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The Honorable Maria Elena Durazo
Chair, Senate Subcommittee 5 on Corrections and Public Safety
State Capital Building, Room 2032
Sacramento, CA 95814

The Honorable Cristina Garcia
Chair, Assembly subcommittee 5 on Public Safety
State Capital Building, Room 2013
Sacramento, CA 95814

Dear Members:

The California Association of Alcohol and Drug Program Executives (CAADPE), is respectfully submitting its comments and recommendations regarding the recently released Legislative Analyst's Office (LAO) report titled, *Improving Parolee Substance Use Disorder Treatment Through Medi-Cal*. While CAADPE fully supports the concepts and goals presented in the LAO report, it is crucial to add additional context and information about the efficacy of immediate enrollment in the current Drug Medi-Cal Organized Delivery System (DMC-ODS) upon release.

CAADPE is a professional association of community-based, nonprofit, substance use disorder treatment agency executives advocating for quality patient care. Its members, licensed and certified by the state, provide substance use disorder services at over 300 sites throughout California and constitute the infrastructure of the state's publicly funded substance use disorder treatment network under the Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC-ODS).

In memoriam
Dale Shimizu



CAADPE members have been delivering services to justice-involved individuals for decades. Several of CAADPE's member agencies have been providing services to the California Department of Corrections and Rehabilitation (CDCR) inmate and parole population as operators of, or subcontractors to, CDCR's Specialized Treatment for Optimized Programming (STOP) program – the main program identified in the LAO Report. The STOP program is designed to assist individuals transition out of prison and return to their homes and community life. In addition to STOP programs, CAADPE members collectively provide in-prison substance use disorder treatment and other re-entry focused services. Throughout its history CAADPE has advocated for quality substance use disorder care. CAADPE has always sought to move programs and services forward in a fiscally responsible, but appropriate, way to ensure continuity of care for this at-risk population.

CDCR's Specialized Treatment for Optimized Programming Design

STOP is a community-based substance use disorder treatment program designed to provide comprehensive evidence-based and gender responsive wraparound reentry services to parolees following their release from state prison. While parolees referred to these programs have an identified substance use disorder, the program delivery is broad, nimble, and responsive to the needs of this complex population. The entirety of STOP is designed to be the bridge from incarceration to home, where participants can successfully navigate the challenges of resuming community life. Importantly, all agencies providing substance use disorder treatment services to STOP enrollees are licensed/certified by the California Department of Health Care Services (DHCS).

STOP offers various levels of service (intensities) so that enrollees can access the appropriate treatment for their assessed level of need. STOP services levels include licensed residential treatment, outpatient services, reentry, and recovery housing, as well as non-medical detoxification services. Notably, detoxification services, while still available, are rarely used since the expansion of Medi-Cal services within California. This particular level of care will normally meet "medical necessity," an important topic in the discussion of DMC-ODS services discussed in more detail below. A critical component of STOP is the wraparound services provided to assist individuals re-settle in their home community. These services include:

- Intensive Case Management,
- Cognitive Behavioral Interventions,
 - Anger Management
 - Criminal Thinking
- Life Skills Programs,
- Community and Family Reunification Services,
- Employment and Educational Services and Referrals,
- Individual, Family, and Group Counseling,
- Faith-Based Services, and
- Long-Term Enrollment and Planning to State Social Services and Permanent Supportive Housing.



As it relates to program placement and delivery, STOP's goal is to ensure participants are placed in the appropriate level of care to effectuate that goal. This means all providers are required to conduct a secondary assessment upon initial placement. These assessments guide individuals into the appropriate level of treatment while aiding in accessing the necessary wraparound services. By having a comprehensive service that can increase or decrease in intensity based upon secondary assessments, substance use disorder treatment providers are able to be nimble in ensuring continuity of care for participants.

Finally, because STOP is the bridge to reentry, a core mission is to connect participants to community and health services offered by certified Medi-Cal providers. This ensures that the transition from STOP to Medi-Cal is seamless and participants have all the community resources they need to thrive in their home communities. Year after year, CDCR has shown that when parolees are connected to these reentry programs, there is substantially reduced recidivism.

Understanding the STOP Program Design and Parole Population

Although the LAO report primarily focuses on substance use disorder treatment, it is important to provide context and underlying methodology for the creation of the STOP program design specific to the parolee population. The parolee population is complex and multi-faceted requiring an immediate and flexible safety-net. Specifically, without an immediate safety net and referral to substance use disorder treatment, individuals that have an identified substance use disorder diagnosis and other substantial needs (e.g., housing, employment) are at a significantly increased likelihood to overdose or recidivate within the first two weeks upon release.

In the years preceding incarceration, these individuals have often struggled with drugs, alcohol, and stable employment. They have likely dealt with trauma before – and during – incarceration and are now being pushed back into local communities after years of incarceration. During the time immediately following release, they must find housing, employment, transportation, and get connected to necessary social and health care services, all while trying to get used to a community that is often vastly different from the time before incarceration. For individuals with substance use disorders, this period, as referenced in the LAO report, have “. . . notably high risks of overdose relative to the public – particularly in the first two weeks following release.” With the return to community life, this pivotal moment in a parolee's life creates substantial stress where this safety net provided by STOP may be the most important and the only resource available to them.

The Current Drug Medi-Cal Organized Delivery System is Not Operationally Conducive to the Reentry Population

Again, while CAADPE agrees with the themes and objectives in the report, simply put, CAADPE does not believe the current structure of the DMC-ODS is designed for this population directly upon release. If CDCR were compelled to solely leverage this system from reentry inception – parolee lives would be at increased risk for recidivism, overdose, and death.



Assessment

The DMC-ODS admission process begins with the initial assessment currently required by Medi-Cal to access the system. The assessment questions, derived from the American Society of Addiction Medicine's Patient Placement Criteria (ASAM-PPC), are designed for those who have continuously resided in the local community, which can often exclude parolees from using services unless they have *active and recent drug use (defined as last 30-days)* [emphasis added] – i.e., have they met "medical necessity." The ASAM-PPC was not developed for, or normed, on a re-entry population. So instantaneously, individuals with trauma who may not answer questions truthfully for fear of guilt or reprisal, or who do not have an immediately active drug use upon release, would be excluded from residential treatment and often outpatient services.

Limitations on Use

Additionally, and as discussed in the report, the LAO notes that there are limitations to the use of the residential substance use treatment DMC-ODS system. Previously, individuals were limited to *two nonconsecutive* 90-day periods in a year. What this functionally means is that for parolees who – already struggling with an array of issues – left an initial 90-day drug treatment for one day, and who are discharged from the program, would have used one of their available two treatment periods in a year. Although that episode limit has been modified, there is now potential that length of funded-stays could be limited to only 30 days under DMC-ODS treatment.

Overall, these issues further the need for overarching conversations around how the DMC-ODS system limits the use for parolees in need of treatment. Substance use disorder treatment, particularly for this population, takes care, patience, and the ability to continue to re-engage through intensive case management and ongoing stabilization. With the previous and future potential limitations, even if parolees make it past the initial assessment phase, they may have services end prematurely – leaving them again susceptible to overdose, reincarceration, or both.

Treatment Provider Capacity

Equally as important in this discussion is Medi-Cal certified drug treatment capacity within local communities. Outside of the fiscal responsibilities that would be required of local counties referenced in the report, there is also a lack of available treatment capacity in the community. Even with available capacity and meeting medical necessity, it takes time to schedule appointments which can often be days to weeks out – all during that critical period of reentry. This will leave many with the option of going to the local emergency room to try and gain access to immediate treatment. In addition, community substance use treatment providers licensed by DHCS are often small and cannot meet the administrative and fiscal burdens of being a Medi-Cal DMC-ODS treatment provider, so many have currently opted to remain out of the Medi-Cal system. If CDCR were to require all providers be Medi-Cal certified, it would instantaneously create significant friction and pressure at the local levels. These include places where treatment beds would have otherwise been used for the local community and are now taken by state parolees, creating further delays in providing care for local areas that rely on these services, and often include marginalized communities and communities of color.



Administrative Requirements on Local Providers

The current DMC-ODS system design creates a significant administrative burden on providers. Because Medi-Cal DMC-ODS requires cost-reimbursement accounting in arrears (i.e., a review/audit of what was paid by Medi-Cal), providers must have substantial financial security. This is because the reimbursement presented in local county approvals could claw-back monies from treatment providers where there were billing disputes due to documentation or authorizations.

Privacy Restrictions Limit Active Case Management

An added complexity to all the above operational issues with the DMC-ODS system, is that intensive case-management is nearly impossible with current privacy restrictions. Between the Health Insurance Portability and Accountability Act (HIPPA), the Code of Federal Regulations, Title 42, Section 2 (42 CFR Part 2), and local agency contract requirements, treatment providers are often excluded from the necessary information to create a comprehensive case management and treatment plan. With this limitation, providers often only have a small understanding into individual engagement, success, difficulties, or even whether individuals are actively attending treatment. CAADPE notes that where data is unavailable on DMC-ODS system use, it is often because of these data and privacy limitations – i.e., once a program provider sends an individual to the DMC-ODS system, the provider is limited to only details shared by the individual in treatment, if and when they choose to do so.

Recommendations, Solutions and Ongoing Work

CAADPE believes that the ideas presented in the LAO report can work with thorough discussions and ultimately solutions implemented outside of CDCR. For example, the State could convene a working group to focus on (1) ensuring the system is designed to both treat the parole and probation reentry population and, (2) that technical assistance and statewide efforts could help develop the DMC-ODS network between DHCS and CDCR so that local communities are not negatively impacted. These alone would be remarkable steps needed to leverage the DMC-ODS by CDCR and its providers.

It should be noted that providers, in partnership with CDCR, have already initiated conversations on further leveraging the DMC-ODS system, but have done so carefully and appropriately because of the structural issues in the system relative to this population. In supporting these efforts, all providers under the STOP program do not exclude individuals who are on Medications for Addiction Treatment (MAT) and concurrently help provide resources to ensure they have access to medication, transportation, and clinical appointments to ensure the continuity of care post-release.

Finally, CAADPE would just briefly note that the LAO report indicates the State could save as much \$25 to \$50 million but proposes potentially offsetting costs of \$18 to \$43 million. CAADPE believes through an understanding of the current system and a thoughtful approach to changes, the state can accomplish greater access for post-release enrollees and greater savings to the state, all while increasing public safety and reducing recidivism.



With the stressors of a global pandemic, an opioid crisis, a continued rise in homelessness, and prison closures on the horizon, we think any immediate changes to this program structure would leave parolees struggling to receive services. CDCR, with legislative approval, has invested tens of millions of dollars to begin changing the in-prison rehabilitative system that had long been too stagnant; now is the time to double-down on these efforts and build on that foundation by reinforcing continuity of care and seamless transition at the most critical time for incarcerated individuals - their release.

CAADPE hopes and envisions a future where all individuals can access the DMC-ODS system but that is not the present reality that treatment providers on-the-ground experience. As treatment providers who have been through the highs and lows of California's changing incarceration policies, CAADPE and its members continue to be steadfast in the commitment to making a safer, more effective, space for treatment and habilitation.

CAADPE welcomes further discussion of the report, the issues identified in this letter, and to collaborate in partnership with state officials to realize the goals of improving the substance use disorder treatment delivery system in California.

Respectfully,

A handwritten signature in blue ink, appearing to read "Albert M. Senella".

Albert M. Senella
President Board of Directors

A handwritten signature in blue ink, appearing to read "Doug Bond".

Doug Bond, co-chair
CAADPE Criminal Justice Committee

A handwritten signature in black ink, appearing to read "Vitka Eisen".

Vitka Eisen, co-chair
CAADPE Criminal Justice Committee

Cc Jessica Devencenzi, Deputy Cabinet Secretary and Deputy Legislative Secretary, Office of Governor Gavin Newsom
Amy Jarvis, Program Budget Manager, California Department of Finance
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