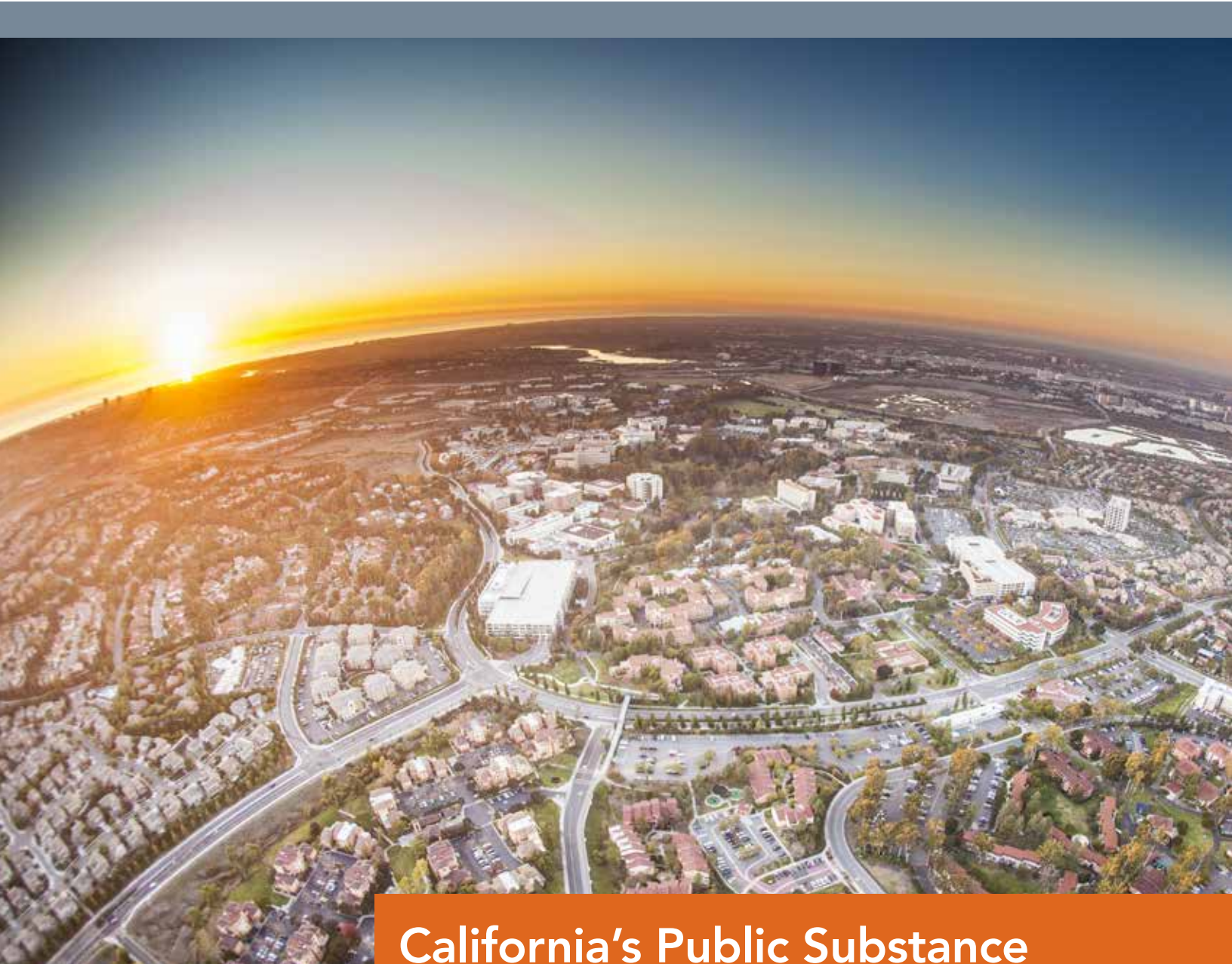




California Health Care Foundation



California's Public Substance Use Disorder Treatment System for Youth: An Overview

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About the Authors

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Luis plays soccer for his high school team. Following an injury on the field, he is prescribed pain medication that he continues to use recreationally after the injury is healed. He also buys pain pills from friends. Once outgoing and social, Luis becomes increasingly withdrawn over several months. After a scare in the emergency room, he discloses to his doctor that he has been using other drugs in addition to pain pills, including alcohol and marijuana. Luis is willing to participate in treatment to address his substance use. Unfortunately, the closest adolescent treatment program is in another city, and his doctor is unsure of how to make a referral.

Introduction

Despite improvements in the broader health care system over the past several years made possible by the Affordable Care Act (ACA), substance use disorders (SUDs) continue to have a negative impact on health care costs and patient health outcomes. According to one report reviewing a variety of data, deaths from drug overdoses increased across all genders and ethnicities and among adults of nearly all ages in the United States between 1999 and 2015.¹ In 2015, over 27 million Americans age 12 and older were classified as current illicit drug users, with approximately 2.2 million of these individuals being adolescents age 12 to 17 (nearly 9% of adolescents in the US).² However, finding age-appropriate public SUD treatment options for youth can be a challenge. This report provides background on youth with SUDs, discusses public programs and funding streams specific to California, and highlights practice opportunities for improving care.

The negative outcomes associated with SUDs, as well as their prevalence, have garnered national attention in recent years, sparking interest among policymakers in identifying and testing new strategies to address them. Federal authorities increasingly offer states the flexibility to implement system-wide reforms that improve care, enhance treatment options, and offer recovery support for people with SUDs.³ In February 2017, San Mateo and Riverside Counties became the first two systems in the country to implement a comprehensive continuum of care for Medicaid beneficiaries with SUDs. This program is part of California's Medicaid 1115 waiver option that supports states in promoting systemic and practice reforms to effectively treat the physical, behavioral, and mental dimensions of SUDs.⁴ Several other states and two-thirds of California counties have submitted proposals to implement similar programs. Additionally, the 21st Century Cures Act, signed in December 2016, includes \$1 billion for opioid prevention and treatment programs.⁵

While these recent initiatives represent increasing commitment by state, federal, and local government to addressing SUDs, few, if any, have focused specifically on the unique needs of youth. Brain development during adolescence means that younger people are particularly vulnerable to SUDs, as early drug use increases a person's chance of developing addiction and can impact brain functions such as memory, motivation, learning, judgment, and behavior control.⁶ The earlier substance use begins, the more likely it is to continue into adulthood.^{7,8} In fact, 90% of Americans who meet the clinical criteria for an SUD began smoking, drinking, or using other drugs before the age of 18.⁹ Given these data, broader strategies for addressing SUDs must include age-appropriate services for youth.

Inconsistencies in Defining Youth

The definitions of "child," "youth," and "adolescent" differ between health care programs and authorities. For example, the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition does not have a minimum age limit for SUD diagnoses. However, the prevalence estimates for youth generally include age 12 to 17. The American Society of Addiction Medicine Criteria defines adolescence in its glossary as age 13 to 18. The American Academy of Pediatrics defines adolescence as age 11 to 21. The Early and Periodic Screening, Diagnosis, and Treatment Medicaid benefit covers individuals under age 21. For the purposes of this report, we will be using the term "youth" generally to mean children and adolescents under age 21.

Background on Youth and Substance Use Disorders

An SUD diagnosis is based on a pathological pattern of behaviors related to use of the substance.¹⁰ A diagnosis considers evidence of social impairment, risk of negative health or social outcomes, impaired behavioral control, and pharmacological criteria, such as tolerance signaled by requiring a markedly increased dose of the substance to achieve the desired effect.¹¹ The federal Substance Abuse and Mental Health Services Administration (SAMHSA) currently uses the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)* to define SUDs as either mild, moderate, or severe, depending on the number of diagnostic criteria met by the person being assessed. According to the DSM-V, the essential feature of an SUD is a “cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.”¹² An SUD diagnosis can be applied to all 10 classes of drugs identified by the DSM-V (see sidebar), other than caffeine. SUDs have the potential to alter brain circuitry post-detoxification, particularly among people with severe disorders.¹³ The recurrent use of problem substances can lead to clinically and functionally significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.¹⁴

Defining Substance Use Disorders

The DSM-V describes substance-related disorders as encompassing 10 separate classes of drugs:

- | | |
|------------------|----------------------|
| 1. Alcohol | 6. Opioids |
| 2. Caffeine | 7. Sedatives |
| 3. Cannabis | 8. Stimulants |
| 4. Hallucinogens | 9. Tobacco |
| 5. Inhalants | 10. Other or Unknown |

The 2015 National Survey on Drug Use and Health conducted by SAMHSA found that past-year use among youth age 12 to 17 in California was roughly 14% for marijuana, nearly 1% for cocaine, and less than 1% for heroin.^{15,16} Past-month use of alcohol among youth age 12 to 20 in California was roughly 21%.¹⁷ According to a 2012 statewide report by the California Department of Health Care Services (DHCS), roughly 8% of California youth age 12 to 17 have a substance use disorder, which is similar to the statewide prevalence estimate for adults with SUD.¹⁸

Table 1. DSM-V Prevalence Estimates, by SUD Age 12 to 17¹⁹

	NATIONAL 12-MONTH PREVALENCE RATE
Alcohol-Related Disorders	4.6%
Cannabis-Related Disorders	3.4%
Hallucinogen-Related Disorders	3% phencyclidine <1% hallucinogen use disorder (other than phencyclidine)
Inhalant-Related Disorders	<1%
Opioid-Related Disorders	1%
Sedative-, Hypnotic-, or Anxiolytic-Related Disorders	<1%

Youth with SUDs often have co-occurring mental health disorders.²⁰ One study found that among youth under age 15 with SUDs, 90% had at least one mental health condition during the past year, while 88% of youth age 15 to 17 with SUDs had a co-occurring mental health condition.²¹

Medi-Cal Coverage of Substance Use Disorder Treatment

In California, youth and their family members who seek treatment must navigate a complicated public health care system where physical health, mental health, and SUD services are administered by different entities and often in an uncoordinated fashion. California's Medicaid program, Medi-Cal, serves nearly 50% of California's children and youth age zero through 20, and provides SUD treatment for beneficiaries who meet the criteria for necessary services.²² Covered SUD services for youth through Medi-Cal include screening and brief intervention in a primary care setting, outpatient counseling, detoxification supports, residential treatment, prescription medication, and other benefits for specified circumstances which are discussed below. SUD treatment services are generally provided to stabilize and rehabilitate Medi-Cal beneficiaries, including youth, who have been recommended by a qualified provider to receive treatment for a diagnosed SUD. The following programs are responsible for assessing and treating SUDs among Medi-Cal beneficiaries under age 21.

Federal Medicaid Coverage Requirements for Youth

In 1967, Congress introduced the Medicaid benefit for children and youth, known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The goal of this benefit is to ensure that children and youth under age 21 who are enrolled in Medicaid receive all medically necessary and age-appropriate health care services, including dental, vision, and any other necessary services for treatment of physical, mental, or other health conditions, including SUDs. According to the Centers for Medicare & Medicaid Services (CMS), this broad scope supports a comprehensive, high-quality health benefit.²³

States share responsibility for implementing the EPSDT benefit with CMS. EPSDT requires states to provide comprehensive services to people under age 21, including appropriate and medically necessary services to "correct and ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services" regardless of whether these services are required under the Medicaid State Plan.²⁴ It is the responsibility of states

to determine medical necessity on a case-by-case basis. States must provide a description of how the additional benefits will be provided, how access to them will be coordinated, and how beneficiaries and providers will be informed of these processes to ensure that eligible individuals have access to the full EPSDT benefit.²⁵ In turn, CMS matches eligible state expenditures for serving beneficiaries under the age of 21 with federal funds.

EPSDT Benefit Responsibility

Under California's Medicaid State Plan, children and youth are entitled to specific services that must be provided and covered without prior authorization.²⁶ This includes a range of SUD screening and treatment services. When services that are not included in the Medicaid State Plan are needed by individuals under age 21, they may in certain circumstances be made available subject to prior authorization (discussed in more detail below).²⁷ In California, Medi-Cal managed care plans (MCPs) are responsible for covering most services required under the EPSDT benefit.²⁸ Other entities, including counties, must provide or arrange and pay for the remaining services. California counties have the primary responsibility for SUD treatment for all Medi-Cal beneficiaries, including youth, while MCPs and the state Department of Health Care Services (DHCS) have responsibility for a few additional components of SUD prevention and treatment (see Table 2 on page 6).

Screening Requirements

MCPs have the primary responsibility for covering preventative services for youth under age 21 as specified by the most recent American Academy of Pediatrics (AAP) periodicity schedule.²⁹ This includes assessment for substance use in youth age 11 to 20.³⁰ The assessment tool recommended by the AAP is the CRAFFT screening tool.³¹ CRAFFT (which stands for the first letters of key words in the six screening questions – Car, Relax, Alone, Forget, Friends, Trouble) is a behavioral health screening tool for use with youth under age 21 and is recommended by the AAP Committee on Substance Abuse.³²

For youth age 18 and over, MCPs are responsible for covering Screening, Brief Intervention, and Referral to Treatment (SBIRT), an evidence-based practice used to identify, reduce, and prevent problematic use and dependence on alcohol and illicit drugs.^{33,34} In California, since

Table 2. EPSDT Services, by Responsible Entity

EPSDT SERVICE	
Medi-Cal Managed Care Plans³⁵	<ul style="list-style-type: none"> ▶ Cover and ensure the provision of screening, preventive, and medically necessary diagnostic and treatment services ▶ Ensure comprehensive case management, including maintaining procedures for monitoring care coordination for all medically necessary services delivered both inside and outside the MCP provider network ▶ Provide all medically necessary services, including those that exceed the amount provided by local education agencies, regional centers, or local government health programs ▶ Provide medically necessary behavioral health therapy for children with autism spectrum disorder ▶ Establish procedures for people to obtain necessary transportation services, both medical and nonmedical ▶ Provide scheduling assistance and necessary transportation to and from appointments for medically necessary services ▶ Provide speech therapy, occupational therapy, and physical therapy without service limitations ▶ Ensure that beneficiaries and their caretakers know what services are available and have access to necessary health care resources and health education ▶ Cover medically necessary services provided by local education agency programs when school is not in session
County Drug Medi-Cal Treatment Programs	▶ SUD treatment services (see Table 3)
County Mental Health Plans	▶ Specialty mental health services
Denti-Cal or Medi-Cal Fee-for-Service Providers	▶ Dental services
California Children’s Services (CCS)	▶ Diagnostic and treatment services for conditions not included in MCP capitated rate (CCS is a state program for children under 21 with eligible diseases and health problems)
Regional Centers	▶ Nonmedical supports and services provided to those with developmental disabilities

2014, SBIRT for alcohol has been covered as a screening and early intervention benefit in primary care for all Medi-Cal beneficiaries age 18 and over.

Depending on the results of the screening, youth may be referred to the county for SUD treatment.

Standard Drug Medi-Cal Treatment and Fee-for-Service Programs

Under California’s Medicaid State Plan, Medi-Cal SUD treatment services are provided to stabilize and rehabilitate beneficiaries who have been referred by qualified physicians or other licensed practitioners of the healing arts to receive treatment for a substance-related

disorder.³⁶ Most of these services are provided through the state’s Drug Medi-Cal (DMC) treatment program. This statewide program is administered by counties in line with a state-county contract for the provision of SUD services within the county service area.³⁷ Counties, in turn, subcontract with certified providers to deliver services. If a county decides not to enter into a DMC treatment program contract with the state, DHCS must directly contract for DMC treatment services in the county, as necessary, to ensure beneficiary access.³⁸ The DMC treatment program provides Medi-Cal beneficiaries, including youth, with medically necessary rehabilitative services that are provided through an individualized client plan prescribed by a licensed physician. Plans are approved and authorized according to state requirements (with the exception

of crisis services, which don't require a client plan).³⁹ Services covered under the State Plan include outpatient counseling, narcotic treatment programs, and residential treatment for pregnant and postpartum individuals.

The state is responsible for ensuring that SUD treatment services are available to youth who are eligible under the provisions of the federal EPSDT benefit.⁴⁰ This means that in addition to the State Plan-covered services, beneficiaries under age 21 are also, subject to prior authorization, entitled to any other health care services necessary to correct or ameliorate illnesses and conditions discovered through screening. This includes any medically necessary services covered under the federal "medical assistance" definition (i.e., "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level").⁴¹ This includes services to treat SUDs. For instance, non-perinatal residential treatment is not covered under the State Plan, but it may be covered based on EPSDT medical necessity for youth under age 21.

In cases where additional services outside of the State Medicaid Plan are necessary, coverage is subject to prior authorization.⁴² Providers must receive authorization from the state or county to provide and be paid for these services. DHCS released guidance in December 2016 that provides counties with additional information about claiming SUD treatment services for beneficiaries under age 21.⁴³ In particular, the notice includes detail on the authorization, documentation, and coding requirements associated with services not covered by the Medicaid State Plan but available to beneficiaries under age 21 through EPSDT.

In addition to the DMC treatment services offered by counties and county-subcontracted providers, DHCS is responsible for additional State Plan-covered SUD treatment services through the state's network of fee-for-service providers. This includes coverage of outpatient heroin or other opioid detoxification services administered or prescribed by a physician. These services are covered for beneficiaries under age 21 when medically necessary.⁴⁴ DHCS is also responsible for coverage of voluntary inpatient detoxification services when delivered in a general acute care hospital, as well as certain prescription medications for the treatment of SUDs

covered by the state's fee-for-service outpatient pharmacy program.^{45,46}

Drug Medi-Cal Organized Delivery System Pilot Program

In August 2015, CMS approved California's Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot program under the provisions of the Section 1115 Medi-Cal 2020 waiver to test the organized delivery of SUD services in the Medi-Cal program. The requirements for participation in the optional county pilot, which will continue through December 31, 2020, are outlined in detail in the waiver's special terms and conditions.⁴⁷ The pilot includes an expansion of services to offer a more complete continuum of care to beneficiaries, without age restriction, and grants counties more control over service delivery, including selective provider contracting and the establishment of "other than State Plan" interim rates. The continuum of care is largely modeled after the levels of care defined in the American Society of Addiction Medicine (ASAM) Criteria, a nationally recognized, comprehensive set of guidelines for the placement, continued stay, and transfer or discharge of patients with SUD and co-occurring conditions.⁴⁸ Services under the pilot are covered for all beneficiaries residing in the pilot county who meet the medical necessity criteria for services. Prior authorization is not required for any covered services other than residential treatment.

The pilot's potential impact on youth services includes the implementation of new assessment criteria, a broader provider network, and improved quality oversight by counties. Compared to the "standard" Drug Medi-Cal program, more services are covered without prior authorization, including recovery services, withdrawal management, and case management.

A key aspect of the pilot program is the requirement that counties adopt the ASAM Criteria definition of medical necessity. The Criteria provide a matrix for matching severity and level of function with type and intensity of service needs. They are intended to help the field move from a program-driven system to an assessment-driven methodology in the treatment and placement of beneficiaries.⁴⁹ For youth under 21, this includes being assessed for their risk of developing an SUD as part of the medical necessity determination.⁵⁰ However, pursuant to the DMC-ODS special terms and conditions, nothing in the DMC-ODS pilot overrides any EPSDT mandates.⁵¹ This

means that beneficiaries under age 21 are still eligible to receive any services covered by the federal “medical assistance” definition that are determined as being necessary to treat an SUD, regardless of whether or not these services are covered under a DMC-ODS pilot.

To participate in the pilot, counties must submit an implementation plan to the state and CMS. Upon approval of the plan and of interim rates, counties enter an intergovernmental agreement with the state outlining the terms for participation in the pilot. In line with the terms of the waiver, pilot counties operate as prepaid inpatient health plans (a federally defined model of managed health care), and are subject to federal managed care requirements, including important beneficiary protections related to access, network adequacy, and quality oversight. As of September 2017, seven counties had implemented services under the pilot and 32 others had submitted plans to participate in the pilot, representing approximately 95% of Medi-Cal beneficiaries.^{52,53}

Dimensions Within the ASAM Matrix for Matching Adolescent Severity and Level of Function with Type and Intensity of Service

- Dimension 1.** Acute Intoxication and/or Withdrawal Potential
- Dimension 2.** Biomedical Conditions and Complications
- Dimension 3.** Emotional, Behavioral, or Cognitive Conditions and Complications
- Dimension 4.** Readiness to Change
- Dimension 5.** Relapse, Continued Use, or Continued Problem Potential
- Dimension 6.** Recovery Environment

Source: *The ASAM Criteria: Treatment for Addictive, Substance-Related, and Co-Occurring Conditions*, 3rd ed., David Mee-Lee (Chevy Chase, MD: American Society of Addiction Medicine, 2013).

Table 3. Substance Use Disorder Services Covered in California’s Medicaid State Plan, by Responsible Payer⁵⁴

SERVICES	
Counties, non-DMC-ODS (through the DMC treatment program, available in all counties)	<ul style="list-style-type: none"> ▶ Outpatient drug-free ▶ Outpatient treatment with Naltrexone ▶ Intensive outpatient treatment ▶ Narcotic treatment program (methadone) ▶ Perinatal residential (≥16 beds for age 21 to 64)
Counties, DMC-ODS (only available to beneficiaries in pilot counties)	<ul style="list-style-type: none"> ▶ All services listed above, plus: ▶ Narcotic treatment program (methadone + additional medications) ▶ Residential treatment services (perinatal + non-perinatal + no bed limit) ▶ Withdrawal management (at least one level) ▶ Recovery services ▶ Case management ▶ Physician consultation ▶ Partial hospitalization (optional) ▶ Additional medication-assisted treatment (optional)
DHCS Fee-for-Service	<ul style="list-style-type: none"> ▶ Outpatient heroin and other opioid detoxification services (physician services) ▶ Voluntary inpatient detoxification (in a general acute care hospital) ▶ Pharmacy
Managed Care Plans	<ul style="list-style-type: none"> ▶ CRAFFT (age 11 to 17) ▶ SBIRT (age 18 and older)

Consent and the State-Only Medi-Cal Minor Consent Program

Under California law, minors may independently consent to certain health care services, including medical care and counseling related to the treatment of an SUD, without the consent of their parent or guardian.⁵⁵ To give consent for SUD treatment services, a minor must be age 12 or older.⁵⁶ State law additionally allows minors to consent to certain other health care services, including those related to sexual assault, pregnancy, family planning, sexually transmitted diseases, and mental health.⁵⁷

Eligible minors who wish to receive confidential care for these services may do so via the Medi-Cal Minor Consent Program.⁵⁸ The program is for youth under 21 years old, unmarried, and claimed as dependents by their parents, including minors who are part of a family not currently eligible for Medi-Cal.^{59,60} The program is considered a “state-only” program (i.e., not covered under California’s State Medicaid Plan), and services rendered through it are not eligible for federal matching funds. Because this program is not a part of the federal Medicaid program, the EPSDT benefit does not apply.

Minors can apply for the Medi-Cal Minor Consent Program on their own behalf — the application does not require parental involvement. The program does not offer ongoing health care coverage; rather, eligibility continues through each successive month during which the patient meets the specified covered condition and has submitted the appropriate paperwork to the county department.⁶¹ This means that a minor may use these services once or on a regular basis. Confidential information received from individuals seeking Medi-Cal Minor Consent services may not be disclosed to their parents without written consent from the applicant.⁶² This confidentiality protection also applies to any treatment records created in the context of Medi-Cal Minor Consent services.⁶³

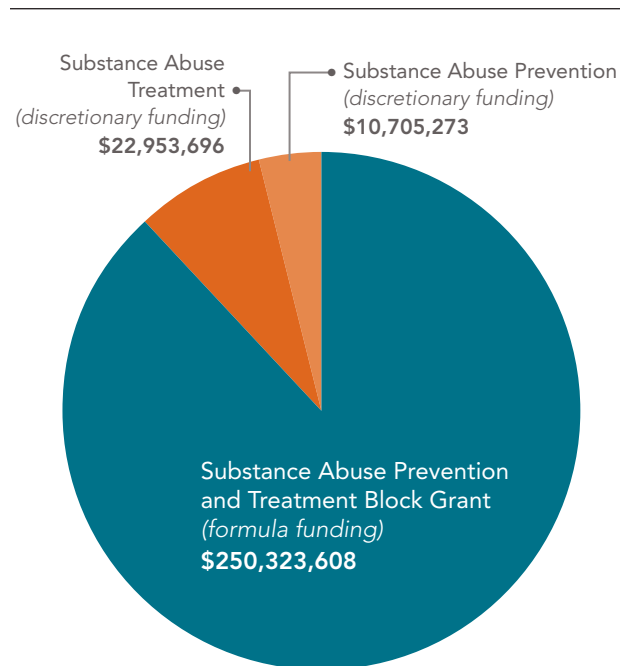
Medi-Cal Minor Consent recipients do not have full-scope benefits and are subject to service restrictions. Authorized services for Minor Consent are limited to specific diagnosis codes appropriate to the Minor Consent aid code.⁶⁴ Youth who want regular full-scope Medi-Cal are still required to have their parents apply on their behalf.

Further, under state law, a minor’s parent or guardian is not liable for payment for Medi-Cal Minor Consent services unless they participate in the counseling program, at which time they become liable for the cost of the services provided to the minor and to the parent or guardian.⁶⁵

Financing of Public Substance Use Disorder Services in California

California’s public SUD treatment system is financed primarily by three funding sources: (1) a federal substance abuse prevention and treatment block grant, (2) realigned tax revenues (county 2011 realignment), and (3) federal financial participation in the reimbursement of eligible Medi-Cal expenditures. Other funding sources include state general funds, federal discretionary funding for substance abuse prevention and treatment programs, and local funds, which vary by county. This section discusses California’s structure for the financing of public SUD services, applicable to beneficiaries of all ages.

Figure 1. Breakdown of Substance Abuse Funding from SAMHSA, California, FY 2015-16



Note: Fiscal (FY) refers to July 1 to June 30.

Source: SAMHSA State Summaries FY 2015-16, California.

Substance Abuse Prevention and Treatment Block Grant (SAMHSA)

Substance Abuse Prevention and Treatment (SAPT) block grants fund local prevention and treatment programs, including programs for youth. Block grant funds are subject to annual federal budget appropriation and oversight by SAMHSA, and must be used to fund activities that are not reimbursable under the Medicaid program. California and its counties are required to maintain and to report on annual maintenance of effort to support continued federal block grant funding.⁶⁶ SAMHSA establishes block grant performance criteria that must be met by states in order for them to continue to receive block grant funds. California received \$250,323,608 in SAPT block grant funding for fiscal year 2015-16.⁶⁷

SAMHSA also provides discretionary funding to states in the form of specialized, limited-term grants.⁶⁸ This funding is in addition to the SAPT block grant. The majority of this funding goes to public agencies and Native American tribes for targeted projects that focus on prevention and treatment.

Drug Medi-Cal Treatment Program

Prior to 2011, the DMC treatment program was administered by the state Department of Alcohol and Drug Programs and was funded with state general funds and matching federal funds at the relevant federal medical assistance percentage. California's Public Safety Realignment of 2011 redirected funding for DMC and other discretionary SUD programs from the state to the counties. Consequently, counties, under contract, must ensure access to covered services and be responsible for covering the nonfederal share of costs incurred in providing DMC services to beneficiaries. Passed in 2012, Proposition 30 guaranteed continued funding of these realignment services, including DMC and other specified SUD services, such as drug courts. Proposition 30 established state funding requirements for counties' new and expanded Medi-Cal treatment obligations in exchange for waiving their state mandate protections.⁶⁹

Reimbursement methodology and claiming provisions. California's Medicaid State Plan specifies the financial provisions for the DMC treatment program.⁷⁰ These include establishing the reimbursement methodology, defining allowable services and units of service, and outlining the cost determination protocol. There is a

statewide maximum allowance for each type of service, excepting narcotic treatment programs, with a maximum reimbursement for each unit of service. Reimbursement is provided on a fee-for-service basis subject to federal and state requirements.⁷¹ Rates for the covered services are determined by the state on an annual basis in line with the criteria outlined in the Medicaid State Plan. Claims for covered services are certified and submitted by the counties for processing through the Health Insurance Portability and Accountability Act (HIPAA)-compliant Short-Doyle claims processing system.

Certified public expenditure requirements. Counties are responsible for incurring and certifying the DMC expenditures required under certified public expenditure (CPE) requirements. A CPE is a statutorily recognized Medicaid financing approach through which a governmental entity, including a governmental provider (e.g., county hospital, local education agency), incurs an expenditure eligible for federal financial participation under the state's approved Medicaid State Plan.⁷² The governmental entity certifies that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or program administration. Counties incur and certify the full expenditure for delivering DMC services to beneficiaries using the dedicated sales tax revenues deposited monthly into their local realignment accounts by the State Controller's Office (SCO). Based on this certification, the state then claims federal financial participation.

Behavioral Health Subaccount. California passed legislation in 2012 (Senate Bill 1020) to revise the provisions that establish the Local Revenue Fund of 2011 by abolishing certain accounts in the fund and creating new accounts, subaccounts, and special accounts in the Fund. This included the establishment of the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund of 2011. The SCO is required to distribute funds in the Behavioral Health Subaccount to counties on a monthly or quarterly basis pursuant to a schedule provided by the Department of Finance. Funds distributed from the subaccount can only be used for specified programs, including SUD programs. However, since the DMC program is a federal entitlement, counties are required to provide Medi-Cal beneficiaries access to all appropriate DMC services without caps.⁷³ The allocation schedule is developed by calculating a target allocation for each county based on complete claims data from a prior year for all realigned specialty mental

health and DMC programs, as well as historical payments for non-Medi-Cal SUD programs.

The second step in the allocation process involves allocating among counties the difference between the amounts of money estimated to be available in the subaccount and the amount needed to meet the target allocation calculated based on the historical information. This is achieved by using the proportion of a county's Medi-Cal enrollment as the distribution methodology. The total subaccount target calculation for SUD programs in fiscal year 2016-17 is \$120,634,487.⁷⁴ Based on the most recent state guidance, beginning with the 2017-18 allocation, the base allocations will consist of the 2016-17 base allocation (calculated in the manner described above) plus the subsequent growth allocations.⁷⁵ This will serve as the "rolling base" mechanism for each county's allocations. If a county terminates or decides not to participate in a DMC treatment program contract, DHCS and the Department of Finance determine how much state funding is necessary to ensure access to these services in a county. They then notify the controller.

Cost reporting. CPE-based financing must recognize actual costs incurred. CMS requires cost reimbursement methodologies for providers using CPEs to document the actual cost of providing the services. Actual cost is typically determined through a statistically valid time study, periodic cost reporting, and reconciliation of any interim payments.⁷⁶ All payments made to DMC-certified providers are subject to cost report reconciliation and settlement on an annual basis.

State general funds. Per the provisions of the 2011 realignment and Proposition 30, counties are only required to provide new benefits added to the DMC program by the state after 2011 if the state provides additional funding. This is relevant to intensive outpatient treatment, which was added to the Medicaid State Plan in 2014 as part of the state's implementation of the ACA. Subject to annual appropriation in the state budget, counties are reimbursed for both the state and federal share for intensive outpatient services.

Drug Medi-Cal Organized Delivery System Pilot Program

The waiver's special terms and conditions specify the requirements for federal reimbursement for DMC-ODS treatment services. Reimbursement is provided to counties on an allowable cost basis, subject to the CPE provisions outlined in the waiver.⁷⁷ Counties are reimbursed throughout the fiscal year based on interim rates, which are subject to state approval. A key financial distinction between the DMC-ODS pilot program and the standard DMC treatment program is that counties are reimbursed at non-Medicaid State Plan rates under the provisions of the waiver. Thus, they are authorized to set interim rates that are cost-based rather than based on the methodology outlined in the Medicaid State Plan.

The current practice for claiming DMC units of service through the Short-Doyle claims processing system will be continued for claiming DMC-ODS units. There will, however, be various additional codes and modifiers to distinguish between new services. The interim federal payments to the counties generated by the claims are subject to annual reconciliation and cost settlement. Subject to appropriation in the annual budget, additional state general funds are available to cover claims for certain expanded services. The state budget for 2017-18 includes a \$124.4 million state general fund for the pilot program.⁷⁸

Promising Practices

Adult SUD treatment models used to treat youth with SUDs often fall short. Recognizing this gap, a variety of organizations have reviewed and recommended promising practices for treating youth with SUDs since the passage of the ACA. The National Association of State Alcohol and Drug Abuse Directors compiled information about existing state guidance for treatment and recovery services targeting youth with SUDs, developed nine core principles of care, and recommended service elements and administrative considerations for states based on their findings.⁷⁹ The National Institute on Drug Abuse developed 13 research-based principles for treating youth with SUDs.⁸⁰ In January 2015, CMS and SAMHSA jointly released an informational bulletin based on findings from a technical expert panel consensus process conducted by SAMHSA to assist states with meeting the

needs of young Medicaid beneficiaries with SUDs and their families.⁸¹

In November 2016, the US Department of Health and Human Services released *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, which provides research, resources, and recommendations for addressing substance use and its consequences. The report contains several recommendations specific to youth, including risk factors and settings that can increase the likelihood of addiction, protective factors that can decrease the likelihood of substance use, and a list of evidence-based screening tools and prevention resources.⁸²

In reviewing these recommendations, the authors of this report identified the following five key themes and best practices for treating SUDs among youth:

- 1. Provide patient-centered care.** Treatment and care should be appropriate to a person's age, stage of development, culture, and gender. The patient should be engaged and involved in their treatment decisions to the extent possible. Family support can help to encourage successful treatment.
- 2. Screen for and address co-occurring disorders.** Treatment should integrate other needs beyond drug use, including medical, social, and psychological factors. Providers should use an integrated care treatment approach that addresses co-occurring SUD and mental health disorders as well as primary care needs. This may include trauma-informed interventions. Providers should identify whether other factors are impacting the individual, such as violence or child abuse, and address these through appropriate legal channels and referrals.
- 3. Use evidence-based practices and programs.** Motivational enhancement therapy (with or without cognitive behavioral therapy) and family-based treatments have demonstrated effectiveness for youth with SUDs. Residential treatment can also support youth in moving to an outpatient setting; it has been found effective for youth with SUDs needing withdrawal management (detox) and for high-intensity services.

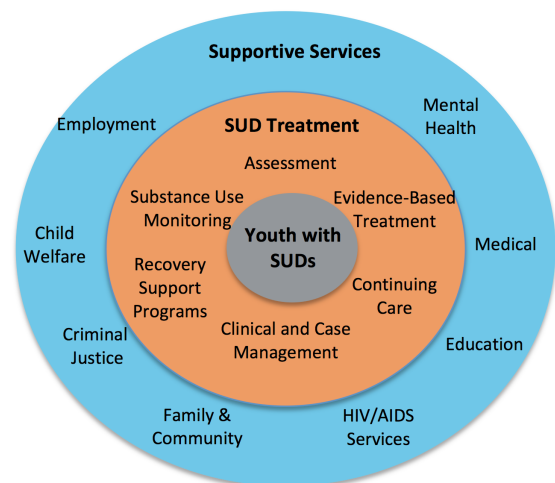
4. Involve families and other community networks.

Support from family members and community resources (e.g., school counselors, parents, peers) during treatment can support youth in recovery. As illustrated in Figure 2, effective SUD treatment for youth often goes beyond the clinical setting, with wraparound and supportive services playing a key role in recovery.

5. Continue to screen for and provide support during recovery.

Recovery support services can improve and help maintain treatment outcomes among youth with SUDs. Continuing care should be made available in a variety of settings within two weeks of leaving treatment.

Figure 2. Comprehensive Treatment Components for Youth with SUDs



Source: Adapted from www.drugabuse.gov.

This guidance is echoed in the ASAM Criteria's recommendations for adolescent clients, which county DMC-ODS pilots are required to follow as they provide assessment and services for youth.⁸³ According to the criteria, program services at every level of care should be designed to meet developmental and other special needs, with the ideal treatment environment for adolescents being physically separate from that of adult patients.⁸⁴ Specifically, the Criteria stress that treatment should address the nuances of the adolescent experience, including cognitive, emotional, physical, psychosocial, social, and moral development, in addition to involvement with alcohol or other drugs.

Evidence-Based Practices for Youth with SUDs

The US Department of Health and Human Services and SAMHSA have partnered to create a treatment locator service to assist families in identifying treatment resources for SUDs. Its toll-free number and website identify alcohol, drug, and mental health treatment facilities and programs, and provide specific information about treatment centers, including whether they serve youth.⁸⁵ SAMHSA also offers free tools and resources to help people find contact information for physicians authorized to treat opioid dependency with buprenorphine, and programs targeting addiction and dependence on opioids, such as heroin or prescription pain relievers.⁸⁶ However, these opioid treatment tools are not geared toward treatment of youth specifically, nor do they necessarily identify programs or physicians who work with Medi-Cal.

SAMHSA also offers a searchable National Registry on Evidence-Based Programs and Practices (NREPP), which includes evidence ratings based on outcomes, program descriptions, and age-range appropriateness, and includes links to program materials and resources.⁸⁷ Programs in this database are currently undergoing a review process that began in 2015. Under the new guidelines, NREPP splits programs into three levels: “Effective” (the evidence base produced strong evidence of a favorable effect), “Promising” (the evidence base produced sufficient evidence of a favorable effect), and “Ineffective” (the evidence base produced insufficient proof of favorable effect). The evidence for these is based on ratings of individual outcomes. An example of a youth-targeted, evidence-based program listed through NREPP, Parenting with Love and Limits, is summarized in the feature box. At the time of this paper’s publication, NREPP listed over 400 interventions for populations of all ages. For SUD prevention, NREPP rates 23 programs targeting youth age 6 to 12 as “Effective” or “Promising,” and 23 programs targeting youth age 13 to 17 as “Effective” or “Promising.” NREPP currently has one program rated as “Promising” for SUD treatment targeting youth age 6 to 12, and 17 programs rated as “Effective” or “Promising” for SUD treatment targeting youth age 13 to 17.

NREPP is also included in the Results First Clearinghouse organized by the Pew Charitable Trust, which compiles ratings for various evidence-based programs in one searchable database.⁸⁸ The Results First Clearinghouse currently lists over 200 interventions with a rating of

“Highest” (evaluation used the strongest research designs, including randomized control trials or high-quality quasi-experimental design) or “Second Highest” (evaluation used a quasi-experimental design and showed evidence that the intervention had a positive impact) for SUD prevention and treatment programs targeting youth.

EXAMPLE PROGRAM

SAMHSA National Registry on Evidence-Based Programs and Practices

Program name. Parenting with Love and Limits

Age range. 10 to 18

Evidence rating. Rated “Promising” in the following areas:

1. Receipt of Mental Health and/or Substance Use Treatment
2. Criminal and Delinquent Behavior

Brief program description. Targets families with youths at risk for out-of-home placement and families with youths returning from an out-of-home placement. The treatment is aimed at families with youth age 10 to 18 who have emotional and behavioral problems. The program combines parenting groups, family therapy, and trauma work into a continuum of care to engage parents.

Medication-Assisted Treatment for Youth with SUD

According to a SAMHSA report, there is evidence that medication-assisted treatment (MAT) may be effective in treating youth with SUD if it is delivered together with psychosocial treatments and case management.⁸⁹ Specific medications that may be effective in youth SUD treatment are:

- ▶ **Methadone treatment** for youth with opioid use disorder and in specially licensed programs permitted by SAMSHA with parental consent
- ▶ **Buprenorphine treatment** for opioid dependent youth age 16 and older

The American Academy of Pediatrics (AAP) Committee on Substance Use and Prevention recommends that pediatricians consider offering or discussing referrals for MAT with their adolescent and young adult patients with severe opioid use disorders.⁹⁰

Drug Medi-Cal Organized Delivery System — Examples from Early Implementers

As part of their DMC-ODS pilots, several California counties are planning to implement prevention and early intervention programs for youth that promote inter-agency collaboration, particularly with the criminal justice system, primary care, child welfare, and schools. This collaboration is critical in identifying substance use early, particularly in youth, and in linking individuals and their families to appropriate treatment resources.

In Riverside County, for example, select school sites will offer screening and referral services to high-risk youth. These students will be screened by prevention specialists in a neutral setting, and the results will determine if a referral to additional support is needed. The county also plans to build on the success of its Friday Night Live program to provide additional opportunities for healthy youth development and skill growth.⁹¹ This statewide program is designed for high school-aged youth and motivated by youth-adult partnerships to improve the local community through service, social action activities, and the promotion of healthy policies that appeal to youth.⁹²

San Mateo County has five full-time SUD case managers who are embedded in primary care teams to directly assist and coordinate SUD services for beneficiaries. One case manager is dedicated to engaging youth who are admitted to psychiatric emergency services with substance use treatment needs.⁹³ Also, the county has identified new providers through a request for proposal process to help close existing gaps in youth treatment. A new outpatient treatment facility provides both youth and adult services, and the county is currently considering an appropriate site with a provider partner for a new youth treatment facility. The county has also identified a provider partner to ensure access to youth residential treatment.

Considerations

Access to timely and age-appropriate SUD prevention, diagnostic, and treatment services is critical to increasing positive outcomes for youth and their families. Addressing SUDs early and effectively in youth can prevent negative outcomes in adulthood, such as loss of employment, chronic physical health conditions associated with long-term substance use, and premature death.

Access to services is often limited by a lack of available providers, particularly residential treatment providers, who are equipped to effectively serve youth. Access is especially limited in rural areas of California. Adaptations to adult SUD treatment models geared at addressing youth often fall short. Youth treatment should be appropriate to a person's age, stage of development, culture, and gender. When possible, providers should participate in trainings focused on youth treatment and use approaches that are evidence-based in terms of their effectiveness for youth with SUD.⁹⁴

At a policy level, California has provided assurances under the State Medicaid Plan that a continuum of care for treating SUDs in youth is available statewide through the EPSDT benefit and other federally supported county-level programs. Historically, however, due to the complex nature of the state's Medi-Cal program and the unique role of counties in administering components of it, including SUD treatment, accessing covered services has proven to be challenging for many youth and their families.

The DMC-ODS pilot program creates an opportunity to improve access to effective treatment for youth. It also raises the following questions that should be considered in efforts to make the continuum of care more accessible and tailored to youth with SUDs.

How can we address capacity and workforce challenges within the system of care for youth with SUDs?

- ▶ **Provider training.** Is there an opportunity to increase the number of providers with the experience necessary to treat youth with SUDs by including youth and SUD-specific modules in provider training curricula?
- ▶ **Outpatient vs. residential.** Is there an opportunity to increase access to and use of specialized intensive outpatient treatment as an alternative to residential treatment?
- ▶ **Coordination with juvenile and adult criminal justice and education partners.** What opportunities exist to better coordinate with schools and juvenile justice partners to find mutually beneficial strategies to better address the needs of youth with SUDs?
- ▶ **Medi-Cal reimbursement rates.** Does the DMC-ODS pilot program create an opportunity to address provider shortages by offering more competitive “other than State Plan” rates to qualified providers in participating counties?

Are we building the right system of care for youth with SUDs?

- ▶ **Stigma.** Is there a way to alter engagement and treatment strategies to lessen the stigma associated with seeking addiction treatment?
- ▶ **Social media.** Is there an opportunity to engage and treat youth through social media or other web-based technology?
- ▶ **Nonpunitive intervention.** What opportunities exist to promote the use of nonpunitive interventions among youth SUD providers?

How can we develop an inventory of evidence-based and best practice approaches to screening for and treating SUD conditions in youth?

- ▶ **ASAM limits.** Does the DMC-ODS pilot program create an opportunity to develop more-comprehensive youth treatment guidelines under ASAM?
- ▶ **Youth-specific recovery supports.** Does the DMC-ODS pilot program offer an opportunity to develop and test peer recovery support models that are youth-specific and age-appropriate?
- ▶ **Youth screening, engagement, and prevention.** Are the current approaches to youth SUD screening, treatment, engagement, and prevention developed with input and guidance from youth with recovery experience?

How can we improve access to youth-specific data to better evaluate the treatment needs and outcomes of youth living with SUDs?

- ▶ **Youth vs. adult.** Can we use the DMC-ODS pilot program evaluation requirements to collect youth-specific data to evaluate the treatment needs and outcomes of youth living with SUDs?

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