

January 26, 2015

Angela Garner  
Deputy Director  
Division of State Demonstrations and Waivers  
Center for Medicaid and CHIP Services, CMS  
7500 Security Boulevard, Mail Stop S2-01-16  
Baltimore, MD 21244-1850

Mehreen Hossain  
Project Officer  
Division of State Demonstrations and Waivers  
Center for Medicaid and CHIP Services, CMS  
7500 Security Boulevard, Mail Stop S2-02-26  
Baltimore, MD 21244-1850

Hye Sun Lee  
Acting Associate Regional Administrator  
Division of Medicaid & Children's Health Operations  
Centers for Medicare and Medicaid Services, Region IX  
90 7<sup>th</sup> Street, Ste 5-300 (5W)  
San Francisco, CA 94103-6707

**Re:** Proposed California Amendment to Bridge to Health Reform  
Demonstration (No. 11-W-00193/9), Drug Medi-Cal Organized Delivery  
System Waiver

**Objections of California Opioid Maintenance Providers (COMP) on Behalf  
of Beneficiaries and Providers of Services**

Dear Ms. Garner, Ms Hossain, and Ms Lee:

I am the CEO of MedMark Treatment Centers, operator of 20 opiate treatment centers, 6 of which are in California. Our California clinics treat over 2,400 patients and I am writing on their behalf. I believe the proposed California Amendment to the Bridge to Health Reform Demonstration project will cause numerous patient problems, most stemming from access issues. The result will be increased recidivism, increased health problems, increased patient deaths, and more patients entering the criminal justice system.

I am concerned that the CA Bridge to Reform Demonstration Amendment (No. 11-W-00193/9) is ill conceived and not well vetted as it relates to Medication Assisted Treatment. As a result, the organized delivery system as proposed will result in decreased access, poor care, and more stigmatization for patients in California. I believe that approving this waiver will undo all of the positive effort that the Sobky v. Smoley ruling has had. In fact, my understanding is that the waiver would prove illegal unless California statutes are changed to undo the positive access results caused by the Sobky ruling.

I. Concerns—Poor Care

By only anticipating 8-12 counties will initially participate (p2) means by definition that 46-50 counties will not. Of note, patients currently are not forced to get treatment in their own county. There is no provision for how patients in a participating county being treated in a non-participating county that is more accessible, will be accommodated. These patients may likely have to transfer clinics or drop out of care.

To the contrary, a patient in a clinic in an opt-in county who does not live in the county may also have to transfer providers (see 1-a-i) and travel further distances. These items are not well vetted in the waiver which creates barriers to care. Why this is a more critical and unique issue for Methadone Treatment is that patients attend clinics daily, sometimes for 1-2 years or more. To disrupt their treatment or force them to switch providers is ill conceived. And as many simply drop from treatment, the drug problem in California, related criminal justice concerns, and the number of health concerns and related deaths will expand.

Many counties in CA do not have a specific knowledge of Methadone Treatment Practices. This is because there has been state wide oversight for over 20 years up to the present. Pushing a general SUD waiver onto even a willing county suggests they could respond to issues with the same level of expertise currently necessary to manage the current programs. We are convinced this level does not exist. Decisions will be made that will not be in the best interest of patients because there is no quality control at the county level to prove they have the ability to make critical decisions. The State currently has offered no plan to oversee the county decision making until a bad decision is made and implemented. That is apparently their definition of providing oversight.

Selective contracting is a way of decreasing services in a county. By decreasing services, the poorer counties save money initially. Counties are not educated, nor do they have the means to economically test the value of methadone treatment services. Decisions to cut services may be in their economic short term interest, but will decrease access and

harm Medicaid patients. There will be no state oversight of this per the waiver until services are closed and problems occur. By then, it will take months if not years to recover.

Methadone Treatment is stigmatized. Having a group of people at the state level who are well studied in this area has supported treatment, access and helped overcome the stigmatization of opiate addicts seeking treatment. Subky vs. Smoley gave them the teeth to fix previous access issues. In fact, the past California governor, Governor Schwarzenegger, proposed to eliminate methadone treatment altogether just a few short years ago and state workers and treatment advocates helped lead the charge with facts and information. It is clear that with 58 counties in California, this knowledge and expertise cannot be found in all counties, and poor decisions like what Governor Schwarzenegger initially tried to make in some of those counties.

The State in discussions to date says it will have oversight authority—yet not one example of how it will provide such authority has been provided to inquiring constituents. While general pollyanna like statements have been made, when queried, there are no clear cut policies, procedures, criteria or standards developed for oversight of methadone treatment services that have been shared. We ask that at minimum, CMS demand this from the State prior to approving the waiver. Better altogether would be CMS excluding Narcotic Treatment Programs from the proposed organized delivery system.

Counties have already demonstrated that Medicaid recipient choice for treatment is not always of interest. While one of our clinics has a 60 patient wait list, we are told by that county that our patients on the wait list can go to “a clinic 5 miles away that has 200 open slots.” Our patients choose to wait for an opening which clearly shows they have a problem going to another clinic—yet this has fallen on deaf ears at the county level. In fact, the State is now intervening in our behalf, something that would be much more difficult to do once the waiver is approved unless what oversight means is clarified by CMS.

We are also aware that the State in this waiver allows counties to select providers, eliminate providers, and can track and change rates but offers no guidance. Some counties have discussed implementing an antiquated and tedious cost-reimbursement system which will delay payments and has been proven to create cost inefficiencies in health care. This is clearly because they believe, despite what history has shown, that this will decrease their costs.

We ask that CMS review this waiver and request specifically for:

1. Either Narcotic Treatment Programs be eliminated from the waiver  
  
or
2. That California articulate in writing to CMS:
  - a) Articulated and written policy, procedures, criteria, and mechanisms for State oversight of county actions
  - b) Specified alternatives to forcing Medicaid patients to travel further to either be treated in a non-opt-in county if they live in such a county and currently get their treatment in a clinic in the opt-in county or to be treated in a county program if they live in the county but live much closer to another program outside the county.
  - c) Any specific data addressing the number of patients forced to transfer or drop out of treatment as a result of implementing the waiver.
  - d) Access problems as counties cut programs and slots, given their power in the waiver to reduce reimbursement and selectively contract. Again, no research or data has been provided by the State. Then articulate how the State will be in a position to approve changes impacting access before they are made.
  - e) Any specific requirements and criteria in the waiver that the county have demonstrated expertise to oversee the services they are selectively contracting for and in particular Opiate Treatment expertise.
  - f) Any mechanisms to insure that the methadone treatment population will not be further stigmatized in decisions to close programs or select less expensive programs because the counties have no current expertise to measure or oversee the clinical results.
  - g) We ask CMS to look into the Calohms program which the State believes is the data oriented outcomes program that counties will use to measure patient success. Almost all providers recognize that this is a flawed system providing misleading information. It has poor definitions for input such that what one clinic calls one item is not followed through by

other clinics, often resulting in meaningless data—garbage in, garbage out.

- h)** In Section V of the waiver, it says methadone treatment clinics can offer buprenorphine treatment. However, there is no mechanism to provide and be reimbursed for the medication currently in California and none is proposed. This needs to be clarified by the State.
- i)** The waiver states “Beneficiaries will be given a choice of providers” in the service areas. The waiver does not require that an opt-in county have 2 or more providers for every type of service and therefore there would be no choice. And as stated previously, opt-in county patients will be required to transfer from near by clinics in a no-opt-in county clinic to go to a further away county clinic. Even if a patient has had a bad experience with that clinic or a provider in the clinic, there is no provision to allow the patient to be treated elsewhere.
- j)** In Section P13iii, Counties must describe how they will guarantee access—yet no specified access requirements are spelled out. Is driving 2 hours for treatment considered reasonable access? Is having one clinic available with a two hour wait considered adequate access? The waiver should address specifics and the State has not offered criteria
- k)** Require State provided guidance and limitations on how counties will be allowed to change rates and the current reimbursement system, given the county’s lack of experience in health care reimbursement.

We ask CMS to not accept generalized pollyanna like statements in the waiver, but demand from the State the answers to the hard questions. How will quality be measured? How will access be measured? How many patients will be required to transfer treatment to another location? How many patients will likely drop out of treatment if accessible treatment is lost? Is there a minimal number of clinics specified for a specific number of patient population? What is the provision for a county to pay for treatment in a non-opt-in county if a patient lives two minutes from that clinic and has been treated there daily for one year and now would have to travel 45 minutes and be forced to go to a new clinic that they might not be able to travel to. What are the identified issues with the current outcome measured system Calohms?

In summary, MedMark Services, a company with six clinics in California, currently treating over 2,400 patients requests that Narcotic Treatment Programs be

exempted from the "Organized Delivery System." We believe the waiver will harm our patients and should be denied. The waiver has failed to address critical concerns specified herein for Narcotic Treatment programs. At minimum, please do not approve this waiver until the questions raised herein have been adequately addressed and the answers are clear and supportable or it becomes ever more clear that the Narcotic Programs should be exempted from the waiver. If you would like more information, please feel free to call or email me.

[dwhite@medmark.com](mailto:dwhite@medmark.com)

214.379.3301

Sincerely,

A handwritten signature in blue ink, appearing to read "David K. White". The signature is written in a cursive style with a large initial "D" and "K".

David K. White, Ph.D.  
President and CEO