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**Comments Regarding the Proposed Bridge to Reform 1115 Waiver Amendment  
Terms and Conditions for California's Drug Medi-Cal Program**

**Submitted by California Opioid Maintenance Providers**

**August 21, 2014**

COMP has reviewed the draft Terms and Conditions released by the Department of Health Care Services on July 16, 2014. We applaud the Department's effort to improve the substance use disorder treatment system in California but remain opposed to the waiver of federal access protections. COMP firmly asserts that the programmatic changes sought by the State can be accomplished through other means, such as enhanced certification standards, without eliminating federal access protections for beneficiaries. The draft Terms and Conditions recently released by the Department fail to adequately address access concerns we have raised previously. The Terms and Conditions ultimately create more questions than answers, as more fully described below in the order in which they appear in the draft document.

**Context**

Before we discuss our comments on the proposed Terms and Conditions, it is important to establish a view of the current system of Opiate Treatment Programs (OTPs) in California.

Since the Sobky Vs. Smoley permanent injunction was implemented in 1994, California has developed what is arguably the most robust system of opiate treatment programs in the country. There are currently approximately 145 licensed programs (more than any other state) spanning much of the state, providing timely access to the major population centers and stretching into many suburban and rural areas. While there are still limited parts of the State without timely access, the vast majority of the population lives within 10 miles of an OTP.

In addition, the passage of legislation in 1997 establishing an evidence-based, fee-for-service reimbursement system resulted in improved patient outcomes. Specifically, the current system pays for two distinct units of service, medication administration and counseling services, each of which are empirically proven to result in the best possible patient outcomes and ensure efficiency and cost-effectiveness.

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Finally, the rigorous, multi-level oversight system ensures program integrity. OTPs in California are regularly evaluated by county, state, federal and accreditation entities to ensure compliance with separate, rigorous standards in all areas of fiscal operations, quality of care, medication oversight and facility safety.

In short, while there continues to be numerous administrative impediments and county efforts to limit access as described in previous documents, over the past 20 years, California has developed a model for providing the best access in the nation. Simultaneously, this model has linked payment for services with quality measures and efficient delivery all while having a record for strong program integrity.

With that context in mind, following are our comments on the proposed Terms and Conditions.

## **Terms And Conditions**

### **Section 1.b. Delivery System**

This section describes the Department's intent to restrict access to services to county of residence. Currently, no such restriction exists. Presently many patient beneficiaries must access services in neighboring counties because of the logistical challenges associated with daily clinic attendance inherent in narcotic treatment program services. For example, many beneficiaries receive daily medication doses, but work outside their counties of residence. Such patients must have easy access to programs near their workplace. Otherwise, they are likely to leave treatment entirely with the result that they will eventually relapse and lose their jobs. Some counties do not have providers willing or able to provide necessary services. In these counties, patients will be denied essential medically necessary treatment. This change will result in beneficiaries being forced to leave treatment where they have achieved stability and recovery. In effect, all counties will be impacted by a residence requirement decreasing access even if only a few counties opt into the waiver.

### **Section 4.a.ii. Responsibilities of Counties for DMC-ODS Benefits**

While the language in the draft suggests that "Access to services must remain at the current level..." there is no description of how that level is measured, or documented, and, most importantly, what happens if access is diminished. Later in the same section of the draft, the proposal requires that counties must maintain and monitor a provider network "sufficient to provide adequate access to all services..." Yet there is no description of who determines network adequacy and what criteria are utilized for the determination. Given the long history of county efforts to limit access as described in previous COMP documents submitted during the stakeholder process, and evidence that existing access problems reported by the state in the county mental health system are unresolved, this empowerment of counties will result in decreased access to NTP services. The Department did not provide any answers to these questions during the stakeholder meeting on July 30, 2014.

In the same section, the Department presents criteria for "establishing and monitoring the network" of providers. Again, these criteria will not accomplish the well-intended goals of ensuring access given the total lack of accountability in a system where access protections are waived.

#### **4.a.iii. Medication Assisted Treatment Services**

COMP is pleased to see language that requires counties to describe how they will guarantee access to Medication Assisted Treatment (MAT). However, the draft Terms and Conditions do not address accountability for failure to either develop a reasonable plan or to follow through on a plan. A county can propose a comprehensive plan, then never execute it. Access will be diminished with no repercussions to the county.

Additionally, while we are pleased to see ideas for MAT expansion, access is not ensured. Again, as pointed out above, there are no criteria for approving a county plan, there is no a mandate for a county to execute that plan, and there is no accountability for counties that fail to execute a plan. Moreover, several of the ideas themselves will not increase access to treatment programs. For example, the draft proposes mobile units to dispense methadone, but mobile units are not being currently approved by the DEA. Also, implementing office based outpatient treatment (OBOT) might increase the prescription of opiate medication, but the experience has been that the vast majority of OBOT practices have no “program,” that is, there is only medication, no psychosocial services, no support groups, no drug testing, no ancillary support services. Worse, there are no requirements that OBOT practices report outcome, admission or other data. There is no indication that OBOT, in real life, is stabilizing patients and leading to recovery. We do know that retention, a key predictor of success in treatment, is very poor in the OBOTs and has been empirically shown to be significantly lower than in structured narcotic treatment programs.

#### **Section 4.a.v.ii DHCS Appeal Process**

A key concern COMP has articulated throughout the stakeholder process has been that counties have a well-documented history of efforts to limit access to NTP services. As such, COMP has consistently opposed the waiver of federal laws pertaining to freedom of choice of providers, statewideness and comparability of services because the waiver will empower counties to implement politically motivated restrictions. DHCS has attempted to create a process for providers to appeal county contracting decisions. However, the appeal process here is narrow, arbitrary and illusory. Specifically, a provider may only appeal a county decision to not contract when the decision is based on network adequacy, a criteria which COMP previously pointed out is not defined and subjective. Counties can deny contracts based on speculative and insubstantial allegations of provider wrongdoing, without any due process or test of the veracity of such allegations. Thus, counties that do not want to provide NTP services will simply deny contracts for reasons other than network adequacy. There will never be an which precludes the opportunity to appeal such decisions. This is a spurious appeal process that will be easily circumvented by counties who wish to terminate provider contracts. DHCS has failed to explain why providers may not appeal county decisions for reasons other than network adequacy.

Even when an appeal would be possible, the process is described as a “facilitated discussion” with a “representative from DHCS.” If inadequate access is found (again, not defined and subjective), then a county would be allowed to develop a corrective action plan (CAP). The CAP may take 12 months to implement, during which time, the provider will close down and no services will be available to its patients. Its patients are likely to relapse and leave treatment altogether. Although the draft says, “DHCS may remove the county from the waiver if the CAP is not implemented,” this means a county may not implement the CAP and still continue limiting access to patient beneficiaries.

Additionally, the draft says, “The decision issued by (a) DHCS (representative) shall be final.” This means, a DHCS employee, regardless of his or her tenure or understanding of the issues, may rule adversely with no third party enforcement.

#### **Section 4.b. Authorization**

According to this section of the draft, DHCS intends to allow counties the ability to “authorize other services” in addition to residential treatment. But prior authorization for methadone maintenance treatment will prevent most beneficiaries who are in desperate need of medically necessary methadone maintenance treatment from actually ever being admitted to treatment because of the state and federal regulations that presently require patients to present for treatment while in physical withdrawal. Withdrawal has been described and addressed by many physicians as an urgent care medical visit, not amenable to waiting for clerical authorization. We know from many decades of experience that if a patient presents for treatment and he or she is turned away for any reason, that that may be the day the person uses an HIV or HCV-infected needle, is arrested and sent to jail or prison, or overdoses and dies. As such, we must, “strike while the iron is hot” and not lose opportunities to capitalize on a patient’s moment of clarity during which he or she recognizes this need and is motivated to seek treatment. The standard of care for access to narcotic treatment programs in California today is treatment on demand. Any effort to require prior authorization will degrade that level of access.

#### **Section 4.c. County Implementation Plan**

This section of the draft includes language describing how a county will propose to participate in the waiver. One glaring omission is any accountability for county plans that fail to measure and ensure access. DHCS staff acknowledged during the July 30, 2014 stakeholder meeting that those details have not yet been “thought through.”

#### **Section 4.e. DMC Certification**

According to this section of the draft, DHCS intends to delegate responsibility to counties for determining which providers may be certified to participate in DMC. This authority will allow a county not to certify providers because the county does not want a particular service, such as NTP services. This will deny a provider the ability to seek a contract and engage in an appeal process. While no such language exists in the current draft document, DHCS staff said at the July 30, 2014 stakeholder meeting that counties will essentially make the recommendation but DHCS Provider Enrollment Division will make the final determination. Moreover, DHCS staff said that counties will not be allowed to add any additional requirements to the state certification criteria and that DHCS would be willing to consider an appeal process for providers denied certification. Further, before the merger of ADP and DHCS, COMP had been assured that the uniformity of program rules and rate setting would remain with the State. This appears to undermine this key state function to ensure that there is not wide divergence of these core program elements depending on local county rules.

**Section 5 DMC-ODS Center State Oversight, Monitoring and Reporting and Section 6.a DMC-ODS County Oversight, Monitoring and Reporting**

Sections 5 and 6 of the draft document would require certain reporting activity for the state and counties in order “to ensure provider compliance and corrective action with provider standards, access, and the delivery of quality care and services.” Timeliness of access to treatment is substantively different than access to first appointments, the only access issue addressed in the current draft.

COMP is also very concerned about what is not included in the draft Terms and Conditions. Most notably, there is no detail about the financial and reimbursement provisions. These details are critical to the delivery of and access to treatment services. As such, there can be no thoughtful, complete evaluation of a waiver without such details. In the absence of financial and reimbursement details, we will repeat our comments articulated more fully in the paper we submitted subsequent to the final Waiver Advisory Group meeting on April 30: *Comments on Proposed Reimbursement Models*. Specifically, while the county mental health association presented details of its cost-reimbursement system, COMP asserts that most reimbursement models are moving away from cost-reimbursement for three primary reasons: 1) it incentivizes inefficiency; 2) it fails to reward programs for positive patient outcomes and 3) it creates additional workload for providers, counties and state staff who must closely track costs and review cost reports. Instead, fee-for-service rewards efficiency, pays for services that correlate with positive outcomes and reduces burdensome paperwork which detracts from service delivery and costs the state money. Until we have details regarding DHCS plans for reimbursement, we’ll limit our comments in this area. For a more detailed discussion of these issues, please see our paper, *Comments on Proposed Reimbursement Models*.

COMP is very concerned about counties that do not opt-in to the waiver. DHCS representatives said at the stakeholder meeting on July 30, 2014 that DHCS would be required to contract directly with providers, but there is no such assurance in the draft.

COMP is also very concerned about the absence of any discussion in the draft Terms and Conditions that addresses patient confidentiality. Confidentiality of the identity, diagnosis and treatment of substance use disorder patients is exceptionally rigid and strict under federal law. Confidentiality covers referral for treatment. The draft document fails to address confidentiality issues and appears in several parts to conflict with confidentiality restrictions of federal law.

In summary, while COMP applauds the State’s effort to improve the SUD system in California, waiving federal access protections will result in the unintended consequence of reducing access and violating patient confidentiality. Therefore, we reiterate our support for making many of the program improvements through a state plan amendment (SPA) and/or state regulation so as to not negatively impact access to these important services. Using a SPA or regulations provides the additional benefit of more easily modifying the program if elements are not working, are too difficult to implement or are producing unintended consequences to patients, counties and the state.

Thank you for your attention to this matter. We look forward to continuing to discuss program improvements and request that this response be included in any written documents summarizing the stakeholder process.