHQIP FUA		
		Referral coordinator for referrals from the ED		
		Timeliness	Implementation	Moderate Confidence

PIPs				
DMC-ODS	Type	PIP Title		
		Intervention		
		Domain	Status at Submission	Validation Rating (Confidence)
Tulare	Clinical	BHQIP POD		
		Motivational reminder calls for members who miss a dose of MAT		
		Access	Second Remeasurement	Moderate Confidence
	Non-Clinical	Increasing the Number of Hispanic Individuals Who Utilize DMC-ODS Services		
		Targeted outreach to the predominantly Hispanic regions of the county		
		Access	Second Remeasurement	High Confidence
Ventura	Clinical	Study of Member Engagement and Retention in Early Outpatient Treatment		
		Client-identified goals to overcome obstacles to attendance		
		Access	Second Remeasurement	Moderate Confidence
	Non-Clinical	BHQIP FUA		
		Training for navigators and ED staff; educational materials for staff and members		
		Timeliness	Baseline Year	Low Confidence
Yolo	Clinical	BHQIP FUA		
		Establish HIE; identify staff to monitor the information and to follow-up with identified members		
		Timeliness	Planning	Low Confidence
	Non-Clinical	BHQIP POD		
		Establish HIE; identify staff to monitor the information and to follow-up with identified members		
		Access	Planning	Low Confidence

TRENDS IN PIP SUBMISSIONS

This year, the percentage of PIPs that had progressed beyond planning to the phase of actively implementing interventions has increased substantially at 66 percent, when compared to only 37 percent of PIPs that were beyond the planning phase in FY 2022-23.

In FY 2023-24, only four Plans did not submit a BHQIP PIP (Kern, Orange, PHC, and Sacramento). Of the 27 Plans that submitted BHQIP PIPs, 18 Plans submitted both FUA and POD for the two PIP requirements, compared to five Plans in FY 2022-23.

Overall, the confidence level assigned to the PIPs is comparable to the prior years as 53 percent of PIPs are rated with Moderate Confidence or High Confidence. The Plans have more clarity in their data collection and analysis plans, selection of PMs, and the foundational research of the problems they are identifying for the PIP. This may be a benefit of this being the seventh year since implementation of the DMC-ODS framework, though only three Plans have experience with PIPs for that entire 7-year period. Additionally, while Plans had submitted PIPs in the past, ongoing workforce issues (noted elsewhere in this report) have resulted in situations in which new staff working in QM were assigned to (and tasked with learning de novo) the PIP process.

PIP TECHNICAL ASSISTANCE

CalEQRO provides TA to all DMC-ODS Plans through multiple channels: during reviews, e-mail, phone, video, and webinars. The intention is to help DMC-ODS programs produce qualified PIPs, with TA ranging from helping to develop measurable aim statements to a comprehensive evaluation of all PIP validation steps.

Sixteen DMC-ODS Plans (52 percent) utilized TA from CalEQRO in the development and support of their PIPs. This was a decrease from the 26 DMC-ODS Plans that utilized TA during FY 2022-23 and the 24 that utilized TA during FY 2021-22. This is likely a reflection of the extensive amount of TA that was required during FY 2022-23 to aid the Plans in launching the BHQIP PIPs. Further, in later phases, more Plans relied on the CalMHSA team for data and analysis, and therefore sought TA from them.

Outside of the review process, CalEQRO provided a total of 43.5 hours of individual TA to those 16 Plans, averaging a total of 2.75 hours of TA per Plan. Additionally, TA was provided to all 31 Plans during the lead-up to and the review itself, either on-site or virtually. The TA consisted of assistance in PIP construction, performing data analysis, modifying PIPs due to COVID-19 impacts, and supplying feedback on PIP design. Feedback from assigned quality review staff took the form of facilitating pre-review PIP sessions, verbal queries, email discussion, and written annotations on PIP submission tool drafts and design challenges. Some Plans also had difficulties collecting and using data to design PIPs targeting a specific problem in their Plan or community.

In addition to the TA described above, during the FY 2023-24 review year, CalEQRO supplemented its TA with PIP clinic webinars and an in-person presentation. The subjects and presentation formats of each PIP TA provided are shown in Table 7-7.

Table 7-7: TA Provided via PIP Clinics by CalEQRO, FY 2023-24

Title of Webinar	Format	Date
PIPs – Opportunities and Lessons to Date	Webinar	September 28, 2023
PIP Designs to Emulate	Webinar	December 18, 2023
Annual Technical Report	In-Person	March 13, 2024

CalEQRO conducted three TA sessions as presentations with an opportunity for questions. Two PIP webinars concentrated on providing assistance to Plans regarding the opportunity to develop PIPs based on the DHCS BHQIP initiative, including some strong Plan examples. A third presentation was provided at the annual QI Coordinator's conference in the context of the FY 2022-23 Annual Technical Report findings, with the PIP discussion focusing on common PIP challenges and solutions.

SUMMARY OF PIP VALIDATION

In summary, for the 31 DMC-ODS Plans, all Plans submitted two PIPs for a total of 62 PIPs. Further, 81 percent had implemented at least one intervention and had begun measuring the effectiveness of that intervention. In FY 2023-24, the most common PIP domain was access, accounting for 35 percent of all submissions, followed closely by quality at 32 percent.

Receiving credit from both DHCS for the CalAIM incentive and CalEQRO for the PIP was highly successful in terms of participation. CalEQRO received numerous PIP submissions (87 percent of Plans submitted one or more) in response to the CalAIM BHQIP initiative; 58 percent of Plans submitted both BHQIP FUA and POD. Many of these PIPs were still in the early stages of implementation, even in the second year, which contributed to the surge in Low Confidence ratings noted above. Despite that reality, quality review staff observed DMC-ODS Plans actively working to navigate the inherent complexities of building necessary collaboration (and eventually data exchange) with MCPs, EDs, and allied healthcare systems.

Despite challenges, most DMC-ODS Plans worked to implement projects that improve access, timeliness, quality, and outcomes for members. This achievement is largely due to the Plans' perseverance in overcoming significant resource and workforce challenges to design and implement PIPs, and more were doing interventions showing progress, combined with CalEQRO's encouragement and TA, which guided them in using this framework to benefit the members served.

Validation of Member Perceptions of Care

INTRODUCTION

Understanding how members perceive their experiences with DMC-ODS programs is a key PM for evaluating both member satisfaction and the quality of care they receive. This feedback can significantly inform service performance assessments and QI efforts. This chapter aims to present member feedback in a way that highlights the strengths and areas for improvement of the DMC-ODS Plans from the members' perspectives. This important evaluation relies primarily on two sources: member focus groups, and the TPS, managed statewide by DHCS's contractor, UCLA – ISAP. The TPS is a set of standardized questions administered annually to all members who are in treatment at the time of the survey, and the focus groups, conducted during EQRs, are designed to collect detailed feedback on members' treatment experiences.

TREATMENT PERCEPTION SURVEY 2023

The TPS was developed to meet CMS requirements for data collection, analysis, and evaluation related to the DMC-ODS demonstration waiver. UCLA's ISAP developed the TPS to assess adult and youth treatment services within the DMC-ODS Plans across specific areas. The adult survey consists of 14 questions that concentrate on four key areas or domains: access to care, quality, outcomes, and general satisfaction. The youth TPS includes the same questions with an additional four along with one extra question focused on quality of the therapeutic alliance.

In FY 2023-24, the TPS was conducted from October 16-20, 2023, in 38 counties encompassing 31 DMC-ODS Plans.[105] This marked the seventh consecutive year of administering the TPS within the DMC-ODS framework. The survey was distributed to both adult and youth members, who receive age group specific surveys, and the results are reported separately for each group.

The TPS is conducted annually by each Plan within a designated 5-day window, as determined by UCLA in collaboration with DHCS. Since its inception, the administration method has evolved significantly. Initially, during the first 3 years (2017-2019), the survey was entirely paper-based, with both one-page and large print versions available. In 2020, a hybrid model combining paper with an online option was introduced, which several DMC-ODS Plans continue to use. This hybrid approach has proven effective in maximizing member participation by accommodating member preference. It has also been successful in reaching a wider range of members across various LOCs, including those individuals who receive services from remote providers as well as various sub-groups such as those that may lack access to technology, individuals experiencing homelessness, persons with co-occurring MH conditions, and/or those identifying with specific racial/ethnic groups. The survey is available in both formats in English and 12 threshold languages: Spanish, Chinese, Tagalog, Farsi, Arabic, Russian, Hmong, Korean, Eastern

[105] https://www.dhcs.ca.gov/Documents/BHIN-23-024-DMC-ODS-Treatment-Perception-Survey.pdf

Armenian, Western Armenian, Vietnamese, and Cambodian, for both adult and youth members.[106] In addition, UCLA provides an instruction manual for Plans to follow.[107]

All member perception items are rated on a 5-point Likert scale, with "Not Applicable" and "Missing" as additional coding options, as follows: 1 = Strongly Disagree, 2 = Disagree, 3 = I am Neutral, 4 = Agree, 5 = Strongly Agree.

Plan-level results are reviewed as a part of each DMC-ODS annual review. During the reviews, CalEQRO engaged in discussions with Plans about their impressions of the annual TPS findings, changes from prior years, and any improvement activities that were implemented, additional analyses conducted, or plans for further improvement based on the survey results. Overall, Plan results tend to be similarly positive to those shared below, but there are often year-to-year changes that indicate potential problem areas. Additionally, CalEQRO encouraged Plans to compare the results by service type and provider to identify other areas that may need improvement. The TPS display of Plan-level results also enabled conversations regarding the degree of participation when considering the number of surveys submitted compared to the number of members in treatment during the survey.

As in previous years, DMC-ODS Plans surveyed programs which included outpatient (OP), IOT, MAT NTP/OTPs, residential treatment, and WM treatment settings. The results CalEQRO shares includes all submitted surveys regardless of treatment setting.

2023 Adult TPS Results

For the 2023 TPS administration, a total of 17,327 adult TPS forms were received, a 22.56 percent increase in survey participation compared to 2022. Comprehensive results for survey year 2023[108] and prior years[109] are available from UCLA ISAP.

Table 8-1 displays the rates of adult members statewide positively endorsing TPS items, and the domain in which those questions are contained. This table displays the year 2023 with the prior 2 years for comparison.

[106] UCLA Integrated Substance Abuse Programs. (2024). *Treatment perception surveys.* https://uclaisap.org/client-treatment-perceptions-survey/

[107] UCLA Integrated Substance Abuse Programs. (August 12, 2024). *2024 treatment perceptions survey (TPS) instruction manual.* https://uclaisap.org/client-treatment-perceptions-survey/docs/2024/2024TPS_InstructionManual_8_16_24.pdf

[108] UCLA Integrated Substance Abuse Programs. (April 8, 2024). *2023 treatment perceptions survey (TPS) report.* https://uclaisap.org/client-treatment-perceptions-survey/docs/2024/2023_TPS_StatwideReport_04-8-24.pdf

[109] UCLA Integrated Substance Abuse Programs. (2024). *Treatment perception surveys.* https://uclaisap.org/client-treatment-perceptions-survey/#abouttps

Table 8-1: Percent of Adult Members Endorsing TPS Items and Domains, CY 2021-23

Domain	Survey Item	CY 2021	CY 2022	CY 2023
Access	Convenient Location	85.3%	85.5%	86.0%
	Convenient Time	89.1%	88.8%	88.3%
Quality	I Chose My Treatment Goals	88.3%	87.2%	85.9%
	Staff Gave Me Enough Time	91.4%	91.3%	91.2%
	Treated with Respect	92.1%	91.9%	91.5%
	Understood Communication	93.6%	93.3%	93.4%
	Cultural Sensitivity	89.7%	89.7%	89.8%
Care Coordination	Work with Physical Health Providers	84.3%	84.7%	82.7%
	Work with Mental Health Providers	83.9%	83.7%	81.8%
	Staff Helped to Connect with Services*	N/A	N/A	80.9%
Outcomes	Better Able to Do Things	87.7%	87.6%	87.2%
	Feel Less Cravings for Drugs and Alcohol*	N/A	N/A	87.0%
General Satisfaction	Felt Welcomed	92.7%	92.7%	92.9%
	Overall Satisfied with Services	90.8%	90.6%	89.8%
	Got the Help I Needed	87.7%	87.2%	85.3%
	Recommend Agency	90.5%	90.1%	90.2%

* New Survey Question for CY 2023

Overview

The average scores for each of the five domains based upon a 1 to 5-point Likert scale ranked strongly disagree to strongly agree, were: Quality = 4.52, General Satisfaction = 4.52, Access = 4.43, Outcomes = 4.43, and Care Coordination = 4.35. These results reflect consistently high levels of satisfaction across all domains, and all were slightly higher than the average scores in 2022.

Overall, positive responses in the TPS ranged from 80.9 percent to 93.4 percent in 2023. The low end of the range is slightly lower than years prior, at 83.9 percent in 2021 and 83.7 percent in 2022. The lowest response in 2023 was to the new question, “Staff helped to connect with services,” in the care coordination domain. The highest ratings each year was in “Understood Communication” in the Quality domain at over 93 percent in all 3 years.

Access

Access to services was generally well-received, with a slight increase of adult members endorsing "Convenient Location" increasing slightly over the years, reaching 86 percent in CY 2023, but "Convenient Time" saw a slight decrease to 88.3 percent. The decline in convenient timing could point to potential gaps in accessibility. “Cultural Sensitivity" has also maintained a high level of endorsement, slightly increasing to 89.8 percent in CY 2023. The new survey question within the Care Coordination domain, "Staff Helped to Connect with Services," was endorsed by 80.90 percent of members in CY 2023.

Quality

Quality is the most positive area, respondents reported very positive experiences with staff communication and respect. Specifically, 93.4 percent felt that their communication with staff was clear and understood, while 91.5 percent felt they were treated with respect. Cultural sensitivity also received favorable feedback, with 89.8 percent endorsing the agency's cultural awareness. Lower than other questions in the Quality domain, 85.9 percent felt they had a say in setting their treatment goals. Despite challenges with maintaining a consistent workforce, 91.2 percent believed staff provided ample time for their concerns.

The findings suggest a generally positive member experience, particularly in the areas of communication and cultural sensitivity, though some areas may benefit from targeted improvements to sustain and enhance these outcomes. The slight increase in accessibility and consistent satisfaction with the quality of care indicate that members feel supported and understood.

Care Coordination

There was a decline in endorsements for Care Coordination, which held the lowest ratings. Both questions regarding working with physical and MH providers rated less than 85 percent in all 3 years. Approximately 82.7 percent of respondents felt well-coordinated with physical health providers, and 81.8 percent felt similarly about MH providers. Support for connecting with other services (the new question in 2023) was somewhat lower at 80.9 percent, suggesting this is an area for potential improvement. This area appears to warrant attention by Plans.

The lower ratings are in the Care Coordination domain, both for coordinating with MH and physical health care providers, as well as the new question regarding connection with other needed services.

Outcomes

The survey revealed a substantial positive impact on members' lives, with 87.2 percent feeling they were better able to manage daily activities, and 87.0 percent reported reduced cravings for drugs and alcohol, reflecting the effectiveness of the services. “Reduced cravings” was a new question in the adult TPS survey in 2023.

General Satisfaction

Within the General Satisfaction domain, "Felt Welcomed" remained very high and stable at 92.9 percent in CY 2023, and "Recommend Agency" was also stable at 90.2 percent. Feeling welcomed and likely to recommend the agency, reflect an overall positive perception of the services provided.

Survey results overall highlight strong performance in accessibility, communication, respect, and overall effectiveness, with some opportunities for enhancement in care coordination and support for connecting with additional services.

2023 Youth TPS Results

The number of youth respondents to the survey has steadily increased over the years, from 435 in 2021 to 579 in 2022, and reaching 847 in 2023. This represents a 33.1 percent increase from 2021 to 2022 and a further 46.3 percent increase from 2022 to 2023. Overall, there has been a 94.7 percent increase in the number of respondents from 2021 to 2023. This growing

participation suggests a widening engagement and potentially more comprehensive insights into the services provided.

Table 8-2 displays the rates of youth members statewide positively endorsing TPS items, and the domain in which those questions are contained. This table displays the year 2023 with the prior 2 years for comparison.

Table 8-2: Percent of Youth Members Endorsing TPS Items and Domains, CY 2021-23

Domain	Survey Item	CY 2021	CY 2022	CY 2023
Access	Convenient Location	84.0%	80.5%	84.7%
	Convenient Time	85.0%	84.2%	87.0%
	Good Enrollment Experience	85.0%	83.4%	86.9%
Quality	I received the Right Services	89.0%	85.3%	86.7%
	Treated with Respect	95.0%	91.9%	93.5%
	Cultural Sensitivity	80.0%	76.0%	76.9%
	Provided Family Services	77.0%	73.3%	73.9%
Therapeutic Alliance	Worked with Counselor on Goals	93.0%	87.0%	90.0%
	Counselor Listened	94.0%	89.4%	93.5%
	Positive/Trusting Relationship	88.0%	82.6%	87.1%
	Counselor Interested in Me	89.0%	85.6%	88.6%
	Liked Counselor	92.0%	88.3%	92.7%
	Counselor Capable of Helping	93.0%	87.0%	92.2%
Care Coordination	Health/Emotional Needs Met	89.0%	88.3%	87.6%
	Helped with Other Issues/Concerns	86.0%	79.8%	83.4%
Outcomes	Better Able to Do Things	81.0%	79.8%	85.1%
	Feel Less Craving*	n/a	n/a	72.9%
General Satisfaction	Overall Satisfied with Services	89.0%	85.3%	89.4%
	Recommend Services	87.0%	81.9%	86.0%

* New Survey Question for CY 2023

Overview

For the 2023 TPS youth administration, the response rate totaled 847 forms. The average scores for each of the TPS six domains, ranked from highest to lowest scoring, were: General Satisfaction = 4.56, Outcomes = 4.43, Therapeutic Alliance = 4.38, Care Coordination = 4.30, Quality = 4.22, and Access = 4.18. These scores demonstrate consistently high levels of satisfaction across all domains.

In most categories, satisfaction decreased from 2021 to 2022, and then ratings increased in the 2023 administration. In 2023, youth positive perceptions ranged from a low of 72.9 percent ("Feel Less Craving," the new question in 2023) to a high of 93.5 percent ("Treated with

Respect" and "Counselor Listened," both in the therapeutic alliance domain. The highest rating across all 3 years was in "Counselor Listened" at 94 percent in 2021. It was similarly high in 2023 at 93.5 percent. Prior to the new question, the lowest rating was in "Provided Family Services" at 77 percent in 2021 and 73.3 percent in 2022.

Access

Youth satisfaction with access to services increased over the years displayed. The percentage of respondents finding the location convenient rose from 80.5 percent in 2022 to 84.7 percent in 2023. Similarly, the percentage endorsing convenient timing improved from 84.2 percent in 2022 to 87.0 percent in 2023. Positive enrollment experience also saw an increase from 83.4 percent in 2022 to 86.9 percent in 2023.

Quality

The four questions in Quality show the most significant variance in positive endorsement. All questions showed increases compared to 2022, though the increases were more modest for "Cultural Sensitivity" and "Provided Family Services" from 76.0 percent to 76.9 percent and from 73.3 percent to 73.9 percent, respectively. Cultural sensitivity was highest at 80 percent in 2021. "Treated with Respect" at 93.5 percent was higher than 2022 but not as high as 2021 when it was 95 percent.

Therapeutic Alliance

There were notable rebounds in therapeutic alliance indicators in 2023. "Worked with Counselor on Goals" increased from 87.0 percent in 2022 to 90.0 percent in 2023, and "Counselor Capable of Helping" rose from 87.0 percent in 2022 to 92.2 percent in 2023. The continuing strength in the results is clear in that satisfaction with counselors has remained consistently high. "Counselor listened" at 93.5 percent almost reached the 2021 rating of 94.0 percent, as did endorsement of a "Positive/Trusting Relationship" at 87.1 percent. "Liked counselor" was highest in 2023 at 92.7 percent.

Care Coordination

Youth satisfaction in care coordination showed mixed results. The percentage of respondents who felt their health and emotional needs were met slightly decreased from 88.3 percent in 2022 to 87.6 percent in 2023. Despite that, there was an improvement in those respondents who felt helped with other issues or concerns, with results rising from 79.8 percent in 2022 to 83.4 percent in 2023.

Outcomes

The percentage of youth feeling better able to do things increased from 79.8 percent in 2022 to 85.1 percent in 2023. However, the new survey question for 2023, "Feel Less Craving," had the lowest endorsement at 72.9 percent, indicating a specific area for program and member-level intervention.

General Satisfaction

Youth member overall satisfaction with services returned to 89.4 percent in 2023, up from 85.3 percent in 2022. The likelihood of recommending services also increased to 86.0 percent in 2023 from 81.9 percent in 2022. These results indicate high general satisfaction among youth members.

These youth-specific findings indicate overall improvements and high satisfaction levels across most domains, with particular gains in access, therapeutic alliance, and general satisfaction. However, the lower scores pertaining to cultural sensitivity, provision of family services, and reduced cravings, highlight specific areas, often essential for successfully engaging adolescents in SUD services for review and need for improvement.

Telehealth

Due to COVID-19 and the increased need to provide services via telehealth, the 2020 TPS added an item asking, "How much of the services you received was by telehealth?"

Among adult members in 2023, 54.4 percent reported receiving at least some services by telehealth, compared to 56.3 percent in 2022. The breakdown of telehealth services by setting is as follows: OP/IOT settings at 35.8 percent, NTP/OTP settings at 39.9 percent, and WM settings at 0.8 percent. Among youth members in 2023, 50.1 percent reported receiving some services by telehealth, slightly higher than 2022 when 49.4 percent of youth received this service modality.

Given the steady growth of telehealth within the programs of the DMC-ODS framework, this query within the TPS form has been removed for future administrations.

Recommendations for TPS Administration

- Strengthen prompting and encouragement efforts to boost response rates in underrepresented groups, including youth, non-English speakers, and specific LOCs, ensuring more comprehensive TPS data.
- Increase the actionability of TPS results by making data viewable by service type, member ethnicity and by provider, allowing for targeted improvements where specific program variances are identified.
- Examine the youth outcome associated with the new question on craving reduction (72.9 percent), which was significantly lower than adults (87 percent).

MEMBER FOCUS GROUPS

The member focus groups are a qualitative activity involving [redacted] members who started treatment with the DMC-ODS in the past year. The focus groups are scheduled to fit members' availability and are conducted by CalEQRO using both in-person and virtual modes. The feedback from these groups often provides detailed insight into member perceptions of care. To thank participants for their time and input, CalEQRO provides gift cards to group participants.

The focus groups are facilitated by Consumer and Family Member Reviewers with lived experience in substance use treatment themselves or as family members of individuals with SUD issues. The groups also include another CalEQRO staff member who takes notes. Reviewers' questions typically focus on access, timeliness, and quality of DMC-ODS services, and specifically address service gaps noted in the previous year's EQR report.

CalEQRO recommends that DMC-ODS staff recruit 12 to 16 participants for the focus group, in anticipation of some attrition of prospective participants, resulting in the preferred focus group size of [redacted] participants. This provides sufficient variation in experiences and allows for some contrasting or differing opinions on services. With fewer numbers of participants, there may be less diversity and richness of experiences and feedback. To ensure confidentiality, at least three

participants are required to conduct the focus group, and the written report is expected to eliminate any uniquely identifying member characteristics.

Selected focus groups may focus on ASAM-designated LOCs, specialty populations (e.g., perinatal, MAT, youth), and/or combinations of LOCs, including RR. In the last review cycle, 64 focus groups were conducted with an average of [redacted] participants per group. Four groups required a Spanish language interpreter. Forty-three focus groups (67 percent) were conducted via videoconferencing, while 21 (33 percent) were held on-site at a program, though the review team may have been virtual. As noted in the Methods chapter, the review team was on-site for five Plans: Fresno, Los Angeles, Riverside, Santa Cruz, and Ventura.

Table 8-3 presents the total number of member focus groups conducted by CalEQRO in FY 2023-24 by type of group.

Table 8-3: DMC-ODS Member Focus Group Sessions by LOC, FY 2023-24

Group Types	
Adult Groups	**#**
Residential	25
OP/IOT	18
MAT	8
Perinatal	5
RSS	3
Combination of LOC	2
Youth Groups	**#**
Combination of LOC	1
Family Members	1
OP/IOT	1
Total Groups	**64**

Of the 31 Plans, 27 (87 percent) hosted two or more focus groups during their reviews. Although historically, small Plans and single-day reviews have typically included only one focus group session, it is clear that more Plans are now hosting multiple focus groups.

Among the 398 participating members, the vast majority of groups were for adults and were held in residential programs (41 percent) and in either outpatient or intensive outpatient (30 percent) settings. Two adult groups (3 percent) were a combination of residential and outpatient. The remaining 16 adult focus groups were focused on areas of MAT (13 percent), perinatal treatment (8 percent), and RSS (5 percent), respectively. Participants of outpatient and intensive outpatient focus groups were often also residing in RR at the time of their participation in the focus group.

Three groups (5 percent) were focused on youth treatment, and one was specifically for family members of youth in treatment. Group participants represented a variety of LOCs, including residential, outpatient, and intensive outpatient.

Additionally, four of the focus groups (6 percent) were requested to be conducted in Spanish with all Spanish-speaking participants.

Feedback from Members

Members across focus groups provided diverse feedback on their treatment experiences, reflecting both effective practices and areas needing improvement. Members reported highly positive experiences with their treatment programs, too numerous to include but are outlined in each Plan report.

In **Santa Barbara**, [redacted] In **Santa Clara**, feedback highlighted the personal touch of counselors, "Counselors with lived experience were incredibly supportive, and the intake process was smooth and efficient." Similarly, members in **Monterey** and **Napa** praised telehealth services, "the ability to have timely assessments via telehealth was crucial [redacted]."

Challenges with accessing comprehensive MH services and adequate support were reported by members in some Plans. A [redacted] Members in Yolo expressed concerns about delays and support limitations, [redacted] "Starting treatment took too long, and finding RSS was difficult." Similar sentiments were echoed by members in San Joaquin and San Bernardino, [redacted] "Long waiting times for residential treatment and coordination issues with providers were major barriers [redacted]."

Member feedback from other DMC-ODS Plans highlighted a need for expanded support services. In Stanislaus, members felt the program was good but noted, "We need more counselors and additional RSS to better support our long-term recovery." In Tulare, members appreciated swift treatment initiation but suggested, "Including more information on healthy boundaries and domestic violence, along with having on-site therapists, would be very beneficial."

Santa Cruz and El Dorado members reported a mix of positive experiences and areas for improvement. [redacted] Santa Cruz commented, "the support provided was valuable, but there's a need for more counselors and better coordination between MH and substance use providers." Similar articulations expressed the need for more coordination support from programs regarding healthcare, criminal justice, probation, and child welfare. El Dorado members valued prompt assessments but noted, "there's a significant need for more recovery resources to support ongoing needs."

Feedback from Alameda and Contra Costa also varied. [redacted] Alameda [redacted] "Accessing counseling services was a challenge [redacted]." Conversely, [redacted] Contra Costa [redacted] suggested, "Enhancing telehealth options and additional support services could make a big difference." Similarly, members from Fresno and Imperial emphasized the importance of timely service initiation and adequate support.

In summary, the feedback from members across different Plans reveals a wide range of experiences, emphasizing both effective practices and areas that require attention. The insights provided underscore the need for improvements in treatment accessibility, support services, and coordination across various regions.

Recommendations from Members

The following recommendations were made by members across the vast majority of focus groups held.

- Increase the availability of RSS, including RR and sober living options, and ensure job support services are available to aid in successful community reintegration.
- Provide adequate resources to fully staff programs, reduce staff burnout and turnover which impacts member care and often results in ad hoc or abrupt shifts in who is assigned to their case.
- Improve coordination and communication among service providers: Strengthen integration between MH and other healthcare and SUD services, develop centralized multi-service sites, and communication among treatment team members. Increase inter-agency educational opportunities to deepen understanding of addiction.
- Address barriers to treatment and improve support coordination by reducing bureaucratic obstacles, enhancing discharge planning, and providing better support for individuals transitioning out of programs. Improve assistance with ancillary needs such as housing, employment, vocational training, childcare, and healthcare linkage.
- Improve Medi-Cal enrollment and transfer processes by addressing status errors, such as misclassification of members as "in custody" or incorrect county listings. Expedite the resolution of these issues to prevent delays in obtaining necessary MH and physical health medications.
- Enhance family support services by increasing the availability of family support groups, improving coordination between SUD and MH providers, and incorporating family visits into structured family reintegration activities. Expand the presence of counselors and therapists who can address family-related issues.

Summary of Member Focus Groups

Plan member focus groups highlighted a range of experiences, both positive and negative, with treatment services. Members from several Plans praised the effectiveness of their treatment programs, noting particularly positive experiences with timely initiation of treatment, culturally sensitive approaches, and the use of telehealth services. These positive experiences were often linked to immediate and efficient service delivery and personalized support.

Conversely, feedback also indicated challenges with accessing mental and other healthcare services and recovery supports, with some members reporting difficulties due to bureaucratic barriers, long wait times, and limited availability of support services. Issues such as delays in starting treatment and difficulties in navigating complex systems were common concerns. Additionally, there were calls for improvements in SUD discharge planning and more comprehensive support resources. Members from various Plans also noted that while they had praise for individual staff, they felt programs needed assistance to hire and train more staff, that SUD materials need updating, and that more emphasis should be placed on assisting them with realities such as housing that they will face once discharged.

Overall, members emphasized the need for continued improvements in various aspects of treatment services, from access to advanced therapeutic care to better coordination among service providers. These insights reflect a broad spectrum of experiences and highlight areas where further enhancements could lead to better outcomes for members.

RECOMMENDATIONS FROM MEMBER FEEDBACK

To address the feedback from members and enhance the effectiveness of treatment programs, the following recommendations are proposed to the DMC-ODS Plans to enhance service delivery and support:

- Increase the availability of RSS by expanding RR, sober living options, and job support services to enhance members' community reintegration.
- Ensure timely access to MH services by improving therapeutic care availability and strengthening integration between MH and SUD services through centralized multi-service sites.
- Reduce bureaucratic barriers and improve treatment and support by enhancing discharge planning processes and providing better assistance for members transitioning between programs.
- Collaborate to address and correct errors in Medi-Cal enrollment and transfer processes to prevent delays in accessing necessary medications and services.
- Based upon TPS results:
    - Review efforts being made to address cultural sensitivity, most especially for youth members.
    - Examine ways to amplify family involvement in the delivery of services to youth members which is a critical element for sustaining gains in treatment.
    - Enhance the complementary role of physical and MH services as part of SUD service delivery.

Information Systems

INTRODUCTION

CalEQRO assesses the extent to which the DMC-ODS and its contract providers meet the Federal data integrity requirements for HIS, as identified in 42 CFR §438.242 and 457.1233, and as outlined in Appendix A of the EQR Protocols issued by CMS. DMC-ODS Plans submitted a completed ISCA prior to the EQR. The ISCA commonly requires input from multiple areas of the organization, such as IT, Finance, Operations, and QM. Specifically, CalEQRO utilizes the ISCA protocol to review the DMC-ODS' EHR, IT/IS, claims, outcomes, and other reporting systems and methodologies to support IS operations and calculate PMs, and whether the DMC-ODS and its contract providers maintain an HIS that collects, analyzes, integrates, and reports data to achieve the objectives of the QAPI program.

INFORMATION SYSTEMS STATEWIDE

In this chapter, CalEQRO examines the functionalities of the EHR systems that were in place during FY 2023-24, along with IT budget, staffing, and other planned IS changes. There was considerable variation in how SUD services were delivered by DMC-ODS Plans, ranging from 100 percent contract provider-operated in Alameda, Los Angeles, Monterey, Sacramento, San Diego, and Yolo – to 92 percent Plan-operated in San Benito and 89 percent Nevada. However, in general, the Plans relied more on contract providers on the SUD side of BH services, and that makes it critical to examine contract providers' access to the Plan EHR systems, data submittal methods, and utilization of the Plans' EHR functionalities. The results presented are based on the status at the time of each Plan's review and may have changed since that time.

The implementation of CalAIM and payment reform required changes in EHR systems that resulted in massive shifts in vendor utilization statewide. CalEQRO found that 18 of the 31 DMC-ODS Plans implemented a new EHR within this last year, and an additional Plan was preparing for the imminent implementation of a new EHR at the time of their review. The past year has been particularly notable in terms of the HIS landscape due to the entry of a new EHR vendor (Streamline Healthcare Solutions ["Streamline"]) that offers a product that was promised to enhance DMC-ODS capabilities to meet CalAIM requirements, including payment reform, as well as providing more seamless care for Medi-Cal members. Other Plans recently went through an EHR change when Cerner was acquired by Oracle Health, and discontinued support for the former Cerner product. The PHC regional DMC-ODS Plan does not have an EHR but rather uses a care management platform, and it is also in the process of transitioning to a new platform. The seven PHC member counties maintain their own EHR systems, and five of those counties implemented new EHRs within the past year. In all, 24 of 37 counties providing DMC-ODS services had changed EHRs, or were in the process of changing EHRs, since their prior review, in addition to PHC's care management platform transition. In other words, 65 percent of counties providing DMC-ODS services have been devoting resources to transitioning to a new EHR, which is a major undertaking.

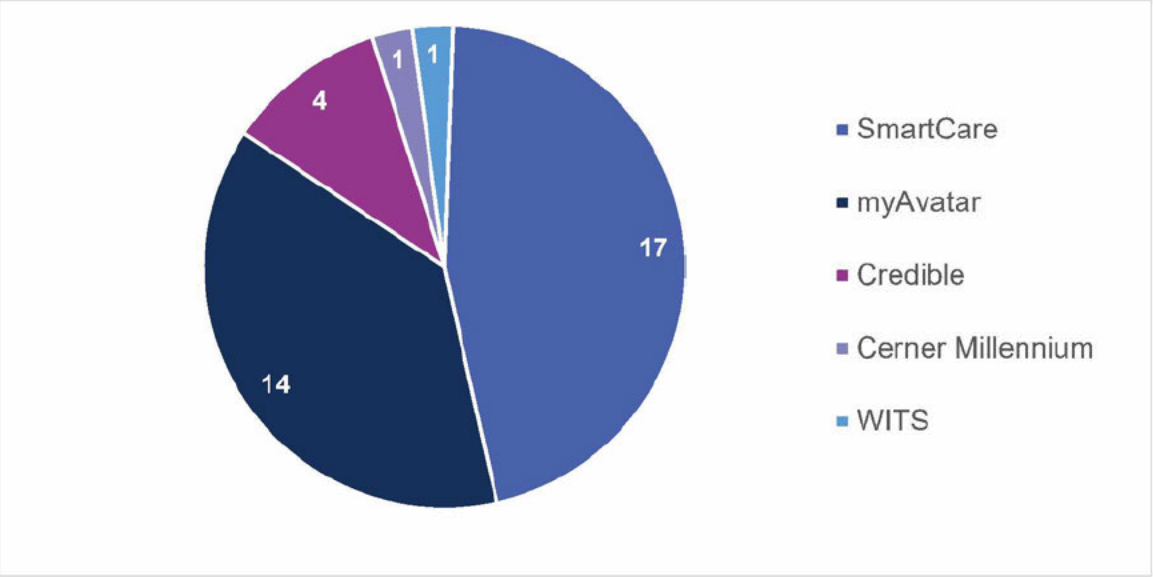
Additionally, this is the first FY in which all DMC-ODS Plans have an EHR in place, as one Plan was still reliant on paper records last FY.

HIS by System and Vendor

In recent years, California BHPs primarily relied on three technology vendors to support HIS in BH: Netsmart Technologies ("Netsmart"), Cerner Corporation, and The Echo Group. Now two vendors dominate the EHR landscape: Streamline and Netsmart were the EHR vendors for 31 of the 37 total counties providing DMC-ODS services. Their products, SmartCare and myAvatar respectively, were the EHRs for 84 percent of the counties delivering DMC-ODS services.

Figure 9-1 summarizes EHR systems in place in the counties providing DMC-ODS services.

Figure 9-1: DMC-ODS County EHR Systems, FY 2023-24



There are 37 individual counties represented in Figure 9-1, as the seven PHC counties are included here to convey the representation of EHRs used across the state most accurately (and PHC itself is not included in the figure above as it does not have an EHR). Of these, 17 counties (46 percent) used SmartCare by Streamline, and 14 counties (38 percent) used myAvatar by Netsmart. Other EHRs and vendors used include Credible by Qualifacts (used by four counties), Web Infrastructure for Treatment Services by FEI Systems Inc. (used by one county), and Cerner Millenium by Oracle Health (also used by one county).

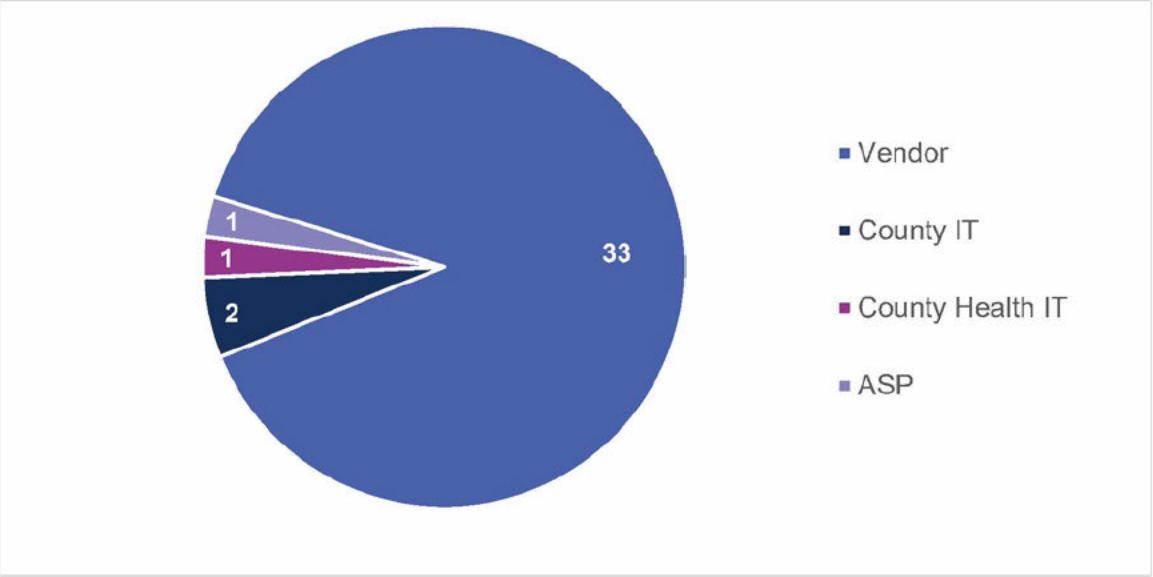
The current vendors continue to modify legacy systems to conform to state and federal data collection and reporting standards or, in the case of Streamline, continue to build out the product to do so.

Hosting of EHR Systems

The hosting of systems by the vendors reduces the need for local IT staff to provide 24/7 operational support. System hosting by vendors usually includes benefits such as heightened system security, business continuity assurances, and 24-hour staffing by qualified technicians. The HIS for the vast majority of counties providing DMC-ODS services were vendor-hosted, and all had implemented, or were in the process of implementing, a system that has core components that support EHR functionalities for the DMC-ODS.

Figure 9-2 illustrates the breakdown of EHR hosting for the 37 counties providing DMC-ODS services.

Figure 9-2: DMC-ODS County EHR Hosting, FY 2023-24



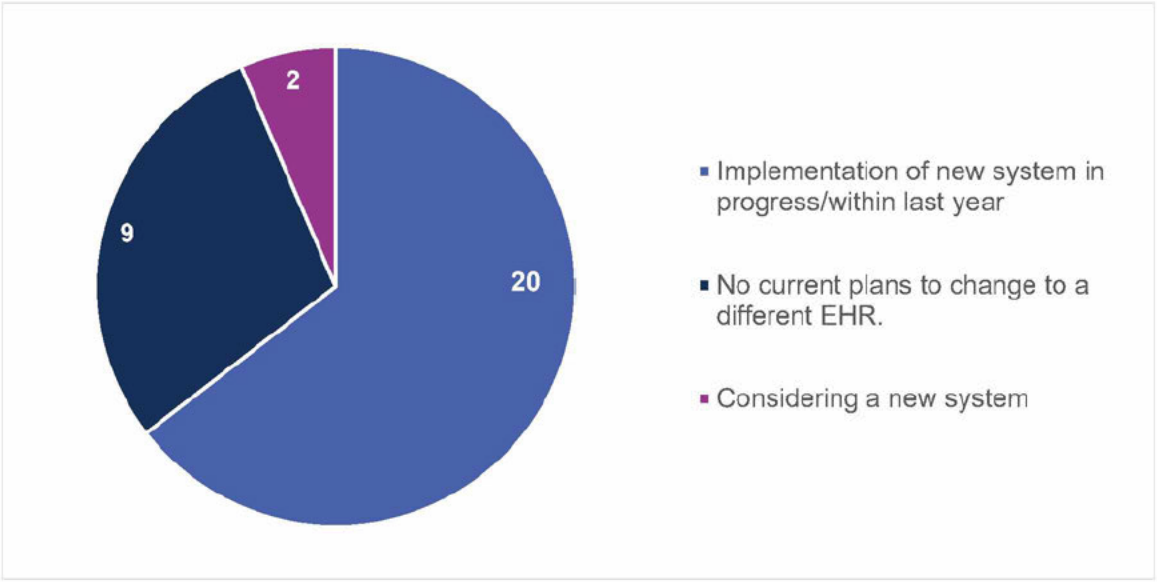
In FY 2023-24, 33 DMC-ODS counties relied on their EHR vendors to host their HIS, compared to 15 in FY 2022-23. Three Plans (Orange, Riverside, and San Francisco) were self-hosted, either by the county IT or health agency IT, and one Plan had their Application Service Provider (ASP) host the EHR (Lassen). A number of factors, including cost-benefit and risk management, are considered in deciding the best hosting arrangements for EHRs. Historically, larger counties with more robust staffing and infrastructure were able to host their own systems at the BH IT, health IT, or county IT levels. Smaller counties were more likely to employ the EHR vendor or an ASP to host and manage their EHR. The substantial increase in vendor-hosted systems that has occurred over the past year is largely due to the many counties that opted in to the multi-county EHR project with the CalMHSA, which provides cloud-based hosting via the vendor, Streamline.

EHR Replacement Status

As previously noted, 65 percent of DMC-ODS counties implemented a new EHR within the last year or were about to implement a new EHR – concurrent with changes necessitated by payment reform – which required the dedication of substantial resources to execute changes in Medi-Cal claiming, contractual updates, related to updated rates, staff workflow and processes, and overall training for clinical and administrative staff and contract providers.

Figure 9-3 represents the EHR replacement status of the 31 DMC-ODS Plans (and, in the case of PHC, the care management platform replacement status).

Figure 9-3: DMC-ODS Plan EHR Replacement Status, FY 2023-24



While 29 percent of the DMC-ODS Plans indicated that they have no plans to replace their current EHRs, there were two Plans that reported they were considering a new system but did not yet have a formal transition plan in place. The majority of DMC-ODSs with a new EHR were participating in the CalMHSA multi-county EHR initiative, having implemented the SmartCare EHR. Two DMC-ODSs exploring their EHR options anticipate a change within the next 2 years.

Those Plans that used the Cerner Community Behavioral Health (CCBH) EHR transitioned because its new owner Oracle discontinued support at the end of CY 2023. This includes those counties that utilized Kings View as the ASP.

Ongoing development efforts continue to bring all EHRs in use up to the standards needed to conform to many of the CalAIM requirements for HIE, integrated care, and payment reform. EHR platforms often lack one or more of the functionalities discussed below, a situation that needs to be remedied to improve care coordination and ensure that ASAM transitions in care are seamlessly recorded in EHRs. Concerns regarding privacy requirements for SUD treatment continue to impede HIE progress in most Plans.

AVAILABILITY OF TELEHEALTH

The past 4 years since the beginning of the pandemic have demonstrated that delivering services via telehealth can benefit both the member and healthcare practitioner. CalEQRO defines telehealth as two-way, interactive treatment sessions between a member and a healthcare professional at a distant site, using interactive telecommunication equipment and/or software that includes, at a minimum, audio and video equipment.

For members, telehealth expands access to care by overcoming the transportation challenges that are often a barrier to services, particularly in rural counties. For providers, telehealth allows for the convenience of service delivery from existing clinical locations and may allow them to serve members more efficiently. Plans have shifted to a variety of telehealth models, taking advantage of state and federal flexibilities/waivers, adjusted service delivery models to include both in-person and video conferencing, and, when possible, provided technology to members who could not otherwise afford it. DHCS has worked to ensure that member choice is

paramount in deciding which mode of service delivery is to be used.[110] Telehealth also helps to support NA requirements and offers more flexibility to both members and providers who are in remote areas of California.

CalEQRO had observed in the FY 2022-23 annual report that all DMC-ODS Plans had at least some telehealth capabilities, depending on the suitability for any given modality of services. This continued to be true in FY 2023-24, as all of the 31 DMC-ODS Plans have continuously ramped up their telehealth services. The most common services accessed via telehealth were medication support, individual therapy sessions, and case management (all available in all Plans), followed by new client intakes and assessments and group therapy sessions (available in 97 percent of Plans). The least common service available via telehealth was crisis services, which were available in 81 percent of Plans.

The total number of members statewide who accessed services via telehealth increased by 81 percent over the previous year (57,086 members reported in FY 2023-24 as compared with 31,489 members in FY 2022-23). Adults (86 percent increase) and youth (90 percent increase), as well as members accessing services in a language other than English (60 percent increase), all had much greater telehealth utilization as compared to the prior year. However, there was only a very small increase (3 percent) in the number of older adults who accessed services via telehealth. The increase in numbers served statewide contributes to some extent to this increase in telehealth, and it may also be in part due to improved tracking. Regardless, telehealth remains prominent for service delivery.

While CalEQRO noted a rapid deployment of telehealth in BHPs, with many committing to making it an important service portal going forward, some challenges remain. These are due in part to outdated computers, phones with limited bandwidth, members' access being limited due to the cost to access the internet in some areas, and challenges faced by some specific populations such as those experiencing homelessness, who have very limited access to the internet. Due to these challenges for video-conferencing, DMC-ODS Plans have noted that telephonic contacts are frequently bundled into their tracking and utilization numbers.

INFORMATION SYSTEMS KEY COMPONENTS

CalEQRO identifies the following Key Components related to DMC-ODS system infrastructure that are necessary to meet the quality and operational requirements to promote positive member outcomes. This section reviews the extent to which DMC-ODSs are fully using their EHR technology, both in executing accurate Medi-Cal claiming and in utilizing EHR data to inform their understanding of service delivery in the DMC-ODS. Optimal use of an EHR includes interoperability and use of the EHR as the medical record across the entire service delivery system. This includes use by not just the county-operated programs, but also any contract provider agencies rendering services. If the EHR does not include all services provided to a member, treatment planning and analytics based on services are limited in usefulness. Technology, effective business processes, and staff skills in extracting and utilizing data for analysis must be present to demonstrate that analytic findings are valid and used to ensure overall quality of the SUD delivery system and organizational operations. It also requires that the technology and program leadership work closely to mutually understand data needs and accurately define what data needs to be extracted for the stated programmatic purpose.

[110] https://www.dhcs.ca.gov/Documents/BHIN-23-018-Updated-Telehealth-Guidance-for-SMHS-and-SUD-Treatment-Servies-in-Medi-Cal.pdf

Each of the six IS Key Components, composed of individual subcomponents, are collectively evaluated to determine an overall Key Component rating of Met, Partially Met, or Not Met; Not Met ratings are further elaborated to promote opportunities for QI.[111]

A summary of statewide performance is depicted in Table 9-1 below.

Table 9-1: Summary of IS Key Components – Statewide FY 2023-24

KC #	Key Components – Information Systems	Met	Partially Met	Not Met	Not Rated
4A	Investment in IT Infrastructure and Resources is a Priority	29	2	0	0
4B	Integrity of Data Collection and Processing	14	16	1	0
4C	Integrity of Medi-Cal Claims Process	17	14	0	0
4D	EHR Functionality	28	1	1	1
4E	Security and Controls	26	5	0	0
4F	Interoperability	21	7	3	0

Four DMC-ODS Plans (13 percent) – **Contra Costa**, **Fresno**, **Nevada**, and **San Francisco** – received ratings of Met for all six Key Components related to IS, indicating that they make optimal use of their EHR functionalities. Investment in IT Infrastructure and Resources is a Priority (4A) had the largest number of Plans receiving a Met rating (29 Plans total). Integrity of Data Collection and Processing (4B) was rated Met for the smallest number of DMC-ODSs at 14 Plans (45 percent), 16 DMC-ODSs (52 percent) receiving a rating of Partially Met, and 1 Plan was rated as Not Met.

The Key Component with the largest number of Plans receiving Not Met ratings was Interoperability (3 Plans). PHC was not rated on EHR functionality as the PHC utilizes a care management platform and the seven counties within the regional Plan have their own EHRs that are independent of the Plan and were not reported on as part of that review.

More Plans were rated Met on each of the Key Components than during the previous FY, with the exception of 4B. Security and Controls (4E) showed the greatest increase in the number of Plans rated Met, followed by EHR Functionality (4D).

Table 9-2 displays the IS Key Components by Plan.*

Table 9-2: IS Key Components by Plan, FY 2023-24

DMC-ODS	4A	4B	4C	4D	4E	4F
Alameda	M	M	PM	M	M	M
Contra Costa	M	M	M	M	M	M
El Dorado	M	PM	M	M	M	PM
Fresno	M	M	M	M	M	M
Imperial	M	PM	M	M	M	PM
Kern	M	PM	M	M	M	M

[111] Historically posted on BHC's CalEQRO website, reports and material produced by BHC will be available through DHCS's website: https://www.dhcs.ca.gov/services/MH

DMC-ODS	4A	4B	4C	4D	4E	4F
Los Angeles	M	M	PM	PM	M	M
Marin	M	PM	PM	M	M	M
Merced	M	PM	M	M	M	M
Monterey	PM	PM	PM	M	M	M
Napa	M	PM	M	M	PM	M
Nevada	M	M	M	M	M	M
Orange	PM	M	M	M	M	PM
Partnership	M	M	PM	NR	M	NM
Placer	M	PM	M	M	M	M
Riverside	M	M	M	M	PM	M
Sacramento	M	PM	PM	M	M	M
San Benito	M	PM	PM	M	M	NM
San Bernardino	M	M	PM	M	M	PM
San Diego	M	PM	M	M	M	PM
San Francisco	M	M	M	M	M	M
San Joaquin	M	M	PM	M	M	M
San Luis Obispo	M	PM	PM	M	PM	M
San Mateo	M	PM	M	M	M	M
Santa Barbara	M	PM	PM	M	M	M
Santa Clara	M	M	M	M	PM	M
Santa Cruz	M	PM	M	M	M	M
Stanislaus	M	M	M	M	M	PM
Tulare	M	PM	PM	M	PM	PM
Ventura	M	M	PM	M	M	M
Yolo	M	NM	PM	NM	M	NM

* Note: M = Met, PM = Partially Met, NM = Not Met, NR = Not Rated

Investment in IT Infrastructure

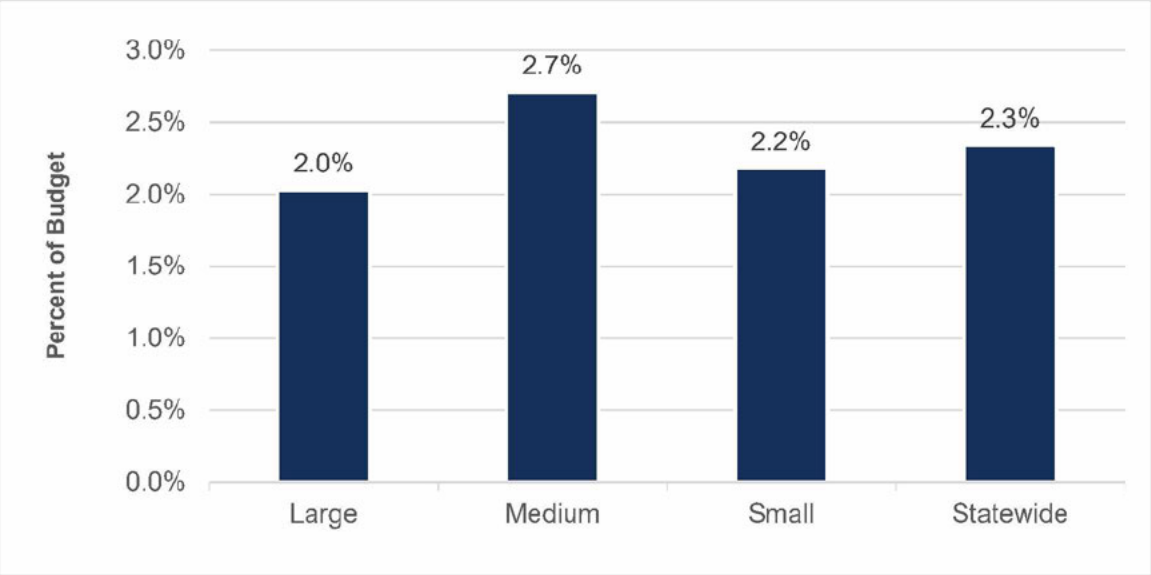
This component evaluates the degree to which a DMC-ODS is dedicating resources to the acquisition and maintenance of IT, which in turn influences the Plan's ability to meet its strategic and operational needs. Most Plans (93.5 percent) received a Met rating for this Key Component, only two were rated Partially Met (6.5 percent), and no Plans received a Not Met rating. This likely reflects the necessity of investment required to transition EHRs and the large number of Plans undergoing that process, as well as the resources needed to comply with CalAIM requirements such as payment reform.

The percentage of the DMC-ODS budget devoted to IS is only one simple indicator of the level of IT resources and capabilities available to support the administration and delivery of services under the DMC-ODS framework. Although there are no standards for the percentage of budget

devoted to IT, there are industry references to between 3 and 6 percent as the average in health care organizations with a full-featured EHR.[112] [113]

The amount of funding for the Plan's IT budget as reported in the ISCA is shown in Figure 9-4.

Figure 9-4: Plan IT Budget by County Size, FY 2023-24



Statewide the DMC-ODS Plans spent an average of 2.3 percent of their total budgets on IS, an increase from the prior year (1.7 percent). IS spending as a percent of total budget increased from the previous FY in all size groups except for small, which decreased from 3.6 percent in FY 2022-23 to 2.2 percent in FY 2023-24. The largest increase was in the medium size group (1.2 percent in FY 2022-23, 2.7 percent in FY 2023-24).

There were some variations in budget allocations by county size, which is to be expected given a small percent of a larger budget (such as is typically seen in larger counties) will translate to more dollars than a small percent of a smaller total budget (with smaller counties typically having smaller total budgets). Medium counties stand out with dedicated the highest percentage of their budget to IS (2.7 percent). Large counties, however, dedicated the smallest proportion of their budget to IS (an average of 2.0 percent). Small counties spent 2.2 percent of their total budget on IS, which is the closest to the overall statewide average. Regardless of the scale of operation and the number of members served by a given Plan, the reality is that IS costs must exceed a minimum baseline in order to maintain operations.

Figure 9-5 illustrates the FY 2023-24 average number of technology and analytical resources staff in DMC-ODS Plans.

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[112] Definitive Healthcare. (July 24, 2024). *Hospitals with the highest IT expenses.* https://www.definitivehc.com/resources/healthcare-insights/25-hospitals-highest-operating-budget#:~:text=The%20average%20IT%20operating%20expense,highest%20estimated%20IT%20operating%20budgets

[113] Medicus IT. (January 30, 2023). *How much should my healthcare organization spend on IT in 2023?* https://knowledge.medicusit.com/how-much-should-my-healthcare-organization-spend-on-it-in-2023#:~:text=While%20there%20is%20no%20exact,total%20revenue%20on%20business%20IT

Figure 9-5: Plan Technology and Analytics Average Staffing by County Size, FY 2023-24

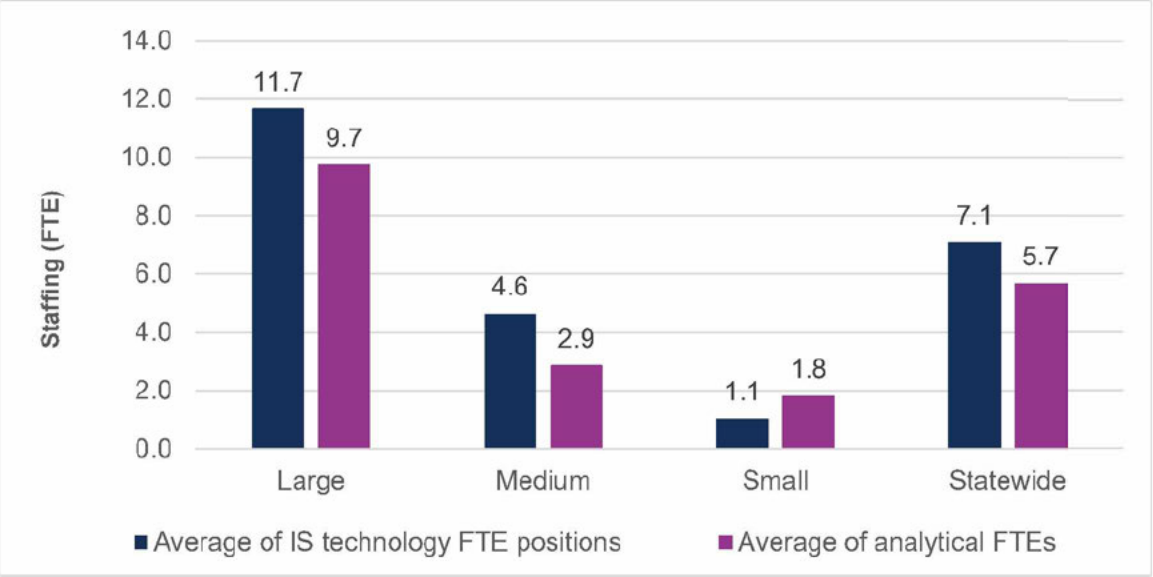


Figure 9-5 above illustrates a shift in staffing over the last year. Average IS full time equivalent staff (FTEs) have decreased both statewide and for all county size groups, whereas average data analytical FTEs have increased both statewide and for all county size groups. The average number of IS FTEs statewide decreased by 35 percent as compared to the previous year, while average analytical FTEs increased by 12 percent. While DMC-ODS Plans generally continued to have more IT personnel than analytical staff, the small county averages reflect higher staffing levels for analytic staff than IS staff for that size group. Staff allocations for analytic FTEs were about 80 percent of the allocations for IT FTEs on average, statewide. The increase in analytical staffing this last year is conducive to more in-house analytic capacity, which CalEQRO has observed tends to occur within larger counties, although Plans in counties of all sizes reported on the ISCA that they had added analytic positions related to CalAIM requirements. Many Plans also acknowledged executing a recalculation of their FTEs in FY 2023-24 in order to more accurately report staffing allocations than in prior EQRs, so not all shifts in the data necessarily reflect changes to the actual dedicated DMC-ODS resources. It is also important to note that Plans reported a greater number of unfilled analytic vacancies than unfilled IS vacancies. Allocated FTE positions that do not get filled do not contribute to the productivity of a unit, and staffing challenges remain in many Plans across the state.

Not surprisingly, large counties had the highest number of FTEs in both categories, and staffing levels were much higher than in the medium and small counties. Although the small counties spent more as a percentage of their total budget on their IS, their IT and analytical FTE staffing allocations were still smaller than the medium counties. Again, this is reflecting that the higher percentage does not translate to more dollars, since the small counties' total budgets are typically much smaller than that of the medium, and even more so the large, counties.

It is generally acknowledged that below a certain threshold of IT and data analytics staff capacity, DMC-ODS Plans would not be able to realize the potential benefits of their EHRs or their practice management systems. Numbers matter, especially as DMC-ODS operations become more complex. However, the numbers alone may not tell the full story. Some small county Plans have long-term legacy staff, and while their staff may be limited in number, those highly experienced staff carry added value due to their experience and expertise. Likewise, some Plans may include analytic staff in other technology or quality divisions or units. If part of a

larger county agency, it is common for some analytic and technology staff resources to be employed at the agency level, rather than dedicated to the DMC-ODS. This means these staff can be tapped to provide necessary support as needed. Plans leveraged ASPs increasingly in the last year, with 81 percent of DMC-ODS Plans reporting an ASP partnership in place to help support the EHR. Finally, some Plans have relationships with universities, consulting organizations, or even their system vendors to augment approved staffing within the DMC-ODS.

There are multiple Plans with notable investments and projects related to IT and data analytics staffing. **Riverside** has robust IT and data analytics staffing to allow for routine maintenance and reporting development, while exploring new technology like predictive artificial intelligence models to inform the focus of member care. **San Francisco** has also dedicated substantial resources, with 80 staff to support the development and implementation of a new EHR.

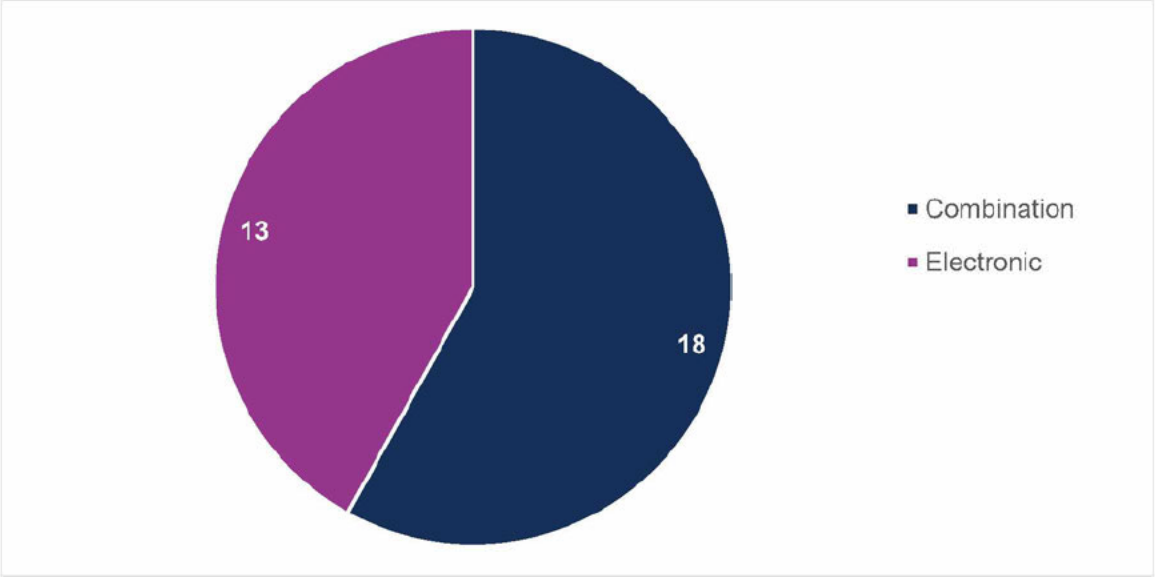
Data Integrity

Data integrity refers to the overall accuracy, completeness, and consistency of data. It is maintained by a collection of processes, rules, and standards implemented to support core EHR functionality. When the integrity of data is secure, the information stored in a database will remain complete, accurate, and reliable no matter how long it is stored or how often it is accessed. Almost half of Plans (45 percent) received a Met rating on this Key Component, with another 52 percent receiving a rating of Partially Met, and just one Plan being rated Not Met. One recurring deficiency reported in EQR sessions for many Plans was the issue of incomplete data available for the entire system of care. The need for further interoperability development to connect the separate EHRs maintained by contract providers was the most common reason for this gap in data. Without a system to combine data electronically, DMC-ODS Plans often rely on manual processes to gather data held outside of the Plan EHR to report on the full system of care. This allows for increased errors throughout the manual process. As Plans move forward with calculating their own BHAS measures, data integrity is important for the validity of their data.

Health records can be electronic, paper, or a hybrid, which has both electronic and paper that support clinical operations. The most efficient method for clinic operations is a fully electronic EHR model. The other two models require providers to initiate requests for a member's health record from a chart room and review paper record documents along with viewing EHR screens for an overview of the member's treatment history. When the data transfer processes are not fully automated, this often leads to manual solutions to data submission, extraction, and analytics for fulfilling reporting requirements.

Figure 9-6 illustrates the aggregated FY 2023-24 chart types across Plans.

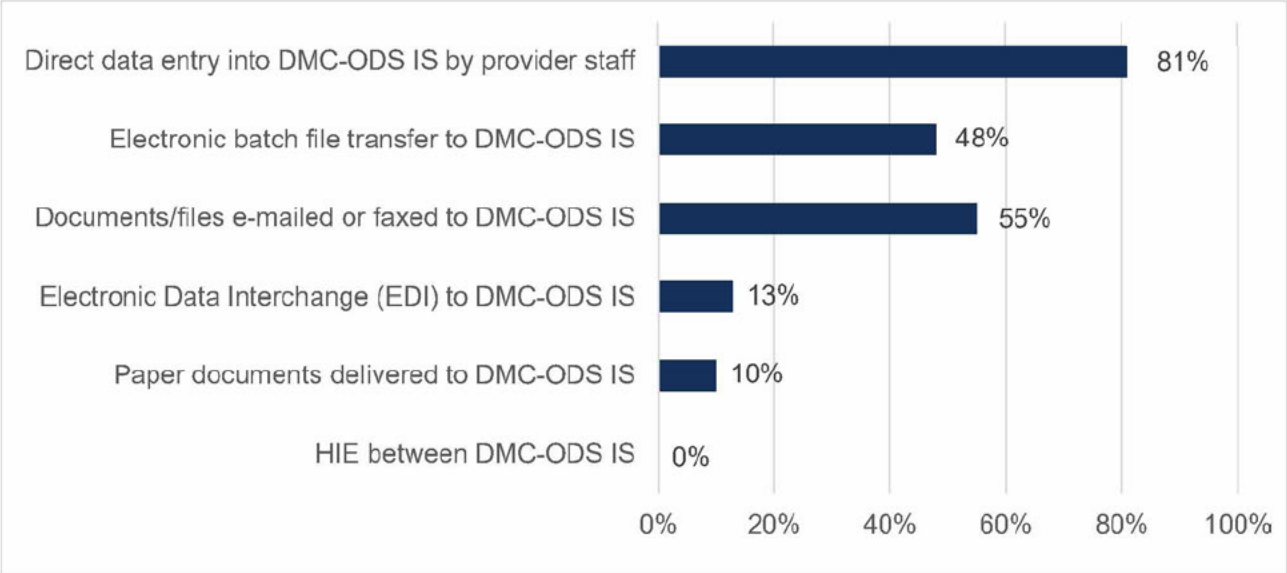
Figure 9-6: DMC-ODS Plan Chart Environment, FY 2023-24



In FY 2023-24, 42 percent of the DMC-ODS Plans indicated that their member records were fully electronic. The majority of Plans (58 percent) maintained the records in a combination of both electronic and paper formats.

Figure 9-7 illustrates the data submission methods utilized by contract providers across DMC-ODS Plans.

Figure 9-7: Contract Provider Data Submission Modalities, FY 2023-24



Note: The percentages add up to greater than 100 percent because many DMC-ODS Plans employ multiple modalities of data submission. Rather, each bar represents the percentage of DMC-ODS Plans that utilize that particular modality of data submission.

Data submission methods vary, influenced by both the DMC-ODS Plan and the contract providers' technological and staffing capabilities. Overall, 81 percent of Plans allowed for the

direct entry of member data into the Plan EHRs, 48 percent utilized electronic batch transfers, and 55 percent received member data by email or fax, and 13 percent utilized electronic data interchange. There are still some Plans utilizing paper document submission (10 percent). It should be noted that using a combination of different data transmittal or entry methods is common practice, and most Plans are using more than one of the methods described here to receive data from contract provider organizations. These processes can naturally have a negative impact on data integrity.

Medi-Cal Claiming Integrity

The integrity of the Medi-Cal claims requires data integrity and further examines that Plans' claims processes include the presence of policies and procedures to administer the Medi-Cal claims processing effectively, eligibility verification procedures in place to ensure appropriate Medi-Cal services are claimed, and that claims are submitted in a timely and accurate manner. The claims denial rate is an objective measure of the integrity of DMC-ODS's claims processing. A well-managed claims system with proper documentation lowers the risk of denied claims from the state, as well as that associated with any future audits.

Of the 31 DMC-ODS Plans, 17 Plans (55 percent) met the Key Component that evaluates claiming integrity and 14 Plans (45 percent) received a Partially Met rating. This was the only Key Component with a decrease in the number of Plans receiving a Met rating as compared to the previous FY. CalEQRO found that many Plans had difficulties submitting claims after the implementation of payment reform, and those Plans that had implemented the SmartCare EHR in partnership with CalMHSA were particularly challenged by an inability to submit claims at all for several months. Ratings reflect Plans' situations at the time of their review, and it is likely that most Plans have resolved claiming issues related to payment reform and EHR transitions since their reviews occurred, particularly for those Plans whose reviews were timed shortly after the go-live of a new EHR earlier in the FY.

For Plans in the process of implementing a new EHR, and those planning to do so in the near future, maintaining a strong process for the integrity of the Medi-Cal claims is critical for generating accurate and timely revenue production throughout implementation – and provides for more valid administrative data for analytic purposes.

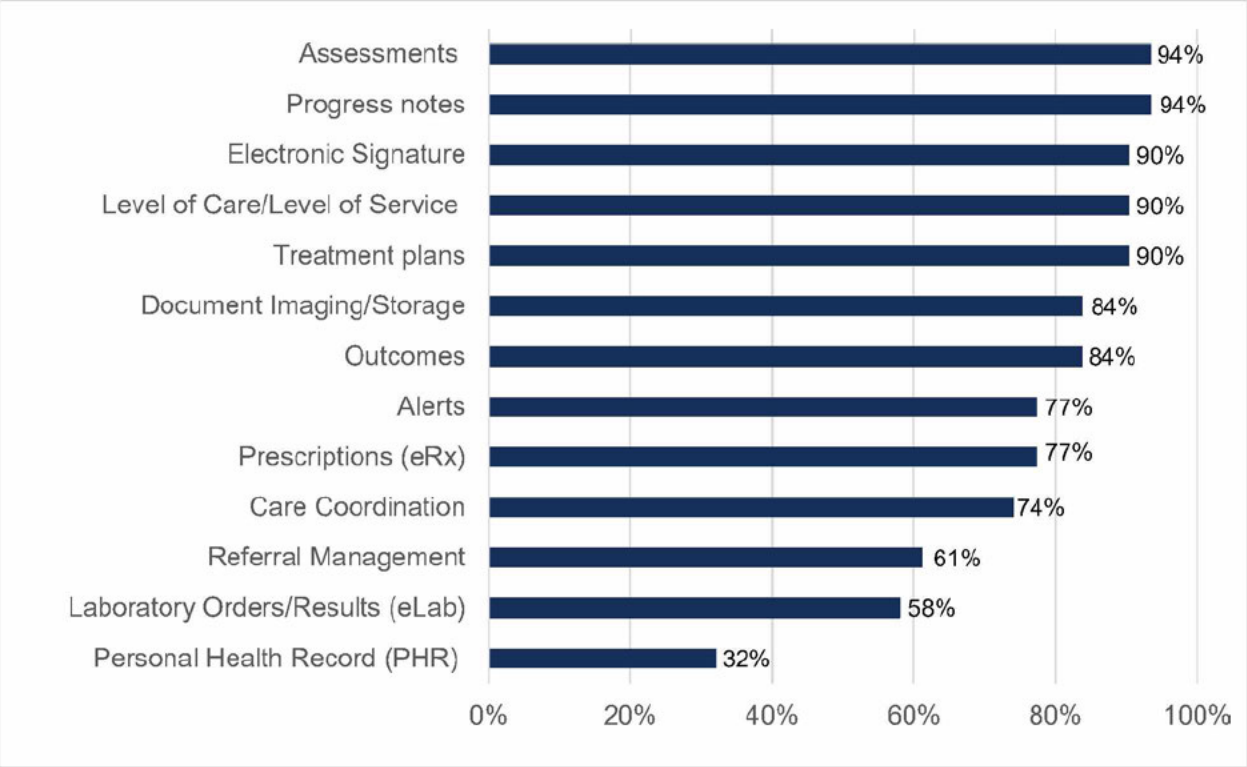
EHR Functionality

The EHR Functionality Key Component addresses the ability to store clinical data electronically as all or part of a member's medical record, accessible by providers and others involved in clinical care.

Most DMC-ODS EHRs have core EHR functionality in place, and 28 Plans (90 percent) received a Met rating, 1 Plan received a Partially Met rating, and 1 Plan received a Not Met rating. PHC was Not Rated due to its use of care management software rather than an EHR. Moreover, the DMC-ODS network of contract providers generally does not have this level of EHR functionality, as many of the contract providers continued to rely on paper medical records or separate EHR systems not evaluated. Contract providers continued to struggle with documentation standards, tracking requirements for timeliness, and double data entry into separate EHRs. Additional information about contract provider access to EHRs follows in the Interoperability section.

Figure 9-8 presents the EHR functionalities in place across DMC-ODS Plans.

Figure 9-8: Plan EHR Functionality, FY 2023-24



In FY 2023-24, nearly all Plans had core operational functionalities such as assessments and progress notes built into their EHRs. All but one of the functionalities included in Figure 9-8 above were in place in the majority of DMC-ODS' EHRs. The least common functionalities available in DMC-ODS EHRs were personal health record (PHR), eLab, and referral management, all of which were implemented in less than two-thirds of all Plans.

In some instances, Plans relied on adjunct or add-on systems for functionalities such as outcomes, e-prescription, LOC, care coordination, and referral management. Plans that lacked the care coordination and referral management functionalities continued to rely on proactive communication from providers and other manual processes to assist in coordination of services as members transitioned between LOCs. Embedding referral management and care coordination alerts into an EHR creates efficiencies and improved quality of care. The lack of eLab implementation statewide also poses a noteworthy challenge for prescribing providers.

Plans continue to require a lot of work in this area. Notably, many of these areas of functionality were in development in prior EHRs used by Plans, and with the transition to new EHRs for so many DMC-ODS Plans, the timeline for development has reset due to the focus on clinical documentation and claiming as the initial priorities. It should also be noted that the presence of any given functionality does not necessarily equal the utilization of that functionality or the data it provides. For example, while ten DMC-ODSs reported having a PHR function available in their EHRs, only four Plans (13 percent of Plans) reported members had access to their PHR. Of those four Plans, only two were able to report how many members had actually accessed their PHRs. **Santa Cruz** demonstrated a strength in this area, with the equivalent of about 39 percent of their members served having accessed a PHR in the previous year. PHR functionality, as reported in the ISCA, was anticipated to be implemented by 74 percent of the DMC-ODS Plans within the next year, so statewide improvements are likely over this time period.

Security

CalEQRO evaluates the safeguards or counter measures present in DMC-ODS IS to avoid, detect, counteract, or minimize security risks to physical property, information, computer systems, or other assets. Of the 31 DMC-ODS Plans, 26 Plans (84 percent) were rated Met on the Key Component that evaluates IS security, and the remaining 5 Plans (16 percent) warranted a Partially Met rating. The lack of two-factor authentication for password changes was a common deficiency contributing to Partially Met ratings.

In general, the DMC-ODSs have strong security and controls over their systems. For many Plans, this is a bifurcated function reliant on both the EHR vendor or the ASP, and operations at the Plan, agency, or county levels. Often the EHR back-up and restoration process after any maintenance or interruption events are the responsibilities of the vendor or the ASP. The DMC-ODS, parent agency, or the county is often responsible for the maintenance of other critical functionalities including internet security, network connections, e-mail, and other communications.

Given the state's experiences with catastrophic wildfires that have interrupted internet availability in affected areas, the development of operations continuity plans (OCPs) became even more important to ensure access to care. During the FY 2023-24 reviews, CalEQRO found that many DMC-ODS Plans reported implementing department OCPs and/or adopting county IT OCPs in the last year. In some instances, the Plans were still in the process of developing an OCP in coordination with county IT departments that may be called upon in the event of natural disasters or cybersecurity issues. CalEQRO made recommendations to several Plans pertaining to this issue.

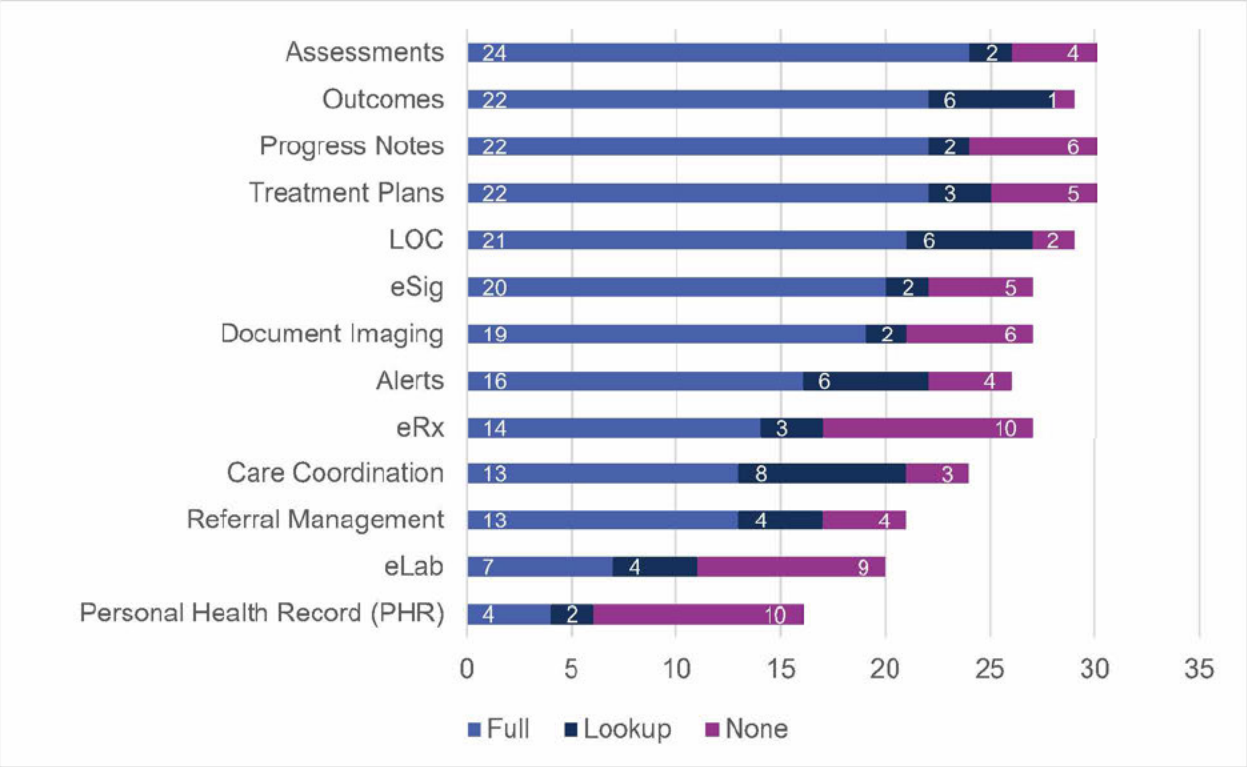
Interoperability

CalEQRO examines both internal interoperability between the DMC-ODSs and their contract providers and external capabilities through participation in an established HIE with other agencies, such as hospitals or primary care providers. An overarching issue associated with implementing the DMC-ODS Plans and utilizing EHRs within them has been the integration of service-level data from contract providers that use separate systems. Generally, Plans communicate with contract providers via two or more submittal methods to exchange member information. Most DMC-ODS Plans received a rating of Met (68 percent) or Partially Met (23 percent), and 10 percent were rated Not Met.

For those contract providers with local EHRs, the ability to electronically exchange member-level clinical transactions with county EHRs was generally lacking or was limited to service transactions. Most contract providers with local EHRs also needed to enter practice management data – demographic, clinical, and service information – directly into Plan systems. Double data entry, along with manual tracking, is very common; in turn, it has implications for full reporting and tracking of the necessary areas designed to gauge system performance.

Figure 9-9 illustrates contract provider access to various EHR functions present across the DMC-ODS Plans.

Figure 9-9: Provider Access to Plan EHR Functionalities, FY 2023-24



Assessments, progress notes, treatment plans, outcomes, and LOC were the most common functionalities for Plans to enable their contract providers' full access. Care coordination was the most common functionality with lookup access, followed closely by outcomes and LOC. In contrast, PHR, eLab, referral management, and care coordination were the least common functionalities fully available to contract providers. The lack of these functionalities, or contract provider access to them, points toward more manual transmission of this information, which is less efficient and introduces additional points in the process for errors to be introduced into the records.

There is quite a bit of momentum surrounding increasing interoperability capabilities in California's landscape at this time. In FY 2021-22, DHCS implemented the CalAIM BHQIP,[114] an incentive program available to Plans until FY 2023-24 that provided an opportunity to DMC-ODS Plans that successfully met certain CalAIM implementation milestones, including CMS Interoperability and Patient Access requirements specified in BHIN 22-068.[115] BHPs were presented with the opportunity to earn incentive payments by completing specific deliverables tied to program milestones,[116] including technology and infrastructure milestones. DHCS encouraged and financially incentivized DMC-ODSs to pursue this opportunity, although participation was not required. Relatedly, California has established a data exchange

[114] https://www.dhcs.ca.gov/Documents/BHIN-21-044-Behavioral-Health-Quality-Improvement-Program-Start-Up-Fund.pdf

[115] https://www.dhcs.ca.gov/Documents/BHIN-22-068-Interoperability-and-Patient-Access-Final-Rule.pdf

[116] https://www.dhcs.ca.gov/Documents/BHIN-22-050-Updated-Guidance-for-CalAIM-BHQIP.pdf

framework[117] that is intended to foster interoperability between a variety of health care systems and increase and enhance the electronic exchange of health information. Finally, calculation of several of the BHAS measures [118] require BHPs to have access to MCP data. All three of these initiatives are contributing to additional attention being paid by Plans to how they can improve interoperability.

In FY 2023-24, 11 of the 31 DMC-ODS Plans reported to CalEQRO that they were participants in an HIE, a more efficient method for two-way exchange of member data between EHR systems. This represents a 57 percent increase in the number of Plans with HIE agreements in place compared with the prior FY reviews. However, most Plans reported they were not yet actually using the HIE to exchange data yet. Joining an HIE is a step in the right direction, but until it is used for the actual bidirectional exchange of information, it can only be seen as laying the groundwork for future improvements. While Plans and vendors are prioritizing work to implement core systems for billing and state data reporting requirements, lingering concerns regarding federal confidentiality laws pertaining to SUD remain a barrier to a more fully integrated IS and full implementation of information exchange through HIEs.

SUMMARY OF INFORMATION SYSTEMS

As the DMC-ODS Plans continue to evolve, their EHR operations have continued to develop as well. One of the main aspects of this has been a surge in the number of Plans implementing new EHRs and actively considering changing EHRs. Alongside the new demands for data exchange and systems integration requirements of CalAIM, DMC-ODS Plans are looking ahead to better EHR infrastructure that will enable them to improve quality of care, while at the same time enhancing their reporting of data for both external and internal stakeholders. The end of vendor support for the CCBH EHR at the end of CY 2023 was also a catalyst for EHR changes for a number of the Plans. When DMC-ODS Plans were asked if they received adequate training and support on CalAIM updates related to payment reform, 68 percent responded that they had received adequate support, citing informational webinars, BHQIP incentive payments, and TA as the primary types of support received.

Another change has been in the area of the conversion of more health information and member records to an electronic format. FY 2023-24 was the first year that every DMC-ODS Plan was using an EHR, having evolved from the paper charts of the past. A majority of the DMC-ODS Plans had at least basic functionalities in their EHRs such as assessment, progress notes, treatment plans, outcomes, and LOC, and provided full or lookup access to their contract providers.

Contract providers are a major part of the DMC-ODS service delivery system and, as such, their access to DMC-ODS EHRs is a critical component in ensuring a high quality of care and supporting transitions in care for members. Integrating contract providers into Plan EHRs as full partners has the potential to create a more seamless interface that can only benefit the DMC-ODS system and the members they serve. Substantial improvements were made over the last year, as DMC-ODS Plans reported in the ISCA that contract providers had the capability to enter services directly into the EHR in 28 of the 31 Plans (90 percent), with the 2 remaining Plans working on adding this functionality moving forward. Plans continue to lag behind in

[117] State of California Center for Data Insights and Innovation. (2024). *Data exchange framework.* https://www.cdii.ca.gov/committees-and-advisory-groups/data-exchange-framework/

[118] https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-24-004-Quality-Measures-and-Performance-Improvement-Requirements.pdf

e-prescription, e-lab functionalities, and PHRs in their EHRs. Development of many functionalities were reset for many Plans due to implementation of new EHRs.

In terms of meeting the infrastructural needs of Plans, as evidenced by budget and staffing, the large DMC-ODS Plans have an edge both in higher dollar budget allocations for IS, and higher numbers of staff (both for IT and analyst FTEs). However, the small and medium counties make up for their lower spending and staffing by leveraging the services provided by ASPs, allowing for greater efficiencies at a lower cost. All of the small county Plans, and 85 percent of medium county Plans worked with an ASP, while 69 percent of large county Plans utilized an ASP. Many Plans opted in to the CalMHSA multi-county EHR initiative with Streamline, anticipating added efficiencies and consistency in development and processes across the statewide system of care. This consistency of process may prove beneficial, especially for larger contract providers that provide services in multiple DMC-ODS Plans which all utilize the SmartCare EHR. Additionally, CalMHSA is providing ASP-like assistance to Plans that have signed on to the project.

Telehealth continued to be a significant mode of service delivery following the prior years' impacts from the pandemic, with 100 percent of DMC-ODS Plans reporting telehealth was utilized within the system of care. The significant investment that the Plans made in telehealth infrastructure has made all DMC-ODS Plans flexible in switching between telehealth and face-to-face services as needed. Telehealth infrastructure has also afforded additional access to outpatient services for individuals residing in remote areas or with significant transportation challenges. As reported in the ISCA, both **Los Angeles** and **Fresno** successfully provided telehealth services to the largest numbers of youth statewide, and **San Bernardino** and **Los Angeles** provided the largest number of telehealth services to adults statewide.

In conclusion, the requirements of CalAIM, the end of support for one legacy EHR system, and the introduction of a new CalMHSA-supported EHR led to substantial changes statewide to the DMC-ODS EHR and practice management systems this last year. The implementation of the multi-county EHR, SmartCare by Streamline (coordinated by CalMHSA), has promised eventual consistency of processes across BHPs that adopt the system. While the transitions to new EHRs promise long-term functionality that will support CalAIM requirements and enhanced functionality, the changes made reset the progress by DMC-ODS Plans in developing and implementing functionality including: PHR, HIE and interoperability efforts, and accurate and timely access to service data system-wide. Multiple DMC-ODS Plans reportedly either began or continued efforts of onboarding contract providers to the Plan EHR. These positive efforts will support the elimination of double data entry in situations where contract providers have the ability to use the county's system as a primary EHR (due to not needing to enter data into both an independent and a county EHRs), a more complete and accurate data set, and enhanced care coordination. Finally, as incidences of drug overdoses and MH crises are rising in both the Medi-Cal and general populations, systemic supports for these critical BH services and access to real-time data have never been more needed to support timely and appropriate care coordination.

Compliance

OBJECTIVE

DHCS conducts annual reviews to measure compliance with the State-County contract, which includes the terms and conditions of the Substance Abuse Use Prevention, Treatment, and Recovery Services Block Grants, the DMC-ODS, and other State and Federal statutes and regulations. The goal of this process is to enhance the substance use disorder continuum of care throughout California through compliance oversight and technical assistance.

TECHNICAL METHODS

Compliance audits of the DMC-ODS programs include the quantitative analysis of SDMC claims data, member files, provider files, and a qualitative analysis of policy and procedural documentation to determine each PIHPs compliance with state and federal standards. SDMC data is collected from each PIHP via DHCS' claims submission process whereas member files, provider files, and any associated documentation is provided by each PIHP at the time of each audit. Compliance results are compiled into a Findings Report which is sent to the PIHP with the associated CAP requirements. In addition, the Department posts each PIHP's findings report on DHCS' website. Upon receiving audit findings, Plans are expected to submit a Plan of Correction. This plan must be approved by DHCS and subsequently implemented by the Plan.

These audits occur annually, whereas the MHP audits have been triennial; and like the MCP audits, Plans have not received a published protocol prior to the audits. Three years of results are reported.

The audit is structured into the categories outlined in Table 10-1 based upon the 14 federal standards.

Table 10-1: Annual Review Protocol Categories for DMC-ODS Plans

Section	Protocol Sections
Section A	Disenrollment: Requirements and Limitations
Section B	Enrollee Rights
Section C	Emergency and Post-stabilization Services
Section D	Availability of Services
Section E	Assurances of Adequate Capacity and Services
Section F	Coordination and Continuity of Care
Section G	Coverage and Authorization of Services
Section H	Provider Selection
Section I	Confidentiality
Section J	Grievance and Appeal Systems
Section K	Sub-contractual Relationships and Delegation

Section	Protocol Sections
Section L	Practice Guidelines
Section M	Health Information Systems
Section N	Quality Assessment and Performance Improvement Program
Section O	Disenrollment: Requirements and Limitations

After completing a review, DHCS issues notification letters to Plans describing identified compliance deficiencies, outlining ongoing monitoring activities, and specifying the timeframe for these activities. DHCS then provides Plans with a resolution letter once the ongoing monitoring activities have been completed.

Ongoing monitoring activities to support improved compliance and quality are described in Table 10-2. If Plans fail to comply with the established ongoing monitoring activities, DHCS will evaluate the situation and may impose administrative and monetary sanctions.

Table 10-2: DMC-ODS Compliance Monitoring Activities

Monitoring Activity	Associated Methodology
Monitoring Calls	Individual monitoring calls/webinars with each DMC-ODS. Monthly monitoring calls are facilitated by DHCS County Monitoring Liaisons and occur regardless of tier placement and other compliance status.
Statewide/Regional TA and Training	TA or training provided to all DMC-ODSs, or groups of DMC-ODS Plans, on specific topics.
Focused TA	TA provided, focusing on a DMC-ODS's particular area or area(s) of noncompliance.
Focused Training	Training provided, focusing on a DMC-ODS's particular area or area(s) of noncompliance.
Focused Desk/On-site Review of the DMC-ODS	Targeted desk or on-site audits of one or more specific areas found to be out of compliance in the DMC-ODS. Focused desk and on-site reviews for the purposes of ongoing monitoring activities are separate from and in addition to other DHCS compliance reviews. If deficiencies are identified during a focused desk or on-site review, DHCS issues a separate Findings Report outlining deficiencies; a new CAP is required. If there are no findings, written notification specifying that there were no findings is provided to the DMC-ODS; a CAP is not required.
CAP Process	A CAP is required for findings of noncompliance. DMC-ODSs are required to submit a CAP to DHCS within 60 days of receipt of the findings report. The CAP must include the following information: • Description of corrective actions, including a timeline for implementation and/or completion of corrective actions. • Proposed (or actual) evidence of correction that will be submitted to DHCS.

Monitoring Activity	Associated Methodology
	• Processes for monitoring the effectiveness of corrective actions over time. • Descriptions of corrective actions required of the county's contract providers to address findings. DHCS confirms receipt of the CAP within 15 business days of submission and follows up with DMC-ODSs if the CAP documents are missing required elements and/or need to be resubmitted. After submission of the CAP, DHCS County Monitoring Units in the Medi Cal Behavioral Health Division approve and monitor the county's progress on the DMC-ODS findings identified in the CAP every 90 days until the deficiencies are remediated.
Appeals	If DMC-ODSs elect to appeal any item within their findings report, they may do so by submitting an appeal, in writing, within 15 business days after the receipt of the findings report. DHCS shall grant or deny the appeal in whole or in part within 30 calendar days after receipt of the appeal. If an appeal is submitted, and/or the original findings are upheld, the DMC-ODS shall send the CAP within 60 calendar days of receipt of the notification from DHCS.

DHCS COMPLIANCE FINDINGS

DHCS reviews each DMC-ODS Plan annually. PHC implemented a seven-county regional model DMC-ODS Plan in CY 2020 and their first compliance audit was in FY 2021-22. The seven counties that constitute the regional model received a single system review audit score in FY 2021-22 but individual county scores in FY 2022-23. Therefore, ratings for 37 counties as opposed to 31 Plans are displayed in Table 10-3.

Table 10-3: DMC-ODS Compliance Findings, FY 2020-23

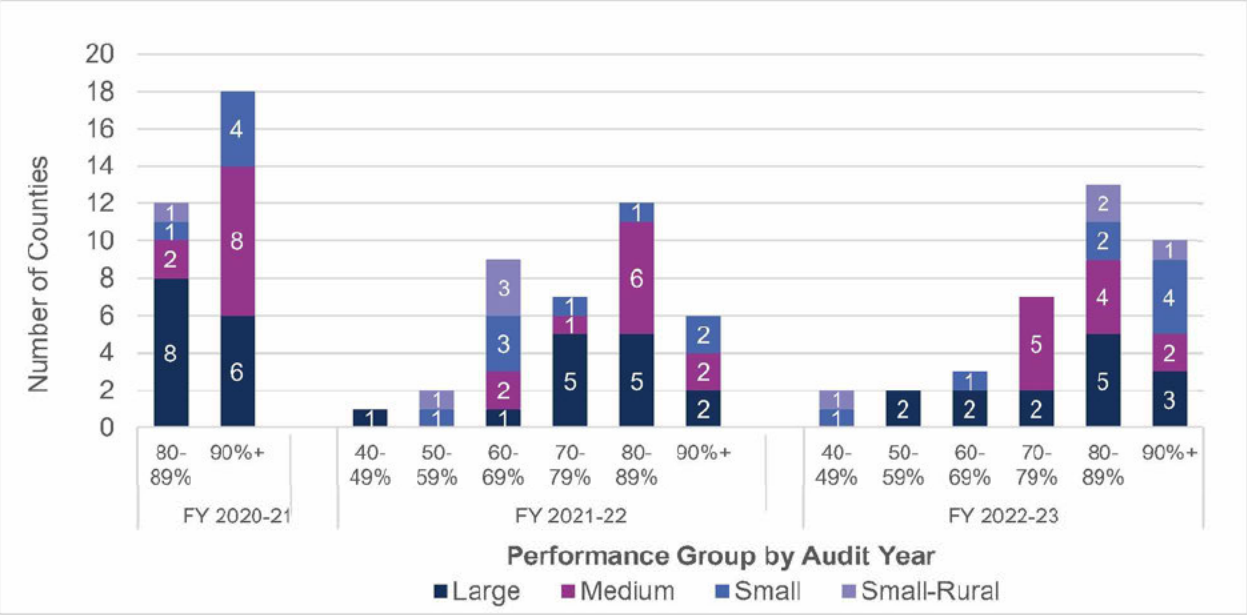
	FY 2020-21	FY 2021-22	FY 2022-23
DMC-ODS	% Compliance	% Compliance	% Compliance
Alameda	90%	74%	63%
Contra Costa	88%	80%	85%
El Dorado	90%	82%	90%
Fresno	88%	72%	90%
Humboldt	N/A	66%	87%
Imperial	92%	90%	92%
Kern	96%	92%	96%
Lassen	N/A	66%	85%
Los Angeles	88%	78%	67%
Marin	92%	94%	94%
Mendocino	N/A	66%	94%
Merced	94%	86%	77%
Modoc	N/A	66%	91%

DMC-ODS	FY 2020-21 % Compliance	FY 2021-22 % Compliance	FY 2022-23 % Compliance
Monterey	92%	84%	73%
Napa	92%	72%	67%
Nevada	88%	54%	46%
Orange	96%	88%	83%
Placer	96%	96%	90%
Riverside	85%	82%	83%
Sacramento	81%	74%	71%
San Benito	83%	56%	48%
San Bernardino	90%	80%	58%
San Diego	92%	82%	85%
San Francisco	85%	62%	85%
San Joaquin	81%	86%	83%
San Luis Obispo	98%	90%	81%
San Mateo	88%	46%	58%
Santa Barbara	94%	88%	96%
Santa Clara	85%	76%	79%
Santa Cruz	90%	84%	85%
Shasta	N/A	66%	85%
Siskiyou	N/A	66%	87%
Solano	N/A	66%	81%
Stanislaus	94%	78%	77%
Tulare	85%	60%	75%
Ventura	96%	100%	92%
Yolo	90%	86%	77%
Average Rates	**90%**	**77%**	**80%**

* These counties were DMC State Plan During FY 2019-20 and began DMC-ODS program during FY 2020-21 through PHC.

Figure 10-1 displays the three years' data and performance grouping by county size.

Figure 10-1: Compliance Results by County Size, FY 2020-23

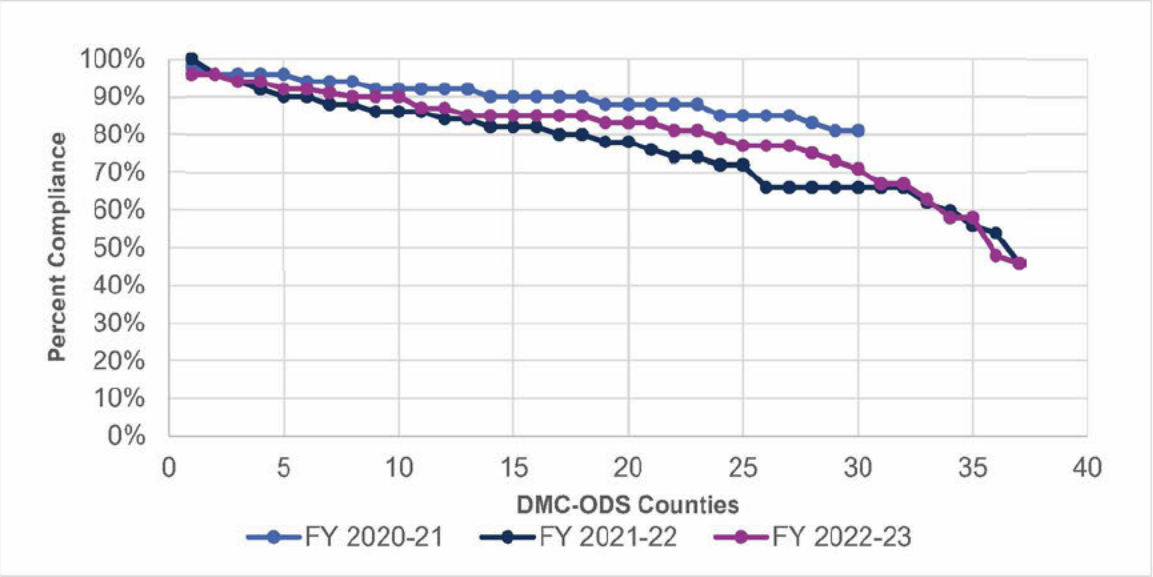


Performance in the 3-year period was strongest in FY 2020-21, when the average and median ratings were 90 percent. FY 2021-22 showed a decrease in average rating (77 percent) as well as the median (78 percent). Results then improved in FY 2022-23, with an 80 percent average and 83 percent median.

For the 3-year period there were no strong trends based upon Plan size. Large and medium Plans were present in all performance categories, though more rated 80 percent or higher. In FY 2021-22, small-rural Plans were lower performers, but this reversed in FY 2022-23, as three of the four were in the top performance categories.

Figure 10-2 illustrates the distribution of compliance rates over the past 3 FYs.

Figure 10-2: Distribution of DMC-ODS System Compliance Rates, FY 2020-23



FY 2020-21 shows the overall highest compliance ratings for the 30 Plans audited that year. FY 2021-22 was the first year with 31 Plans and 38 counties, and compliance performance was below the prior year. Performance in FY 2022-23 showed more counties with higher ratings compared to FY 2021-22.

CONCLUSIONS AND SUMMARY OF COMPLIANCE FINDINGS

FY 2020 21 was the strongest of the three years, with a 90 percent average rating across Plans, and no Plans rating under 80 percent. The average rates over the subsequent FYs were 77 and 80 percent, respectively.

Of the 18 Plans that rated 90 percent or higher in FY 2020-21, only five (Ventura, Placer, Marin, Kern, and Imperial) were rated 90 percent or higher for the two subsequent years. Of the ten Plans that scored 90 percent or higher in FY 2022-23, eight scored 80 percent or higher in FY 2021-22. Those same Plans also scored 80 percent or higher in FY 2020-21, but there were six counties in total due to the two PHC counties that were not audited that year. FY 2022-23 is the only year that two Plans (San Benito and Nevada) rated below 50 percent, and FY 2021-22 results showed one Plan (San Mateo) with a rating below 50 percent.

This report also contains Protocol Compliance information included in Appendix 4, displayed to remedy prior CMS findings. These findings include 30 DMC-ODS Plans and one of the PHC counties (Humboldt). Strong performance is reported, with 20 counties (65 percent) receiving Met ratings in all 14 areas.

INTRODUCTION

CalEQRO reviews were characterized by multiple common themes affecting the Plans One of the most consistent of these themes expressed by both Plans and their contract providers was the adverse impact of a diminished workforce, with staff still retiring early, leaving the field, or transitioning to telehealth positions in the private sector. Most Plans reported double-digit vacancy rates, with recruitment efforts yielding few or even no viable candidates. Consistent with prior review years, members reported observing staff shortages, which often result in new or untrained staff joining treatment teams. This situation contributes to the increased stress and burnout among employees, who are burdened with large caseloads and ever-expanding job duties to cover vacancies.

DMC-ODS Plans remain strongly committed to serving the Medi-Cal population by focusing on expanded access portals, providing low-barrier opportunities, and addressing the needs of indecisive and vulnerable subpopulations. Many Plans have established new leadership positions or strategic initiatives aimed at improving equitable access to care. CalEQRO notes that while access and improvements in outreach and engagement have increased service availability to diverse populations, there are still opportunities for improvement in service utilization and outcomes. Specifically, program and staff level service and outcome data linked to CalOMS or the ASAM reveal an ongoing need to develop or refine effective and efficient solutions to enhance care. Beyond the clinical and program paradigm, concerns that exist about care coordination frequently involve limitations on sharing patient information. These limitations arise from the absence of a unified EHR system and/or the federal confidentiality regulations governing SUD treatment. Fortunately, the introduction of BHQIP performance improvement strategies between behavioral and physical health has begun to create pathways to bridge this gap.

DMC-ODS Plans have continued to focus on both stabilizing and expanding their system of care. Gaps in service are being identified, and most Plans have developed both interim and long-term strategies to address them. Similar efforts are underway to increase member enrollment in underutilized services such as RSS and case management. Beyond their own networks, coordinated projects with key partners such as FQHCs and county-operated jail inmate services have effectively expanded capacity for Medi-Cal members in each county. Despite labor challenges, ongoing strategies are focused on building the workforce and infrastructure in preparation for CalAIM.

CalEQRO has also noted that advancing prevention, a long-recognized essential element in both the SUD field and physical health, is crucial for addressing health outcomes. Research consistently shows that individuals who engage in preventative activities achieve better outcomes across various health care fields, including cancer, and chronic diseases as well as MH and substance abuse. In that regard, DMC-ODS Plans have actively engaged with their communities to address the drug overdose epidemic. They participate in opioid safety coalitions and educate both the community and allied care providers about local substance use patterns and associated risk. As noted earlier in this report, overdose fatalities remain high both nationally as well as in California, largely due to the increasing prevalence of fentanyl. CalEQRO review staff note that many Plans are actively involved in distributing fentanyl test strips, providing overdose reversal training, distributing naloxone, and engaging in community

messaging. Similar prevention strategies are being implemented for alcohol and other drugs, which also contribute to the prevalence of SUDs and adverse health outcomes, including death.

ACCESS

The statewide DMC-ODS system is still relatively young, with many Plans continuing to develop new programs and services that were not previously included in DMC State Plan contracts. In 2022, the total number of Medi-Cal members served slightly increased for the adult and youth populations but continued to decline for older adults. Program numbers increased by 1.9 percent compared to the previous review cycle, but overall PR fell. This decline is related to the 8.0 percent increase in Medi-Cal enrollments. As Plans enhance their systems of care to address community needs, they are now focusing more on engaging populations who need treatment but have not yet sought care.

Plans have actively increased enrollment in case management services as well as RSS, which have positively correlated with better engagement and retention in care. Such services, including care coordination, strengthen connections to community resources that address a range of health-related issues and social determinants of health. Adequate housing remains a statewide challenge, particularly for individuals undergoing SUD treatment. Members are often unhoused or housing insecure and may need to secure new housing to avoid toxic influences from past associates and to be in an environment that supports their wellness and recovery.

In CY 2022, the number of members served increased in both the youth and adult populations compared to the previous year, while the number of older adult members decreased slightly. It's important to note that service options for youth are limited and, when available, tend to be under-utilized. Many Plans have observed a continued decrease in older adults, with smaller numbers seen in CY 2022 claims compared to the previous year.

TIMELINESS

While most the Plans can track the majority of time-to-service metrics, many have been constrained by infrastructure limitations and the challenge of developing a unified EHR since the DMC-ODS framework's implementation. Despite the data limitations noted earlier in this report, timeliness results from the DMC-ODS Plans over the past review year indicate improvements in certain key metrics, including the offering and delivery of first non-urgent services.

However, as previously noted, some Plans still struggle with tracking time for NTP/OTP services, and there was a significant increase in the time to service for urgent service requests overall. These delays are a crucial concern, as each day without treatment can diminish a person's motivation. Monitoring wait times, and especially changes in wait times, is essential for effectively managing care delivery systems. When services become less timely, prompt improvement actions are necessary.

Many Plans and their overall BH departments are now implementing a new multi-county EHR system, which will be configured to track timeliness metrics, a crucial requirement for effective reporting. It should be noted, however, during the review year that Plans reported ongoing delays with the new system, which compromised its ability to collect, track, and report on all metrics. Many resorted to parallel tracking methods, often returning to manual spreadsheets or other workarounds. Near the end of the review year, it appeared that some Plans reported that they had access to the back end of the system and could begin writing their own reports.

QUALITY OF CARE

CalEQRO's review and assessment of SUD service quality indicates an overall positive trend for the DMC-ODS Plans, with either consistent ratings or modest gains in metrics. This is evidenced by improvements in ratings for TPS, CalOMS, and most of the PMs.

A foundation for improved efficacy in care is supported by the QAPI WPs most of which are integrated within local BH departments. DMC-ODS Plans generally benefited from combining resources through unified service models and QM systems. However, CalEQRO continues to encourage Plans to identify and define initiative objectives tailored to the specific needs of the SUD system and its members. EQR staff noted that many of the QAPI WPs now include goals that extend beyond compliance with the DMC-ODS contract. This approach will ensure that the strengths of a recovery treatment model are maintained alongside broader department priorities.

As noted in this report, the quality evaluation included a review of the system's capacity to provide services across all LOCs as well as the criteria for placement determinations. This focused on ensuring that the ASAM criteria accurately align with assessment findings and recommended treatment needs. Over the past review cycle, Plans maintained a high level of congruence in all three intake measurement points. To some extent, congruence appears linked to Plans' ongoing expansion of service capacity and LOC types within their continuum of care. These efforts aim to meet assessed community needs effectively, with ASAM results showing success, as few than 1 percent of members in one Plan were placed in an alternate LOC due to resource limitations.

TPS results and feedback from member stakeholder focus groups are also key indicators, confirming that members are receiving the help they feel they need and will help them in their recovery. Many Plans have focused on improving TPS response rates by offering both in-person and online surveys to improve convenience for members. TPS findings have remained relatively stable, showing positive endorsement of improved outcomes due to treatment. The increased percentage of standard discharges in the CalOMS data set further supports this perspective. CalEQRO continues to encourage Plans to use TPS results as a marker of success in service delivery. Likewise, TPS results are essential for strategic planning, system adjustments, and performance improvement initiatives due to their emphasis on member-centered care. Review sessions with members found that participating in the TPS reenforces their involvement in decision-making about their healthcare choices. It serves as a valuable investment in their care by giving them a meaningful role in enhancing the quality of services.

Feedback from member focus groups provided valuable insights into the quality of care received and the impact of treatment on their lives and goals. During this review cycle, 43 focus groups (67 percent) were conducted via videoconferencing and 21 (33 percent) were held in person. In at least four groups, interpreters facilitated communication for all Spanish-speaking participants, and interpreters were routinely used for one or two members in other groups. Common themes expressed statewide by members in these sessions included concerns about workforce shortages and access to transportation. Similarly, members reported inconsistencies in coordinating with mental and physical healthcare providers, allied entities such as the courts, probation, and child welfare agencies, and in discharge planning, often leaving members to manage their own housing or vocational challenges. There was near universal praise for staff as well as for the culturally responsive services provided.

Case management and care coordination have continued to gain prominence within the DMC-ODS systems. Case managers often follow members across LOCs and conduct extensive outreach to help them engage in or remain in treatment. In many ways, their approach has

become more intensive compared to the previous clinical model of case management. Likewise, providing care coordination across the treatment spectrum – ranging from pre-admission to aftercare – and within various staffing models (including central and/or de-centralized case managers, peers, alumni, and system navigators) has been challenging for Plans struggling with vacancies and resource constraints, especially given the increasing demand for these supports. When available and consistently well-staffed, Plans have observed a correlation between improved retention and better outcomes. Continued support for the evolution of case management in this flexible, member-centered direction is highly recommended to enhance quality.

Data indicators from TPS, CalOMS and PMs support the analysis findings, showing positive trends in initiation, engagement, and LOS/retention. As noted in this report, the percentage of members with longer LOS in an uninterrupted sequence of treatments has increased year over year at the 90-, 180-, and 270-day markers. A longer LOS is a known factor associated with improved outcomes. CalOMS data from Plans show a reduction in summary exits, with 40.7 percent leaving care administratively in 2022, down from 47.1 percent in 2020. Members with a standard discharge increased by nearly 6 percentage points in 2022, reaching 49.8 percent compared to 43.9 percent in 2020. Functional improvements detailed in this report show that members not only receive services but also experience positive changes in housing and employment status from admission to discharge.

All Plans submitted two PIPs this year, and most submitted the BHQIP to fulfill one or both PIP requirements. The BHQIP brought additional resources and a simplified submission document – though simplified sometimes it did not provide enough structure for Plans to include sufficient detail for PIP validation. Now that the BHQIP project has concluded, Plans will need to dedicate resources to developing and implementing new PIPs.

INFORMATION SYSTEMS

Several foundational recommendations regarding structure and operations are presented throughout the report and summarized in this conclusion. Due to various historical factors, the DMC-ODS IS systems, especially those of contract agencies, lack adequate HIS infrastructure to operate efficiently as managed care systems. A majority of contracted programs still rely on paper charts or use a hybrid system with some electronic capacity. This limits the ability to communicate electronically between providers and counties regarding member care in real time – and little progress on PHR access for members to communicate with their treatment teams. A plan for investing in HIS is recommended to ensure that DMC-ODS health system standards are established and can operate seamlessly across broader healthcare and hospital systems.

In FY 2023-24, 65 percent of 38 counties providing DMC-ODS services have been devoting resources to transitioning to a new EHR, and 46 percent of those transitioning EHRs were participating in the CalMHSA multi-county EHR initiative, implementing the SmartCare EHR by Streamline. While the CalMHSA project provides support to Plans utilizing SmartCare, additional assistance is needed for Plans working to adapt their older EHRs.

Plans also dedicated substantial resources to executing payment reform, which involved renegotiating reimbursement rates and updating contracts with providers, training staff, and updating workflows and claiming processes at the beginning of the FY. In many cases, claiming was reportedly delayed, sometimes for several months, due to pending modifications to Plan EHRs. In some cases, delays in claiming resulted in financial concerns for Plans and their providers due to their not receiving reimbursements from July through the beginning of CY 2024. However, CalMHSA worked with the SmartCare Plans to try to resolve these issues and

continues to pursue the objective of developing and building out the potential of this new EHR system, especially its reporting functionality.

While IT staffing levels were down statewide this FY, Plans have been investing in additional data analytic staff to try to adhere to expanded data reporting requirements. Plans continue to struggle to collect complete and accurate data, particularly from contract providers – which are in many Plans responsible for delivering the majority of SUD treatment services. Nonetheless, it is possible that the sheer volume of Plans that decided to implement the SmartCare EHR will also prove beneficial in increasing interoperability with contract providers. One of the barriers to contract-provider EHR access has been persuading providers who work across multiple Plans to use a common EHR (as different Plans use different EHRs). If all providers within a DMC-ODS's system of care used the same EHR, however, duplication of effort caused by the need to enter member-related data into divergent systems would be remediated, data-entry errors might be thereby reduced due to streamlining the process of information capture, and the ability to evaluate and maintain overall data integrity would likely be increased.\With CalAIM's focus on service quality rather than just documentation quality, providers remain hopeful for reduced documentation burdens. However, perceptions are mixed regarding whether this has been fully realized.

Interoperability is increasingly important within the CalAIM framework and is necessary for Plans to calculate the new quality measures, which necessitates information exchange with at a minimum with hospitals and MCPs. While the proportion of DMC-ODSs reporting membership in an HIE increased 57 percent compared with the prior FY, CalEQRO found that beyond solidifying a contract, very few were using the HIE to exchange information. Becoming a member is an important first step, but Plans must use their HIEs for data exchange to leverage their benefits.

RECOMMENDATIONS

DMC-ODS Plans continue to make progress in improving access, timeliness, and quality. Many noteworthy practices have been identified among Plans that have demonstrated particularly outstanding metrics in these areas.

Support for addressing challenges faced by Plans is essential. These recommendations proposed are based on reviews of the 31 Plans, including the information garnered from members, provider networks, and other stakeholders involved in the reviews. All recommendations do not apply to all Plans, but they were selected because they apply to most Plans to varying degrees.

Plan recommendations are followed by an additional set of recommendations directed to DHCS. These recommendations require statewide coordination, leadership, or resources. Sometimes the DHCS recommendation is a complementary recommendation to those made to the Plans.

Recommendations for DMC-ODS Plan Consideration

Access

1. Expand service capacity for certain treatment modalities that are either absent or insufficient in number, particularly youth services and residential treatment options closer to home.
2. Develop and implement outreach and community education strategies to reach underserved populations addressing stigma and promoting health equity. This supports local CCP goals as well as the CQS.

3. Enhance services by increasing the use of paraprofessionals and peers, especially for system navigation, member engagement, and case management.
4. Conduct screenings through Access Call Centers rather than refer directly to providers that may not be the proper ASAM LOC – to include screenings, service information, and linkage to ASAM LOCs identified in screenings for more rapid linkage to care.

Timeliness

1. Address timeliness tracking gaps by minimizing manual processes and establishing regular reporting to assess system responsiveness to member needs.
2. Ensure consistent identification and tracking of members with urgent conditions and acute service needs. This population should be considered for outreach if they do not engage in care.
3. Implement performance metrics to track no-shows for intakes systemwide and across all LOCs. Manual submissions from contract providers are prone to being inaccurate or incomplete.

Quality

1. Continue adopting telehealth to improve access, while balancing it with individualized needs and in-person care, particularly in group settings beneficial for SUD treatment.
2. Expand care coordination by increasing the use of RSS and case management functions to ensure smooth transitions across LOCs.
3. Leverage technology to enhance care coordination across systems such as criminal justice, health, and child welfare to better connect members to SUD treatment and collaborate on their care when appropriate.
4. Continue information exchange efforts with MCPs for ED events and for MAT access sand utilization.
5. When the ASAM non-congruence category “Other” shows significant numbers, analyze reasons and determine whether this represents member-specific needs or potentially training issues on category selection.

Information Systems

1. Plans that currently use member identification numbers other than Client Index Numbers (CINs) should transition to using CINs as their primary identification. Numerous TADT submissions from Plans used other identifications (or CINs that were truncated or adulterated in some way). As Plans are increasingly expected to exchange information electronically with outside entities, including hospitals and MCPs, it is crucial to use a unique identifier that is not recognizable solely within individual Plans to match datasets for analysis.
2. Invest in IT infrastructure development, including interoperability, care management, and referral coordination, as well as HIE functionality to better manage linkages, coordinate care, and effectively manage care across systems. This will be essential for the data exchange necessary to successfully report on the BHAS measures. Care coordination toward holistic member-centered is also an important activity noted in the CQS.
3. Strengthen EHR functionality to support routine extraction of data for timeliness assessment and other types of reporting and continue to enhance data analytic staffing resources within Plans. Effectuating this objective requires either contract providers’ use of

the county's EHR or electronic interface between disparate systems. Some contract providers work with multiple Plans – all of which may have different EHRs – and so the Plan's EHR is often not inclusive of all clinical service data. Plans working with agencies in this position should work to develop strategies that will foster interoperability and data exchange.

4. Embed ASAM functionality into EHRs so that service patterns can be analyzed, reported, and monitored in light of the LOC results.

Recommendations for DHCS Consideration

These recommendations are intended to align, when possible, with the CQS. They are furnished to identify how the State can target goals and objectives in the CQS under 42 CFR Section 438.40 to support quality, timeliness, and access to health care services furnished to Medi-Cal members, as required in 42 CFR Section 438.364(a)(4).

Access

1. Continue and, expand where possible, statewide strategies geared to improve the BH workforce crisis, including engagement with certifying organizations and educational institutions. This may include advocacy for and support of innovative recruitment and retention practices by counties, targeted education and training incentives, legislation, and funding to stabilize the statewide SUD treatment workforce. State-level leadership that encourages expansion of master's programs and other certification programs at California colleges is necessary to increase the number of professionals in the BH field.
2. To promote statewide equitable access and align with the 2022 CQS, assist DMC State Plan counties that have not joined DMC-ODS in considering regional or other collaborative participation. Consider financial incentives that create a safety net for smaller Plans that cannot operationally tolerate the financial risk or develop the needed LOCs locally. The PHC regional plan may serve as a model that could be replicated.
3. Consider implementing time or distance standards, special incentives or rates, for both residential treatment and residential WM to encourage DMC-ODS Plans with low population density and rural locations to prioritize local capacity development, improving accessibility for members who resist clinically indicated care due to distance from home. Other options to consider for addressing these needs suggested by administrators include being able to contract using flexible rates with closer facilities in border states.

Timeliness

1. There have been consistent problems with some Plans with timeliness rates not meeting standards for offered appointments. DHCS intervention could encourage improvement in these timeliness areas.

Quality

1. Establish threshold indicators for DMC-ODS Plans to track and identify performance-based solutions for high CalOMS administrative discharges which represent early withdrawal from treatment. These could warrant PIPs or other QI projects to encourage improvements.
2. Clarify guidelines for the CCP framework, which Plans understood were expecting but have yet to receive. This will allow Plans to update their health equity strategies more comprehensively and uniformly, aligning with current CQS.

3. Foster expansion of RR housing options, where possible, including for members with children and those transitioning from intensive residential programs who are unhoused.

Information Systems

1. Major investments in core IS infrastructure and interoperability are needed to enhance EHR access across providers and to improve interoperability and HIE options between counties, their providers, and health systems. Data exchange efforts are needed between MCPs and the DMC-ODS programs for medication information related to MAT treatment, for BHAS measure reporting and to ensure the best possible access and outcomes for members. DMC-ODS Plans report that this coordination is challenging, and DHCS coordinated efforts with MCPs and DMC-ODS Plans would be positive. DHCS efforts and BHQIP incentives related to these issues with ED events were positive in establishing working relationships but largely have not resulted in actual data exchange.

APPENDIX 1: DRUG MEDI-CAL CLAIM DEFINITIONS

Drug Medi-Cal Claims Code Definitions and Data Sources	
Last Modified: BHC December 2023	Source: Medi-Cal Aid Code Chart Master – December 13, 2020
Source: Data is derived from statewide source files.	
1. Drug Medi-Cal approved and denied claims - Substance Use Disorder Services, DHCS	
2. Monthly Medi-Cal Eligibility Determination System (MEDS) MMEF – Statewide Medi-Cal Eligibility Data	
3. Provider File – (MPF) Statewide master provider file. Includes providers CalOMS or Provider ID number.	
4. CalOMS Treatment Data	
5. ASAM assessment tool	
Process Date: The date DHCS processes files for CalEQRO The files include claims for the service period indicated, calendar year (CY) or fiscal year (FY), processed through the preceding month. For example, the CY 2021 file with a DHCS process date of May 2022 includes claims with service dates between January 1 and December 31, 2021 processed by DHCS through April 2022.	
MMEF file includes beneficiary Medi-Cal eligibility for April, plus 15 prior months.	
Data Definitions: Selected elements displayed within this report are defined below.	
Penetration rate	The number of Medi-Cal beneficiaries served per year divided by the average number of Medi-Cal eligibles per month. The denominator is the monthly average of Medi-Cal eligibles over a 12-month period.
Approved claims per beneficiary served per year	The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year.
Eligibility Selection Criteria:	
Medi-Cal beneficiaries for whom the DMC-ODS is the "County of Fiscal Responsibility" are included, even when the beneficiary was served by another DMC-ODS. Reside in a county that opts into the Demonstration Waiver.	
Medi-Cal age groups determined by beneficiary's age on January 1 of the reporting CY **Youth Group** – age 12-17 **Adult Group** – age 18-64 **Older Adult Group** – age >64	
Age Group - Beneficiary's age group is determined by beneficiary's age on January 1 of the reporting calendar year.	
Eligibility Categories	Drug Medi-Cal aid codes used to report approved claims by eligibility category.
Disabled	2H,36,60,63,64,66,67,68,6C,6E,6G,6H,6N,6P,6R,6V,6W,6X,6Y, L6, L7, K7
Foster Care	2P,2R,2S,2T,2U,40,42,43,46,49,4F,4G,4H,4L, 4N,4S,4T,4W, 5D, 5K,5L.
MCHIP	Expanded eligibility for certain populations of children as defined in federal law as targeted low-income children who would not otherwise qualify for Medi-Cal. E1, E2, E4, E5, H0, H1, H2, H3, H4, H5, H6, H9, M5, M6, T1, T2, T3, T4, T5, T6, T7, 5C, 5D, 7X, 8X, 8P, 8R, 8T
Other Child	Beneficiary age is less than 18 AND has one of the following aid codes: 0A, 0E, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 06, 07, 08, 2A, 2C, 2E, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 44, 45, 47, 4A, 4E, 4M, 54, 59, 5E, 5F,72,74,7A,7J, 7K,7M, 7N, 7P, 7S, 7W, 82, 83, 8E,8G, 8L, 8U, 8V, 8W, H7, H8, J1, J2, K1, M3, M7, M9, P1, P3, P2, P4, P5, P7, P9,R1
Family Adult	Beneficiary age is greater than or equal to 18 AND has one of the following aid codes: 0A, 0E, 0M, 0N, 0P, 0W, 01, 02, 03, 04, 06, 07, 08, 2A, 2C, 2E, 20, 23, 24, 26, 27, 30, 32, 33, 34, 35, 37, 38,

Drug Medi-Cal Claims Code Definitions and Data Sources	
Last Modified: BHC December 2023	Source: Medi-Cal Aid Code Chart Master – December 13, 2020
Source: Data is derived from statewide source files.	
	39, 3A, 3C, 3D, 3E, 3G, 3F, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 44, 45, 47, 4A, 4E, 4M, 54, 59, 5E, 5F,72,74,7A,7J, 7K,7M, 7N, 7P, 7S, 7W, 82, 83, 8E,8G, 8L, 8U, 8V, 8W, H7, H8, J1, J2, K1, M3, M7, M9, P1, P3, P2, P4, P5, P7, P9,R1
Eligibility Categories	Drug Medi-Cal aid codes used to report approved claims by eligibility category.
Affordable Care Act (ACA)	ACA aid codes were effective January 1, 2014. The FFP is 100% from 2014 through 2016. In future years it will step down to 95% for 2017; 94% for 2018; 93% for 2019; 90% for 2020 and thereafter. 7U, K6, L1, M1, M2
Other Adult	Beneficiary age is greater than 19 AND has one of the following aid codes: 0G, 1E, 1H, 1U, 1X, 1Y,2E,3T,3V,48,5F,5T,5W,58,7C, 76,82, 83, 86, 87, 10, 13, 14, 16, 17, 55, 6A, 6J, 6U, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, G6, G8, J3, J4, J6, J8, K8, K9, M0, M4, M8, P3
Excluded aid codes - not DMC funded or inactive in MEDS.	0,00,0L, 0R, 0U,0V,0T, 0X, 0Y, O6,2A,2V, 3V, 3W,46, 4P, 4U, 4V, 50, 53, 5K, 5V, 5J,5R, 6S, 6T, 71, 73, 77, 7D, 7F, 7G, 7H, 7T, 7V, 80, 81, 85, 88, 89, 8F, 8N, NH, 9G, 9R, A1, F1, G9, K2, K3, IE, RR, E6, E7, F2, FX, F3, F4, G0, G1, G4, G3, G5, G7, G9, J5, J6, J7, K2, K3, M4, N0, N5, N6, N7, N8, P0, P8, T0, T8, T9, X7, V2
Eligibility Status	Three-byte code – Byte one reflects beneficiary's eligibility status; Byte two Medi-Cal ID card issuance; Byte three Pre/Post eligibility status information and eligibility established for retroactive months. Eligibility status must be LT 499 to be counted in "Average Number of Eligibles per Month" count for a month.
	1st Digit =Medi-Cal/CMSP/Other Eligible Status **0** Eligible with no conditions (includes zero SOC) **1** Share of Cost to be met by LTC claim. **2** LTC/SOC plus other conditions (i.e., 1+3) **3** Other conditions - Certified SOC, Restricted Service, Minor Consent or Partial Health Care Plan **4** Medi-Cal eligible with Full Service Medi-Cal Health Care Plan Coverage **5** Unmet Share of Cost Obligation (Uncertified SOC) **6** Health and Welfare Program other than Medi-Cal/MSP eligible Specified Low-Income Medicare Beneficiary, Qualified Disabled and Working Individuals, Out –of –State Foster Care, Unborn, Healthy Families, County MI, Child Health and Disability Prevention Program State Only, Medicare Code Editor State & County, Health Care Cost Institute, AIM Pregnant Mother) **7** Hold **8** Qualified Medicare Beneficiary pending Medicare part A & B confirmation. **9** Ineligible **2nd Digit =Normal/Exception Eligibility** **0** Normal Eligible **1** Unconfirmed Immediate Need eligible reported more than 1 month prior **2** Unconfirmed Immediate Need Eligible reported 1 month prior **3** Unconfirmed Immediate Need Eligible reported in current month **4** Forced eligible due to late termination **5** Partial Month Eligibility (Healthy Families, etc.) **7** Exception eligible **8** Forced eligible from MEDS hold **9** Full Month Eligibility (Healthy Families, etc.) **3rd Digit=Timeliness /Misc. Information** **1** Regular eligible reported timely **2** Regular eligible reported retroactively **3** 3-month retroactive eligible **4** Continuing eligible reported timely

Drug Medi-Cal Claims Code Definitions and Data Sources	
Last Modified: BHC December 2023	Source: Medi-Cal Aid Code Chart Master – December 13, 2020
Source: Data is derived from statewide source files.	
	5 Continuing eligible reported retroactively **6** Ramos/Pickle/In-Home Supportive Services/Other Extended eligible **7** Aid Paid Pending Ramos/Myers **8** Hold from LTC/SOC status **9** Ineligible or Regular hold
Share of Cost	Share of cost the beneficiary is obligated to meet before Medi-Cal eligible and SDMC claims are approved for payment. Beneficiaries with SOC are not included in the "Average Number of Eligibles per Month" count for a month until SOC is zero dollars for that month.

Level of Care: Defined by Procedure Code and Modifiers; Revenue and Procedure Code System
Source: Mental Health and Substance Use Disorders Services (MHSUDS), Information Notice 17-045 (superseded by 21—075) and 19-032 and BHIN 20-028

Service Categories	Procedure Code/ Revenue Code	Modifiers/ Procedure Code System	Unit Measurement	Unit Formula
Narcotic Treatment Program (NTP) Methadone Dose	H0020	UA & HG	Dose	unit = one or more
Narcotic Treatment Program (NTP) Individual and Group Counseling	H0004, H0005	UA & HG	Minutes	Two methods: (unit * 10) = minutes OR unit = minutes
Narcotic Treatment Program (NTP) Case Management and Consultation	G9008, H0006	UA & HG	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes
Residential Hospital – 4.0, 3.7	0953 (Revenue)	PCS = HZ Demonstration Project Indicator (DPI) = RH40 or RH37	Day	unit = one or more
WM 4.0, 3.7	0953 (Revenue)	PCS = HZ2ZZZZ DPI = WM40 or WM37	Day	unit = one or more
Residential Day -3.5, 3.3, 3.1	H0019	U1, or U2, or U3	Day	unit = one
Residential - 3.5, 3.3, 3.1 - Case Management and Consultation	G9008, H0006	U1, or U2, or U3	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes
Residential Withdrawal Management -3.2	H0012	U9	Day	unit = one
Residential Withdrawal Management – 3.2 Case Management and Consultation	G9008, H0006	U9	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes
Ambulatory Withdrawal Management -	H0014	U4 & U7 or U5 & U7 or U4 & U8 or U5 & U8 or U4 & UB or U5 & UB	Day	unit = one

Drug Medi-Cal Claims Code Definitions and Data Sources				
Last Modified: BHC December 2023		Source: Medi-Cal Aid Code Chart Master – December 13, 2020		
Source: Data is derived from statewide source files.				
Ambulatory Withdrawal Management - Case Management and Consultation	G9008, H0006	U4 & U7 or U5 & U7 or U4 & U8 or U5 & U8 or U4 & UB or U5 & UB	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes
Medication Assisted Treatment (MAT) Non-Methadone MAT – NTP Service	S5000, S5001	UA & HG	Dose	unit = one or more
Medication Assisted Treatment (MAT) Non-Methadone MAT – Non-NTP Service	S5000, S5001	U7 or U8 or U1 or U2 or U3 or U9	Dose	unit = one or more
MAT Counseling	H2010	U1 or U2 or U3 or U7 or U8 or U9 or UB	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes
Partial Hospitalization	S0201	UB	Day	unit = one
Partial Hospitalization - Case Management and Consultation	H0006, G9008	UB	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes
Intensive Outpatient Treatment – Patient Education	H0015	U8	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes
Intensive Outpatient Treatment - Case Management and Consultation	H0006, G9008	U8	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes
Outpatient Services – Individual and Group Counseling	H0004, H0005	U7	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes
Outpatient Services – Case Management and Consultation	H0006, G9008	U7	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes
Recovery Support Services - Individual and Group Counseling, Case Management	H0004, H0005, H0006	U6	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes
Recovery Support Services - Recovery Monitoring/ Substance Abuse Assistance	T1012	U6	Minutes	Two methods: (unit * 15) = minutes OR unit = minutes

Situational Modifiers: necessary to submit certain claims. Source: DMC Provider Billing Manual DHCS has simplified the modifiers for telehealth, which will be required by all Counties and providers by 11/1/21
HA - Adolescent/youth under age 21 at time of service. Will be validated with MEDS at time of claim adjudication.
HD – Identifies pregnancy and perinatal services.
GQ – Identifies store and forward (e-consult in DMC-ODS) services.
GT – Identifies services delivered via tele-video.
SC – Identifies services delivered via telephone.
59 – Identifies a distinct procedural service.
76 – Identifies repeat procedure (service) by same person (clinician).
77 – Identifies repeat procedure (service) by different person (clinician).

Level of Care: Case Management
Defined by Procedure Code and Modifier
Source: MHSUDS, Information Notices – 17-045 (superseded by 21-075) and 18-005 (superseded by 21-075)

Program	Procedure Code	Modifiers	Unit Measurement
Narcotic Treatment Program (NTP)	H0006	UG	Minutes
Residential - 3.5, 3.3, 3.1	H0006	U1, U2, U3	Minutes
Residential Withdrawal Management – 3.2	H0006	U9	Minutes
Partial Hospitalization	H0006	UB	Minutes
Intensive Outpatient Treatment	H0006	U8	Minutes
Outpatient Services	H0006	U7	Minutes
Recovery Support Services	H0006	U6	Minutes

Level of Care: Recovery Services
Defined by Procedure Code and Modifier
Source: MHSUDS, Information Notices - 17-045 (superseded by 21-075) and 18-005 (superseded by 21-075)

Program	Procedure Code	Modifiers	Unit Measurement
Narcotic Treatment Program (NTP)	T1012	U6 + UA	Minutes
Residential - 3.5, 3.3, 3.1	T1012	U6 + U1 or U2or U3	Minutes
Residential Withdrawal Management – 3.2	T1012	U6 + U9	Minutes
Partial Hospitalization	T1012	U6 + UB	Minutes
Intensive Outpatient Treatment	T1012	U6 + U8	Minutes
Outpatient Services	T1012	U6 + U7	Minutes

ASAM Levels of Care – Treatment
Source: MHSUDS, Information Notice 15-035 (superseded by 21-075)

Level	Service Criteria	Description
0.5	Early Intervention	Assessment and education for at-risk individuals
1	Outpatient services	Less than 9 hours service/week for Adults. Less than 6 hours service for Youth.
2.1	Intensive outpatient	More than 9 hours service/week for Adults. Six or more hours service/week for Youth.
2.5	Partial Hospitalization	20 or more hours service/week in a structured program for multidimensional instability.

3.1	Clinically Managed Low-intensity Residential	24-hour structure with trained personnel; at least 5 hours clinical service/week.
3.3	Clinically Managed High-intensity Residential	24-hour care with trained counselors; less-intense milieu and group treatment.
3.5	Clinically Managed High-intensity Residential	24-hour care with trained counselors; to prepare for outpatient treatment.
3.7	Medically Monitored Intensive Inpatient	24-hour nursing care with physician availability for significant problems.
4	Medically Monitored Intensive Inpatient	24-hour nursing care and daily physician care for severe, unstable problems.
OTP	Opioid Treatment	Daily or several times weekly opioid medication and counseling.

ASAM Levels of Care – Withdrawal Management
Source: MHSUDS, Information Notice 2015-048 (superseded by 21-034)

Level	Service Criteria	Description
1 – WM	Ambulatory withdrawal management	Mild withdrawal with daily or less than daily outpatient supervision; without extended on-site monitoring.
2 – WM	Ambulatory withdrawal management	Moderate withdrawal with all-day withdrawal management support and supervision; with extended on-site monitoring.
3.2 – WM	Residential withdrawal management	Minimal to moderate withdrawal, but needs 24-hour support to complete withdrawal management; unlikely to complete without medical and nursing monitoring.
3.7 – WM	Medically Managed Inpatient withdrawal management	Severe withdrawal and needs 24-hours nursing care and daily physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring.
4 – WM	Medically Managed Inpatient withdrawal management	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and managed medical instability.

Beneficiary Race/Ethnicity Codes

1 = White	2 = Hispanic	3 = Black	4 = Asian/Pacific Islander
5 = Alaska Native or American Indian	7 = Filipino	8 = No valid data reported	9 = Decline to state
A = Amerasian	C = Chinese	H = Cambodian	J = Japanese
K = Korean	M = Samoan	N = Asian Indian	P = Hawaiian
R = Guamanian	T = Laotian	V = Vietnamese	Z = Other

Beneficiary Race/Ethnicity Groups	MEDS Code
White	1
Hispanic	2
African-American	3
Asian/Pacific Islander	4, 7, A, C, H, J, K, M, N, P, R, T, V
Native American	5
Other	8, 9, Z

Beneficiary Languages	BHIN 20-070	MEDS Code	
0 = American Sign	1 = Spanish	2 = Cantonese	3 = Japanese
4 = Korean	5 = Tagalog	6 = Other Non-English	7 = English
8 = No Valid Data Reported	9 = No Response, Client Declined	A = Other Sign Language	B = Mandarin
C =Other Chinese Languages	D = Cambodian	E = Armenian	F = Ilocano
G = Mien	H = Hmong	I = Lao	J = Turkish
K = Hebrew	L = French	M = Polish	N = Russian
P = Portuguese	Q = Italian	R = Arabic	S = Samoan
T = Thai	U = Farsi	V = Vietnamese	

Beneficiary Primary Language Groups	MEDS Codes
English	Code = 7 - Not threshold language
Spanish	Code = 1 - Threshold language for 46 counties
Arabic	Code = R - Los Angeles, Orange, Sacramento, San Diego
Armenian	Code = E - Los Angeles
Cambodian	Code = D – Los Angeles
Cantonese	Code = 2 – Alameda, Los Angeles, Sacramento, San Francisco, San Mateo, Santa Clara
Farsi	Code = U – Los Angeles, Orange, Sacramento, San Diego
Hmong	Code = H – Fresno, Sacramento

Beneficiary Primary Language Groups	MEDS Codes
Korean	Code = 4 – Los Angeles, Orange
Mandarin	Code = B – Alameda, Los Angeles, Orange, San Bernardino, San Francisco, Santa Clara
Other Chinese Languages	Code = C – Los Angeles
Russian	Code = N – Los Angeles, Sacramento, San Francisco
Tagalog	Code = 5 – Alameda, Los Angeles, San Diego, Santa Clara
Vietnamese	Code = V – Alameda, Los Angeles, Orange, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara
Non-Threshold Languages	Codes = 3, 6, F, G, I, J, K, L, M, P, Q, S, T (Not threshold languages)
Sign Languages	Codes = 0, A (Not threshold languages)
Decline to State/Missing Data	Codes = 8, 9 (Not threshold languages)

MEDS County Codes			
01 = Alameda	02 = Alpine	03 = Amador	04 = Butte
05 = Calaveras	06 = Colusa	07 = Contra Costa	08 = Del Norte
09 = El Dorado	10 = Fresno	11 = Glenn	12 = Humboldt
13 = Imperial	14 = Inyo	15 = Kern	16 = Kings
17 = Lake	18 = Lassen	19 = Los Angeles	20 = Madera

21 = Marin	22 = Mariposa	23 = Mendocino	24 = Merced
25 = Modoc	26 = Mono	27 = Monterey	28 = Napa
29 = Nevada	30 = Orange	31 = Placer/Sierra	32 = Plumas
33 = Riverside	34 = Sacramento	35 = San Benito	36 = San Bernardino
37 = San Diego	38 = San Francisco	39 = San Joaquin	40 = San Luis Obispo
41 = San Mateo	42 = Santa Barbara	43 = Santa Clara	44 = Santa Cruz
45 = Shasta	47 = Siskiyou	48 = Solano	49 = Sonoma
50 = Stanislaus	51 = Sutter/Yuba	52 = Tehama	53 = Trinity
54 = Tulare	55 = Tuolumne	56 = Ventura	57 = Yolo

Counties by DHCS Regions	**County Code**
Bay Area	01, 07, 21, 27, 28, 35, 38, 41, 43, 44, 48, 49
Central	02, 03, 05, 09, 10, 16, 20, 22, 24, 26, 31, 34, 39, 50, 51, 54, 55, 57
Los Angeles	19
Southern	13, 15, 30, 33, 36, 37, 40, 42, 56
Superior	04, 06, 08, 11, 12, 14, 17, 18, 23, 25, 29, 32, 45, 47, 52, 53

Counties by DHCS County Sizes	**County Code**
Large	01, 07, 10, 15, 19, 30, 33, 34, 36, 37, 38, 43, 56
Medium	04, 21, 24, 27, 31, 39, 40, 41, 42, 44, 48, 49, 50, 54, 57
Small	09, 12, 13, 16, 17, 20, 23, 28, 29, 35, 45, 51, 52, 55
Small-Rural	02, 03, 05, 06, 08, 11, 14, 18, 22, 25, 26, 32, 47, 53

Diagnosis Category Source: Information Notices - 17-034 (superseded by 21-020) and 17-063 (superseded by 21-020) and 19-013 (superseded by 21-010 or 20-074E) and BHIN 20-074	**International Classification of Diseases 10th Revision (ICD-10) Outpatient Diagnosis Codes** (bold ICD-10 notes new diagnoses)
Alcohol Use Disorder	F1010, F1011, F10120, F10129, **F1013**, **F10130**, **F10131**, **F10132**, **F10139**, F1020, F1021, F10220, F10229, F10230, F10239, F10920, F10929, **F1093**, **F10930**, **F10931**, **F10932**, **F10939**
Cannabis Use	F1210, F1211, F12120, F12129, **F1213**, F1220, F1221, F12220, F12229, F1223, F1290, F12920, F12929, F1293
Cocaine Abuse or Dependence	F1410, F1411, F14120, F14129, **F1413**, F1420, F1421, F14220, F14229, F1423, F1490, F14920, F14929, **F1493**
Hallucinogen Dependence or Unspecified	F1610, F1611, F16120, F16129, F1620, F1621, F16220, F16229, F1690, F16920, F16929
Inhalant Abuse/Dependence /Unspecified	F1821, F1810, F1811, F18120, F18129, F1820, F18220, F18229, F1890, F18920, F18929
Opioid	F1110, F1111, F11120, F11129, **F1113**, F1120, F1121, F11220, F11229, F1123, F1190, F11920, F11929, F1193
Other Stimulant Abuse/Dependence	F1510, F1511, F15120, F15129, **F1513**, F1520, F1521, F15220, F15229, F1523, F1590, F15920, F15929, F1593

Other Psychoactive Substance	F1910, F1911, F19120, F19129, **F1913**, **F19130**, **F19131**, **F19132**, **F19139**, F1920, F1921, F19220, F19229, F19230, F19239, F1990, F19920, F19929
Sedative, Hypnotic Abuse/Dependence	F1310, F1311, F13120, F13129, **F1313**, **F13130**, **F13131**, **F13132**, **F13139,** F1320, F1321, F13220, F13229, F13230, F13239, F1390, F13920, F13921, F13929, F13930, F13939
Other	Other ICD-10 codes not listed above which were submitted thru DMC claim transactions

APPENDIX 2: COUNTIES BY SIZE AND REGION

County	Size	Region
Alameda	Large	Bay Area
Alpine*	Small-rural	Central
Amador*	Small-rural	Central
Butte*	Medium	Superior
Calaveras*	Small-rural	Central
Colusa*	Small-rural	Superior
Contra Costa	Large	Bay Area
Del Norte*	Small-rural	Superior
El Dorado	Small	Central
Fresno	Large	Central
Glenn*	Small-rural	Superior
Humboldt	Small	Superior
Imperial	Small	Southern
Inyo*	Small-rural	Central
Kern	Large	Southern
Kings*	Small	Central
Lake**	Small	Superior
Lassen	Small-rural	Superior
Los Angeles	Very Large	Los Angeles
Madera*	Small	Central
Marin	Medium	Bay Area
Mariposa**	Small-rural	Central
Mendocino	Small	Superior
Merced	Medium	Central
Modoc	Small-rural	Superior
Mono*	Small-rural	Central
Monterey	Medium	Bay Area
Napa	Small	Bay Area
Nevada	Small	Superior
Orange	Large	Southern
Placer	Medium	Central
Plumas*	Small-rural	Superior
Riverside	Large	Southern
Sacramento	Large	Central

County	Size	Region
San Benito	Small	Bay Area
San Bernardino	Large	Southern
San Diego	Large	Southern
San Francisco	Large	Bay Area
San Joaquin	Large	Central
San Luis Obispo	Medium	Southern
San Mateo	Large	Bay Area
Santa Barbara	Medium	Southern
Santa Clara	Large	Bay Area
Santa Cruz	Medium	Bay Area
Shasta	Small	Superior
Sierra*	Medium	Central
Siskiyou	Small-rural	Superior
Solano	Medium	Bay Area
Sonoma	Medium	Bay Area
Stanislaus	Medium	Central
Sutter*	Small	Central
Tehama*	Small	Superior
Trinity*	Small-rural	Superior
Tulare	Medium	Central
Tuolumne*	Medium	Central
Ventura	Large	Southern
Yolo	Medium	Central
Yuba*	Small	Central

*Not in DMC-ODS

**Not in DMC-ODS for the time period of this report

APPENDIX 3: MAPS OF CALIFORNIA COUNTIES


California Counties by Region
Bay Area
Central
Los Angeles
Southern
Superior
Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Glenn
Butte
Sierra
Mendocino
Yuba
Nevada
Placer
Lake
Colusa
Sutter
El Dorado
Yolo
Sonoma
Napa
Sacramento
Alpine
Amador
Solano
Calaveras
Marin
Tuolumne
San Joaquin
Mono
Contra Costa
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Merced
Madera
Santa Cruz
Fresno
San Benito
Inyo
Tulare
Monterey
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Santa Barbara
Orange
Riverside
Los Angeles
Ventura
San Diego
Imperial
Los Angeles

APPENDIX 4: DHCS EQR PROTOCOL 3 COMPLIANCE REMEDIATION

The following information was provided to BHC by DHCS to be included in the annual reporting to remediate ongoing CMS Protocol 3 Compliance Findings.

Protocol 3 Compliance Review Information		
Requirement	**PIHP**	**EQR Submission**
The objective(s) of the compliance review.	DMC-ODS	DHCS conducts annual reviews to measure compliance with the State-County contract, which includes the terms and conditions of the SABG Block Grant, the DMC-ODS, and other State and Federal statutes and regulations. The goal of this process is to enhance the substance use disorder continuum of care throughout California through compliance oversight and technical assistance.
	MHP (SMHS)	DHCS conducts triennial reviews of each county MHP to determine compliance with federal and state regulations as well as the terms of the MHP contract. The goal of this process is to ensure compliance and to identify opportunities for improvement.
The technical methods of data collection and analysis for the compliance review.	DMC-ODS	Compliance audits of County Specialty Mental Health (SMH) and Drug Medi-Cal Organized Delivery System (DMC-ODS) programs include the quantitative analysis of SDMC claims data, member files, provider files, and a qualitative analysis of policy and procedural documentation to determine each PIHPs compliance with state and federal standards. SDMC data is collected from each PIHP via DHCS' claims submission process whereas member files, provider files, and any associated documentation is provided by each PIHP at the time of each audit. Compliance results are compiled into a findings report which is sent to the PIHP with the associated CAP requirements. In addition, the Department posts each PIHP's findings report on DHCS' website.
	MHP (SMHS)	
The results, a description of the results, and any validation of the compliance review.	DMC-ODS	Results are provided on the pages that follow.
	MHP (SMHS)	
Conclusions drawn from the results of the compliance review.	DMC-ODS	BHC will review the approved A&I Compliance Review Results to write narrative statements documenting the percentage of plans meeting each of the 14 federal standards.
	MHP (SMHS)	

Dates of Compliance Review	Plan Name	Compliance Items ** Met (M) / Partially Met (PM) / Not Met (NM) / Not Reviewed (NR)														Did DHCS impose a corrective action plan (CAP) based on the compliance review findings?	Current Status of the CAP (Open/Closed /Not Applicable)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14		
03/08/23	Alameda	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
02/09/23	Contra Costa	M	M	M	M	M	M	M	PM	M	M	M	M	M	M	Yes	Closed
06/15/23	El Dorado	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
02/16/23	Fresno	M	M	M	M	M	M	M	PM	M	M	M	M	M	M	Yes	Closed
06/15/23	Humboldt	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
03/15/23	Imperial	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
05/11/23	Kern	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
05/17/23	Los Angeles	M	M	M	M	M	M	M	M	M	PM	M	M	M	M	Yes	Closed
04/26/23	Marin	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
03/16/22	Merced	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
04/04/23	Monterey	M	PM	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
06/28/23	Napa	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
06/20/23	Nevada	M	PM	M	PM	PM	PM	PM	M	M	M	M	M	M	M	Yes	Closed
05/31/23	Orange	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
04/18/23	Placer	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
04/12/23	Riverside	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
03/28/23	Sacramento	M	M	M	M	M	M	M	PM	M	PM	M	M	M	M	Yes	Closed
02/23/23	San Benito	M	PM	M	PM	PM	PM	PM	M	M	M	M	M	M	M	Yes	Closed
01/11/23	San Bernardino	M	PM	M	PM	PM	PM	PM	PM	M	M	M	M	M	M	Yes	Closed
04/04/23	San Diego	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Open
02/21/23	San Francisco	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Open
04/14/23	San Joaquin	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
04/04/23	San Luis Obispo	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Open
01/24/23	San Mateo	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed

Dates of Compliance Review	Plan Name	Compliance Items ** Met (M) / Partially Met (PM) / Not Met (NM) / Not Reviewed (NR)														Did DHCS impose a corrective action plan (CAP) based on the compliance review findings?	Current Status of the CAP (Open/Closed /Not Applicable)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14		
06/28/23	Santa Barbara	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
02/14/23	Santa Clara	M	M	M	M	M	M	M	M	M	PM	M	M	M	M	Yes	Closed
06/29/23	Santa Cruz	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
01/10/23	Stanislaus	M	M	M	M	M	M	M	PM	M	M	M	M	M	M	Yes	Closed
02/16/23	Tulare	M	M	M	M	M	M	M	PM	M	M	M	M	M	M	Yes	Closed
03/15/23	Ventura	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed
06/14/23	Yolo	M	M	M	M	M	M	M	M	M	M	M	M	M	M	Yes	Closed

Compliance items 1-14 referenced above are defined below:

Item	** Code of Federal Regulation Standards - Met/Partially Met/Not Met/Not Reviewed	Reference
1	Disenrollment: Requirements and Limitations	§ 438.56
2	Enrollee Rights	§ 438.100
3	Emergency and Post-stabilization Services	§ 438.114
4	Availability of Services	§ 438.206
5	Assurances of Adequate Capacity and Services	§ 438.207
6	Coordination and Continuity of Care	§ 438.208
7	Coverage and Authorization of Services	§ 438.210
8	Provider Selection	§ 438.214
9	Confidentiality	§ 438.224
10	Grievance and Appeal Systems	§ 438.228
11	Subcontractual Relationships and Delegation	§ 438.230
12	Practice Guidelines	§ 438.236
13	Health Information Systems	§ 438.242
14	Quality Assessment and Performance Improvement Program	§ 438.330