CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Impacts of Realignment of Substance Use Disorder Services 2021 Report to the Legislature

Submitted by the Department of Health Care Services
Pursuant to the Requirements of
Health and Safety Code Section 11756.8

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*Includes a count less than 11 and complimentary cell suppression to protect confidentiality.

Overview

The annual Impacts of Realignment of Substance Use Disorder (SUD) Services 2021 Report to the Legislature from the Department of Health Care Services (DHCS) provides an overview of the impact of the 2011 Public Safety Realignment (2011 Realignment) of SUD program services. This report illustrates the amount of realigned funds expended for SUD treatment services, unique counts of Drug Medi-Cal (DMC) service recipients, and the treatment outcomes of service recipients. Note that cost report data utilized for the purposes of this report, fiscal years 2011-12 through 2015-16, is prior to implementation of the DMC Organized Delivery System (ODS) waiver. The intent of this report is to assist in monitoring changes over time and the degree to which programs are meeting state- and county-defined outcome measures. Outcome measures are based on data from three sources:

1. County reported treatment expenditures from cost reports (Substance Abuse Prevention and Treatment Block Grant [SABG] funding and DMC funding);
2. Data from the Short-Doyle Medi-Cal Remediation Technology (SMART) system; and
3. Service recipient data reported through the California Outcomes Measurement System Treatment (CalOMS Tx).

Background

Enactment of the 2011 Realignment marked a significant shift in the state's role in administering programs and functions related to SUD services. Prior to the 2011 Realignment, many public SUD programs and services were provided locally by counties with the program policy authority and funding[1] responsibilities residing with the state. The Fiscal Year (FY) 2011-12 Budget Act, through Senate Bill (SB) 1020 (Committee on Budget and Fiscal Review, Chapter 40, Statutes of 2011) and Proposition 30 of November 2012, resulted in the realignment of these programs to the counties. It is the intent of this report to provide information to the Legislature, the public, and SUD services stakeholders regarding the impact of the 2011 Realignment over the period of time it has been in effect.

Data Considerations

Treatment Expenditure Data

Expenditures reflect funding for treatment services from both 2011 Realignment, including Women's and Children's Residential Treatment Services Subaccount expenditures, and federal funding, including the SABG, and DMC funding. The expenditure data is based on cost reports for actual treatment services claims submitted

[1] This Legislative Report encompasses services funded by multiple funding sources including Substance Abuse Prevention Treatment Block Grants (SABG), SAMHSA, Medicaid (federal share), General Fund (non-federal share), Collaborative Justice Courts Substance Abuse Focus Grant (SAFG), and Dependency Drug Court (DDC) Augmentation Grant.

by counties for FY 2016-17. This report provides the most current cost report data, which was finalized in April 2021.

Appendix A provides a summary of statewide treatment expenditures and unique drug Medi-Cal service recipients between FY 2011-12 and FY 2016-17. SUD treatment includes the following treatment services (see Appendix F for definitions of funding sources and service types):

- Outpatient Methadone Detoxification (Detox)
- Inpatient Methadone Detox
- Outpatient Narcotic Treatment Program (NTP) Maintenance
- Outpatient Treatment (also known as Outpatient Drug Free, or ODF)
- Interim Treatment Services
- Outpatient NTP
- Intensive Outpatient Treatment Services
- Rehabilitative Ambulatory Detox (non-methadone)
- Free Standing Residential Detox
- Perinatal and Other Residential Treatment – Short-Term and Long-Term Residential Treatment
- Voluntary Inpatient Detoxification (24 hours)
- Hospital Inpatient Residential (24 hours)
- Chemical Dependency Recovery Hospital
- Drug Court and Other Treatment Related Services

SMART: Unique Counts of DMC Treatment Service Recipients

The unique DMC client data for FY 2016-17 was collected from the SMART system. "Unique" service recipient counts in Appendix C are defined as the number of individuals who received a DMC treatment service as opposed to the total DMC services provided. Data for Sutter and Yuba Counties are combined and displayed as one county in both Appendix B and Appendix C.

CalOMS Tx: Service Recipient Outcomes

The CalOMS Tx system collects outcome data measures, at the time of the recipient's admission and discharge from publicly funded SUD treatment services and/or licensed NTPs. CalOMS Tx collects a variety of treatment service recipient outcome measures in seven life domains: Alcohol Use, Other Drug Use, Employment/Education, Legal/Criminal Justice, Medical/Physical Health, Mental Health, and Social/Family. Outcome measures collected in these areas indicate the impact of treatment services. These CalOMS Tx measures, along with the percentage of administrative discharges (i.e., the service recipient left treatment prior to their planned discharge and could not be reached for discharge data collection), can be used to measure and compare service recipient outcomes across multiple years. CalOMS Tx does not track data on the specific funds used to provide services, but for purposes of consistency, the CalOMS Tx data is included for FY 2017-18. Outcomes are only reported at the statewide level. The historical outcomes reporting methodology did not accurately reflect all recipients' actual outcomes, because counties vary substantially in the number of discharges reported

that do not contain client data regarding level of functioning. The discharge data is necessary to provide generalizable and comparable outcomes across counties. See Appendix D for details.

Findings

Treatment Expenditures

The summary treatment expenditures from FY 2011-12 to FY 2016-17 increased by $103,278,279 at the statewide level; an increase of 31.13 percent. Treatment expenditures statewide in FY 2011-12 were $331,717,082 compared to $434,995,361 in FY 2016-17 (see Appendix A). Comparing FY 2015-16 to 2016-17, 68.42 percent of counties showed an increase in treatment expenditures, with ten counties increasing $1 million or more in expenditures from FY 2015-16 to FY 2016-17. The counties experiencing the greatest increase in treatment expenditures were Los Angeles County increasing by $14,769,844, Riverside County increasing by $10,086,388, and Fresno County increasing by $7,818,478. Treatment expenditures for 29 of the 57 counties increased ten percent or more from FY 2015-16 to FY 2016-17 with nine counties showing an increase of more than 50 percent (see Appendix A). This increase in expenditures may be due to an overall increase in client counts and DHCS' effort to increase county participation in the Drug Medi-Cal Organized Delivery System (DMC-ODS).

Counties Administering DMC and Unique DMC Client Counts

Fifty-seven counties administered the DMC program[2] in FY 2016-17. Of the 57 counties administering the DMC program in FY 2016-17, only 46 of the counties reported unique DMC service recipient counts. Of those 46 counties, 16 of the counties reported decreases in unique counts of DMC service recipients, compared to FY 2011-12: Alameda, El Dorado, Humboldt, Imperial, Kern, Kings, Lake, Los Angeles, Madera, Mariposa, Mendocino, Merced, Nevada, San Benito, San Francisco, and Sonoma. Conversely, 18 counties had substantial increases (10 percent or more) in unique counts of DMC service recipients, with Glenn County increasing by over 100 percent. The unique DMC service recipient count from FY 2011-12 to FY 2016-17 increased by 37,243 unique recipients at the statewide level; an increase of 66.96 percent. Recipients statewide in FY 2011-12 were 55,622 compared to 92,865 in FY 2016-17 (see Appendices B and C.)

Treatment Service Recipient Outcomes

Treatment service recipient data included in this report are for outpatient services. This service type represents the largest proportion of treatment admissions to publicly-monitored treatment programs. In addition, outpatient services is typically the last service type in an episode of treatment (i.e., when a service recipient progresses from more intensive to less intensive treatment services). The five key measures for outcomes in the chart in Appendix D provide service recipient outcomes by year for

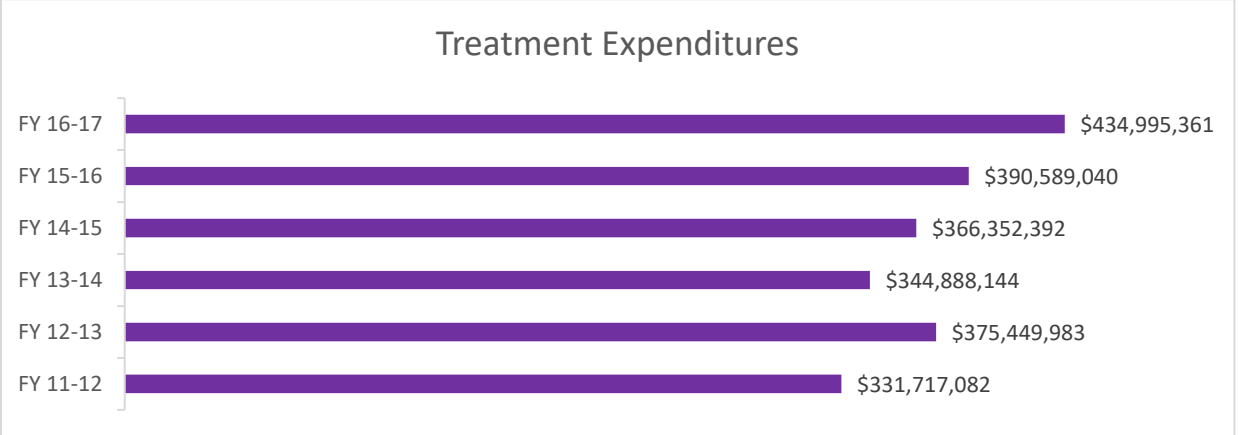
[2] For the purposes of the Legislative Report, DMC refers to the core set of SUD treatment services offered in both DMC and DMC-ODS counties.

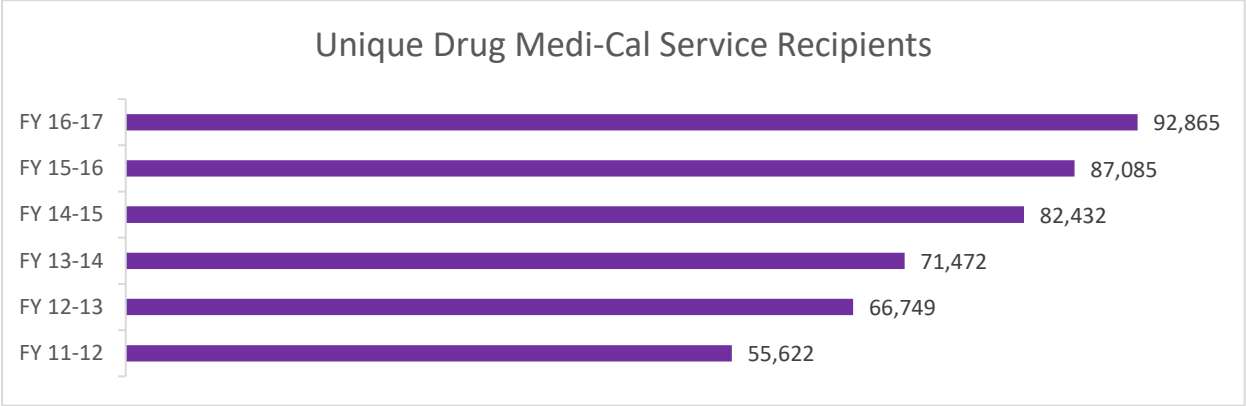
outpatient services. From FY 2011-12 through FY 2017-18, CalOMS Tx data indicated that outpatient service recipient outcomes showed improvement in employment, whereas no improvement was made for the remaining outcome measures (No Arrests, Not Homeless, No Alcohol and Other Drug (AOD) Use, and Four or More Days Social Support).

While percentages for the "Four or More Days Social Support" outcome have remained relatively stable across fiscal years, and the number of clients reporting sustainable employment improved, the data outcome measures collected for "No Arrests," "Not Homeless" and "No AOD Use" are slightly worsening over time. In detail, outpatient service recipients with no arrests decreased by 5.6 percent from 56.2 percent in FY 2011-12 to 50.6 percent in FY 2017-18 (outcome measure reported as "No Arrests"). The percentage of clients reporting they are not experiencing homelessness decreased by 9.2 percent from 56 percent in FY 2011-12 to 46.8 percent in FY 2017-18 (outcome measure reported as "Not Homeless"). However, this is in the context of a severely worsening homelessness problem in California. According to the Homeless Policy Institute at the University of Southern California, homelessness has grown 22 percent over the last decade. Additionally, homelessness increased another 16 percent between 2018 and 2019, so we may continue to see worsening trends in future reports, as clients in drug treatment often experience challenges with employment and housing security. While the data doesn't allow this level of analysis, worsening arrest rates could be linked to the increase in homelessness, as homelessness highly increases the risk of criminal justice involvement. Client reports of no alcohol or drug use also decreased by over 7.2 percent from 43 percent in FY 2011-12 to 35.8 percent in FY 2017-18 (outcome measure reported as "No AOD Use"). It is important to note with these data that the main challenge in analyzing, measuring and reporting these trends completely and accurately is the increasing percentage of missing outcome data reported in CalOMS Tx (refer to Appendix E).

Appendix A
Statewide Treatment Expenditures and Unique Drug Medi-Cal Service Recipients Summary FYs 2011-17

	Treatment Expenditures	Unique Drug Medi-Cal Service Recipients
FY 11-12	$331,717,082	55,622
FY 12-13	$375,449,983	66,749
FY 13-14	$344,888,144	71,472
FY 14-15	$366,352,392	82,432
FY 15-16	$390,589,040	87,085
FY 16-17	$434,995,361	92,865
Difference FY 11-12 & FY 16-17	$103,278,279	37,243
Percentage Change FY 11-12 & FY 16-17	31.13%	66.96%





Appendix B
Treatment Expenditures by County FYs 2015-16 & 2016-17

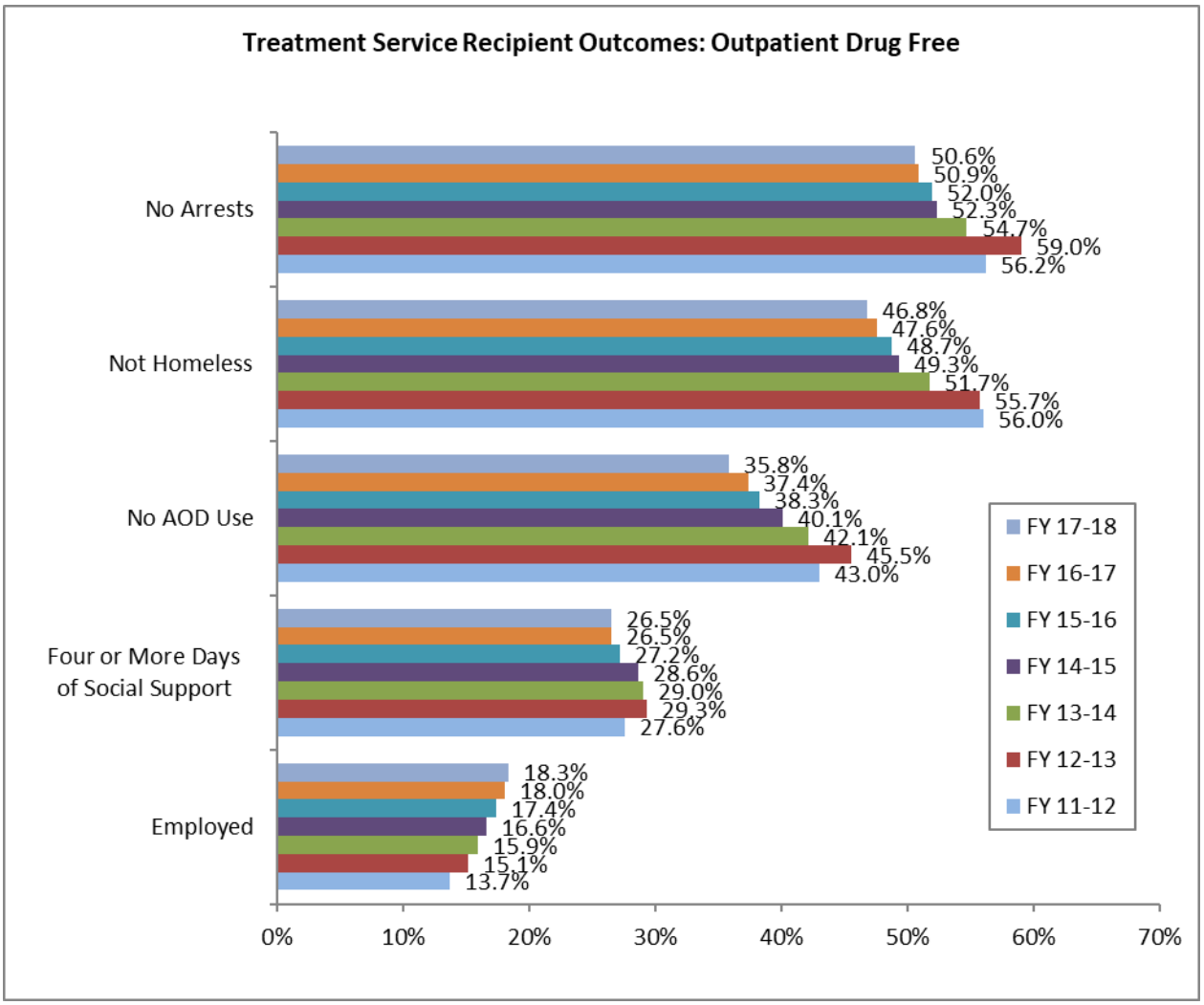
County	Totals		County	Totals	
	FY 15-16	FY 16-17		FY 15-16	FY 16-17
Alameda	$20,464,981	$20,936,653	Orange	$18,739,502	$19,097,269
Alpine	$56,944	$69,183	Placer	$3,312,312	$3,654,257
Amador	$121,503	$49,669	Plumas	$124,510	$199,720
Butte	$4,112,734	$4,325,614	Riverside	$12,741,949	$22,828,287
Calaveras	$56,309	$102,288	Sacramento	$20,026,006	$22,032,667
Colusa	$238,514	$224,536	San Benito	$535,914	$514,097
Contra Costa	$12,611,237	$12,856,789	San Bernardino	$15,911,369	$17,205,518
Del Norte	$164,028	$210,565	San Diego	$16,613,118	$17,863,296
El Dorado	$1,339,125	$455,311	San Francisco	$24,541,536	$19,926,598
Fresno	$18,932,505	$26,742,983	San Joaquin	$13,615,277	$14,424,747
Glenn	$191,029	$231,266	San Luis Obispo	$4,912,436	$4,595,553
Humboldt	$1,333,730	$1,046,263	San Mateo	$6,521,280	$6,765,543
Imperial	$103,177	$164,268	Santa Barbara	$6,761,437	$7,936,496
Inyo	$59,598	$159,236	Santa Clara	$9,822,367	$11,894,050
Kern	$11,496,068	$14,447,898	Santa Cruz	$5,664,655	$5,694,847
Kings	$1,034,581	$1,347,201	Shasta	$1,023,465	$1,581,911
Lake	$757,915	$999,997	Sierra	$66,806	$117,351
Lassen	$121,735	$194,574	Siskiyou	$379,325	$183,249
Los Angeles	$108,354,002	$123,123,846	Solano	$3,178,785	$3,867,691
Madera	$833,963	$720,767	Sonoma	$4,798,620	$5,364,148
Marin	$2,580,612	$2,992,696	Stanislaus	$7,800,541	$7,154,687
Mariposa	$91,004	$50,817	Sutter/Yuba	$1,025,440	$427,885
Mendocino	$846,521	$1,100,493	Tehama	$295,205	$439,344
Merced	$4,079,971	$4,051,338	Trinity	$79,435	$249,828
Modoc	$144,109	$109,313	Tulare	$6,119,092	$5,782,597
Mono	$258,119	$258,119	Tuolumne	$211,164	$174,395
Monterey	$3,466,325	$4,984,877	Ventura	$9,277,777	$10,141,452
Napa	$1,380,170	$1,318,837	Yolo	$634,330	$737,356
Nevada	$624,878	$865,128	Statewide	$390,589,040	$434,995,361

Appendix C
Unique Drug Medi-Cal Service Recipients Appendix C
Unique Drug Medi-Cal Service Recipients by County FYs 2015-16 & 2016-17

County	Totals		County	Totals	
	FY 15-16	FY 16-17		FY 15-16	FY 16-17
Alameda	4,049	3,891	Orange	2,374	3,108
Butte	1,567	1,659	Placer	1,203	1,368
Contra Costa	1,772	1,779	Riverside	4,396	5,470
El Dorado	338	299	Sacramento	5,893	5,983
Fresno	5,709	6,429	San Benito	218	186
Glenn	82	169	San Bernardino	4,156	4,984
Humboldt	335	300	San Diego	7,138	7,535
Imperial	791	758	San Francisco	3,502	3,388
Inyo	*	*	San Joaquin	3,149	3,277
Kern	3,120	3,108	San Luis Obispo	1,314	1,475
Kings	381	328	San Mateo	597	855
Lake	318	253	Santa Barbara	2,624	2,824
Lassen	85	121	Santa Clara	2,591	3,067
Los Angeles	15,824	15,406	Santa Cruz	845	845
Madera	321	287	Shasta	969	1,117
Marin	274	454	Solano	1,126	1,155
Mariposa	62	49	Sonoma	1,465	1,256
Mendocino	179	177	Stanislaus	1,426	1,427
Merced	878	832	Sutter-Yuba	700	723
Modoc	*	*	Trinity	88	90
Monterey	699	824	Tulare	799	1,520
Napa	262	314	Ventura	2,728	2,944
Nevada	449	444	Yolo	197	332
			Statewide	87,085	92,865

*Includes a count less than 11 and complimentary cell suppression to protect confidentiality.

Appendix D



Future Updates

Future reports will continue to include updates to the summary treatment expenditure and service recipient outcomes to support the ongoing monitoring of 2011 Realignment impacts.

Appendix E
Data Quality Considerations for Treatment Outcomes

Historically, SUD treatment outcomes referred to measured changes in service recipient functioning in seven life domains: Alcohol Use, Other Drug Use, Employment/Education, Legal/Criminal Justice, Medical/Physical Health, Mental Health, and Social/Family. The same measures of service recipient functioning (e.g., frequency of primary drug use in the past 30 days) are collected at two points in time: at admission to treatment and at discharge. Changes in service recipient functioning were determined by comparing admission and discharge data, through the different responses at the two points in time, and then quantifying the changes (e.g., percent change) in responses. For simplicity, responses were often categorized into two groups: “positive” actions (e.g., no drug use) and “negative” actions (e.g., used drugs one or more times). These measured changes in service recipient functioning were referred to as “service recipient outcomes.”

This outcome measurement method was historically used to develop all basic outcome statistics for a given time period (e.g., a fiscal year), county, or a specific SUD treatment service type (e.g., residential, outpatient).

Functioning in the 30 days prior to treatment discharge offers a better indication of service recipient functioning; rather than the quantified change between admission and discharge, as calculated by the percent change between data captured 30 days prior to admission and 30 days prior to discharge. For example, since many service recipients are coming from controlled environments (e.g., jail, prison) or other SUD treatment services, many service recipients report not using drugs in the month prior to admission, which does not accurately reflect their true drug utilization. Additionally, social support recovery activity participation is more important during the 30-day period prior to discharge from treatment, when the service recipient is moving in the continuum of care from treatment to longer-term recovery (e.g., disease management). Similar to data collection regarding drug use at admission, some service recipients also report little to no participation in social support recovery activities at the beginning of treatment. Therefore, measuring social support recovery activity participation is more appropriately measured in the month prior to discharge.

An “administrative discharge” is a type of discharge that is used when a service recipient leaves the treatment program and the provider is unable to contact them (in person or by phone). Minimal data are required to “administratively” report the close of the corresponding CalOMS Tx admission record, which would indicate that the service recipient is no longer in the program. Since the service recipient cannot be located, no outcome (i.e., service recipient functioning) data are collected. In contrast, when a service recipient remains in treatment as planned, and is available for discharge interview (in-person or by phone), a standard discharge report is completed which contains all the necessary service recipient functioning data to measure outcomes.

There are substantial variations in the percentage of “administrative” discharges found across years, counties, and specific treatment service types. In general, it is reasonable to assume that the outcomes for service recipients discharged administratively would be worse than for those with planned discharges. Thus, generalizing outcomes of all treatment service recipients from the outcome data collected in the standard discharges (from the service recipients with planned discharges) creates a positive bias. Counties (or fiscal years) with a larger percent of administrative discharges may appear to produce more positive outcomes since the outcomes would be generated from service recipients with completed standard discharge reports. Outcome measurement bias and variability are reduced when the administrative/missing discharge data are factored into comparisons across years and between counties or providers. Based on these findings, this methodology of examining the desired level of client functioning in the 30 days prior to discharge is used for the five outcome measures shown in this report (see page 4).

Example:

> During a *given time period, County A has 1,200 total discharge records. Of those 1,200 records, 10.5 percent (or 126) are missing data. The 1,074 discharge records (1,200 minus 126) with data show that 201 clients are employed and 873 are not. Dividing 201 by 1074 equals approximately 19 percent who are employed. County B has 83 total discharge records, with 81.9 percent (or 68) of the discharge records missing data. The 15 discharge records (83 minus 68) with data show that five clients are employed and ten are not employed. Dividing 5 by 15 equals approximately 33 percent employed. Since the records with missing data are excluded from the denominator when calculating percentages, these comparative statistics erroneously show that County B has better employment outcomes than County A.*
>
> *If the records with the missing data are included in the denominator, then more objective outcome comparisons across counties can be made. For example, County A had 1,200 total discharge records with 201 of them documenting employment at discharge. Therefore, County A shows 16.7 percent employed at discharge (201 divided by 1,200). County B had 83 total discharges, with 5 documenting employment. Therefore, County B shows 6 percent employed at discharge (5 divided by 83).*

This example underscores the importance of ongoing data quality monitoring and management. The state will continue to work with the counties and direct service providers to improve data quality and minimize the number of administrative discharges.

Appendix F
Definitions

Chemical Dependency Recovery Hospital (CDRH): Treatment programs located in a CDRH facility licensed by the California Department of Public Health.

Drug Courts: A permissible use of funding in the Behavioral Health Services subaccount. “Drug courts” or “drug court operations” refers to the provision of intensive drug treatment services, and close supervision to promptly address relapses for individuals whose involvement in the court system is a result of substance abuse. Drug court program administration was realigned under SB 1014 (Committee on Budget and Fiscal Review, Chapter 36, Statutes of 2011) and historically included the following programs: Comprehensive Drug Court Implementation Act, Drug Court Partnership, and Dependency Drug Court services.

Drug Medi-Cal (DMC): Medi-Cal SUD treatment services provided as a carve-out from other standard Medi-Cal services. These SUD treatment services are provided to Medi-Cal beneficiaries through the statewide DMC program, which does not include the 37 counties participating in the Drug Medi-Cal Organized Delivery System. The DMC program is currently administered in 21 counties through contracts between DHCS and the county SUD administration office or between DHCS and a DMC certified provider. DMC treatment services include the following SUD treatment service types: outpatient services (also known as outpatient drug free or ODF), intensive outpatient treatment, narcotic treatment program, peer support services (optional for DMC counties to cover), medications for addiction treatment (for alcohol use disorders, opioid use disorders, and other non-opioid use disorders), SUD crisis intervention services, and perinatal residential treatment.

Drug Medi-Cal Organized Delivery System (DMC-ODS): Provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for SUD treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidence-based practices in SUD treatment and coordinates with other systems of care. The DMC-ODS program is administered through a managed care delivery system in 37 counties through contracts between DHCS and the county SUD administration office. DMC-ODS services include outpatient services (also known as outpatient drug free or ODF), intensive outpatient treatment, partial hospitalization services (optional for DMC-ODS counties to cover), residential treatment, inpatient treatment (optional for DMC-ODS counties to cover), withdrawal management, narcotic treatment program services, medications for addiction treatment (for alcohol use disorders, opioid use disorders, and other non-opioid use disorders), recovery services, peer support specialist services (optional for DMC-ODS counties to cover), care coordination services, SUD crisis intervention services, and clinician consultation (reimbursable activity; not a distinct service).

Voluntary Inpatient Detoxification (24 hours): Hospital and non-hospital detoxification services. Hospital detoxification services (Hospital Inpatient Detoxification – 24 Hours) are provided in a licensed hospital where participants are hospitalized for medical support during the planned SUD withdrawal period. Non-hospital detoxification services (Free-Standing Residential Detoxification) are provided in a residential facility and support to assist the participant during a planned SUD withdrawal period.

Hospital Inpatient Residential (24 hours): Non-detoxification medical care provided in a hospital facility in conjunction with treatment services for substance use disorders.

Inpatient Methadone Detox: Rendered in a controlled, 24-hour hospital setting. Provides narcotic withdrawal treatment to service recipients undergoing a period of planned withdrawal from narcotic dependence.

Intensive Outpatient: Provided to beneficiaries when medically necessary in a structured programming environment (offering a minimum of 9 hours with a maximum of 19 hours a week for adults, and a minimum of 6 hours with a maximum of 19 hours a week for adolescents). Services may exceed the maximum based on individual medical necessity.

Interim Treatment Services (CalWORKs Only): Services designed to determine need for more intensive SUD treatment. This includes provision of up to eight weeks of group and/or individual counseling sessions, in a nonresidential/outpatient setting until such time SUD treatment service needs are determined and available.

Medications for Addiction Treatment (also known as medication-assisted treatment or MAT): medications for opioid use disorder and other substance use disorders, provided at any level of care, usually in combination with counseling and other treatment services.

Non-DMC: SUD treatment programs and services funded with sources other than DMC, such as Substance Abuse Prevention and Treatment Block Grant dollars from the federal Substance Abuse and Mental Health Services Administration.

Outpatient Services (also known as Outpatient Drug Free or ODF): Treatment or recovery services provided in an outpatient setting. SUD treatment services include individual and/or group counseling that may or may not include medication.

Outpatient Detox: Rendered in less than 24 hours that provide for safe withdrawal in an ambulatory setting. Services are designed to support and assist participants undergoing a period of planned withdrawal from SUD dependence, and develop plans for continued service. Administration of prescribed medication may be included in this type of service.

Outpatient Methadone Detox: Rendered in less than 24 hours that provide narcotic withdrawal treatment to service recipients who are undergoing a period of planned withdrawal from narcotic dependence.

Outpatient Narcotic Treatment Program (NTP): Outpatient treatment and recovery services that include the provision of medications for addiction treatment (MAT) in an outpatient setting and include individual and/or group counseling.

Rehabilitative Ambulatory Detox (non-methadone): Outpatient treatment services rendered in less than 24 hours that provide for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological).

Perinatal and Other Residential Treatment: Short-term (<30 days) and long-term (>30 days) treatment services provided in a residential setting. Services may include the following elements: personal recovery and treatment planning, educational sessions, social and recreational activities, individual and group sessions, and assistance in obtaining health, social, vocational, or other community services.

Women's and Children's Residential Treatment Services (WCRTS): One of the funding sources within the Behavioral Health Services subaccount is the WCRTS special account. The term refers to the funding source as well as the WCRTS program. WCRTS includes women's treatment programs, perinatal certified programs, women's and children's programs (services for both mother and child), family services, and comprehensive family-centered treatment programs.