



State of California—Health and Human Services Agency
Department of Health Care Services



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GOVERNOR

Date: July 16, 2014

To: Stakeholders and Interested Parties

From: Karen Baylor, Deputy Director, Department of Health Care Services

The Department of Health Care Services is pursuing a Drug Medi-Cal (DMC) Organized Delivery System Waiver Amendment that would amend DHCS' current Section 1115 Bridge to Reform Demonstration Waiver. The amendment seeks to demonstrate how organized substance use disorder care increases the success of DMC beneficiaries.

This draft amendment reflects input provided to the Department of Health Care Services through the DMC Waiver Advisory Workgroup and the general public. Participants in this stakeholder process have included counties, provider associations, Alcohol and Other Drug counselor certifying organizations, managed care health plans, public interest advocates, and legislative staff. The next Waiver Advisory Group will be held on July 30, 2014, from 9:00am-4:00pm at the California State Association of Counties Conference Center. Additional meeting information is available on DHCS' website located at <http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD-UpcomingMeetings.aspx>.

Enclosed for your review and input are the draft Special Terms and Conditions (STC's). The draft STC's have not been reviewed or approved by the Centers for Medicare and Medicaid Services. There are also portions of the STC's which would need federal approval from the Substance Abuse and Mental Health Services Administration (SAMHSA). These draft amendments reflect the programmatic components of the DMC Organized Delivery System Waiver Amendment. Financial provisions are still under development, and will be provided at a later date. All stakeholders were encouraged to submit comments to: MHSUDStakeholderInput@dhcs.ca.gov

→ In counties that opt in, the draft amendments would change the following basic characteristics of the DMC program, which is defined in the current State Plan Amendment, by:

- **Continuum of Care:** Putting together into a continuum of care those services available to address substance use, including: early intervention, physician consultation, outpatient treatment, case management, medication assisted treatment, recovery services, recovery residence, withdrawal management, and residential treatment.
- **Assessment Tool:** Establishing the American Society of Addiction Medicine (ASAM) assessment tool to determine the most appropriate level of care so that clients can enter the system at the appropriate level and step up or step down in intensive services, based on their response to treatment.
- **Case Management and Residency:** Providing case management services to ensure that the client is moving through the continuum of care, and providing that counties coordinate care for those residing within the county.
- **Selective Provider Contracting:** Giving counties more authority to select quality providers. Safeguards include providing that counties cannot discriminate against providers, that beneficiaries will have choice within a service area, and that a county cannot limit access.
- **Provider Appeals Process:** Creating a provider contract appeal process where providers can appeal to the county and then the state. State appeals will focus solely on ensuring network adequacy.
- **Provider Certification:** Partnering with counties to certify DMC providers, with counties conducting application reviews and on-site reviews and issuing provisional certification, and the State cross-checking the provider against its databases for final approval.
- **Clear State and County Roles:** Counties will be responsible for oversight and monitoring of providers as specified in their county contract.
- **Coordination:** Supporting coordination and integration across systems, such as with the provision that counties enter into Memoranda of Understanding (MOUs) with managed care health plans for referrals and coordination, providing that county substance use programs collaborate with criminal justice partners.
- **Authorization and Utilization Management:** Providing that counties authorize services, with residential treatment required and others as counties determine, and ensuring Utilization Management.
- **Workforce:** Expanding service providers to include Licensed Practitioners of the Healing Arts for the assessment of beneficiaries, and other functions within their scope of practice.
- **Program Improvement:** Promoting a consumer-focus, using evidence based practices including medication assisted treatment services and increasing system capacity for youth services.

**CA Bridge to Health Reform
Drug Medi-Cal Organized Delivery System Waiver
(July 2014)**

Drug Medi-Cal Organized Delivery System

- 1. Drug Medi-Cal Eligibility and Delivery System.** The “Drug Medi-Cal Organized Delivery System (DMC-ODS)” provides a continuum of care modeled after the ASAM Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs.

a. DMC Beneficiaries

i. DMC-ODS beneficiaries:

- Are adolescents 12-17 and adults ages 18-64;
- Are self-referred or receive referral by another person or organization, including but not limited to, physical health providers, law enforcement, family members, mental health care providers, schools, and county departments;
- Derive their Medicaid eligibility from the State Plan and meet the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and meet medical necessity criteria for services received as determined by American Society of Addiction Medicine (ASAM) Criteria;
- Fit into the DMC continuum of care of services based on the American Society of Addiction Medicine Criteria; and,
- Reside in a county that opts into the Demonstration Waiver.

- ii. Intersection with the Criminal Justice System:** Beneficiaries involved in the criminal justice system often are harder to treat for SUD. While research has shown that the criminal justice population can respond effectively to treatment services, the beneficiary may require more intensive services. Additional services for this population may include:

- Eligibility: Counties recognize and educate staff and collaborative partners that Parole and Probation status is not a barrier to expanded Medi-Cal substance use disorder treatment services if the parolees and probations are eligible.

- Lengths of Stay: Additional lengths of stay for withdrawal, residential, and Recovery Residence services for criminal justice offenders if assessed for need (e.g. up to 6 months residential).
- Promising Practices: Counties utilize promising practices such as Drug Court collateral services.

b. Delivery System

DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into the Waiver. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and receive DMC services in their county of residence so long as the individual resides within the geographic service area where DMC-ODS services are provided. Upon approval of an implementation plan, the State will contract with the county to provide DMC-ODS services. The county will subcontract with DMC certified providers to provide all services outlined in the DMC-ODS. Participating counties with the approval from the State, may develop regional delivery systems or request flexibility in delivery system design or comparability of services and counties may act jointly in order to deliver these services.

c. DMC-ODS Program Eligibility Criteria

The DMC-ODS benefit shall be available to all beneficiaries who meet the requirements of STC 1(a) and for whom DMC-ODS is available based on STC 1(b) and who qualify based on the medical criteria outlined below. In order for Drug Medi-Cal reimbursement, the beneficiary must meet the following medical necessity criteria:

- Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders;
- Meet the definition of medical necessity for services based on the ASAM Criteria. Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, medical necessity encompasses all six dimensions so that a more holistic concept would be clinical necessity, necessity of care or clinical appropriateness.

d. DMC-ODS Eligibility Determination

Eligibility determination for the DMC-ODS benefit will be performed as follows:

- The eligibility determination will be conducted by the county or county contracted provider. When the county contracted provider conducts the initial eligibility, it will be reviewed and approved by the county prior to

payment for services. Eligibility determinations can also be conducted through a centralized assessment process.

- ii. The initial eligibility determination for the DMC-ODS benefit will be performed through a face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA), which includes the following: physician, licensed/waivered psychologist, licensed/waivered/registered social worker, licensed/waivered/registered marriage and family therapist, licensed/waivered/registered Licensed Professional Clinical Counselor or registered nurse and nurse practitioners. After establishing a diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services.
- iii. Eligibility for ongoing receipt of DMC-ODS is determined at least every six months through the reauthorization process for individuals determined by the Medical Director, licensed physician or LPHA to be clinically appropriate.

e. ASAM Criteria

A primary goal underlying the ASAM Criteria is for the patient to be placed in the most appropriate level of care. For both clinical and financial reasons, the preferable level of care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient. The ASAM Criteria is a single, common standard for assessing patient needs, optimizing placement, determining medical necessity, and documenting the appropriateness of reimbursement. ASAM Criteria uses six unique dimensions, which represent different life areas that together impact any and all assessment, service planning, and level of care placement decisions. The ASAM Criteria structures multidimensional assessment around six dimensions to provide a common language of holistic, biopsychosocial assessment and treatment across addiction treatment, physical health and mental health services.

The ASAM Criteria provides a consensus based model of placement criteria and matches a patient's severity of SUD illness with treatment levels that run a continuum marked by five basic levels of care, numbered Level 0.5 (early intervention) through Level 4 (medically managed intensive inpatient services).

There are several ASAM training opportunities available for providers and counties. The ASAM eTraining series educates clinicians, counselors and other professionals involved in standardizing assessment, treatment and continued care. One-on-one consultation is also available to review individual or group cases with the Chief Editor of the ASAM Criteria. Additionally, there is a two-day training which provides participants with opportunities for skill practice at every stage of the treatment process: assessment, engagement, treatment planning, continuing care and discharge or transfer. There are also a variety of webinars available.

At a minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care. A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver.

f. Grievances and Appeals

- i. Each County shall have an internal grievance process that allows a beneficiary, or provider on behalf of the beneficiary, to challenge a denial of coverage of services or denial of payment for services by a participating County. This process shall meet the requirements of 42 CFR Part 438, Subpart F.
- ii. The Department of Health Care Services will provide beneficiaries access to a state fair hearing process that meets the requirements of 42 CFR Part 431, Subpart E. Beneficiaries must exhaust the County internal grievance process before enrollees may request a state fair hearing. A beneficiary must file an appeal with the Department of Health Care Service's State fair hearing process within 30 days of exhausting the County internal grievance process.

2. **DMC-ODS Benefit and Individual Treatment Plan (ITP)**

DMC-ODS benefits include the following:

- a. Core Services: A continuum of care ensures that clients can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. The following services shall be provided to all eligible DMC-ODS beneficiaries for the identified level of care as follows.

ASAM Criteria Continuum of Care Services and the DMC-ODS System

ASAM Level of Care	Title	Description	Provider
0.5	Early Intervention	Assessment and education for at-risk individuals who do not meet diagnostic criteria for SUD	SBIRT Providers, DHCS Licensed DUI Providers
1	Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies	DHCS Certified Outpatient Facilities
2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	DHCS Certified Intensive Outpatient Facilities
2.5	Partial Hospitalization Services	20 or more hours of service/week for multidimensional instability not requiring 24-hour care	DHCS Certified Intensive Outpatient Facilities

3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 20 hours of clinical service/week	DHCS Licensed Residential Providers
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community	DHCS Licensed Residential Providers
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community	DHCS Licensed Residential Providers
3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor availability	Chemical Dependency Recovery Hospitals
4	Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage patient in treatment	Chemical Dependency Recovery Hospitals, Hospital
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder	DHCS Licensed NTP Maintenance Providers, Physician, NP/PA to prescribe

ASAM Criteria Withdrawal Services (Detoxification/Withdrawal Management)
and the DMC-ODS System

Level of Withdrawal Management	Level	Description	Provider
Ambulatory withdrawal management without extended on-site monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	DHCS Certified Outpatient Facility with Detox Certification; Physician, NP/PA to prescribe; or OTP for opioids.
Ambulatory withdrawal management with extended on-site monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.	DHCS Certified Outpatient Facility with Detox Certification; Physician, NP/PA to prescribe; or OTP for opioids.

Clinically managed residential withdrawal management	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	DHCS Licensed Residential Facility with Detox Certification; Physician, NP/PA to prescribe; ability to promptly receive step-downs from acute level 4.
Medically monitored inpatient withdrawal management	3.7-WM	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.	Chemical Dependency Recovery Hospitals; ability to promptly receive step-downs from acute level 4
Medically managed intensive inpatient withdrawal management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Hospital, sometimes ICU. Physicians, NP/PA with hospitalist skills, Chemical Dependency Recovery Hospital

i. Early Intervention (ASAM Level 0.5) services explore and address any problems or risk factors that appear to be related to use of alcohol and/or other drugs and addictive behaviors and that help the individual to recognize the harmful consequences of high-risk use or behavior. Such individuals may not appear to meet the diagnosis for a substance use or addictive disorder, but require early intervention for education and further assessment. While none of these services will be funded through the Waiver, the services are an integral part of the continuum of care. Early intervention services may include:

- **SBIRT:** The Screening, Brief Intervention, and Referral to Treatment initiative screens adults ages 18 years or older for alcohol misuse. It provides persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services, as medically necessary. SBIRT attempts to intervene early with non-addicted people, and to identify those who do have a substance use disorder and need linking to formal treatment. This benefit is covered under all Medi-Cal delivery systems. Managed Care Plans will make referrals from SBIRT to the county for treatment through the DMC-ODS.
- **DUI:** Driving Under the Influence Programs are mandated by the court depending on the Blood Alcohol Content and number of DUI offenses. California provides the Wet Reckless; first offender (3-month and 9-month), and multiple offender programs (18-month and 30-month). Completion of the program is a prerequisite to reinstitution of driving privileges. An alcohol and drug assessment is required for all participants upon enrolling in the DUI program. The DUI program is paid for entirely with client fees and no government funding. DUI programs will make referrals, after reviewing the assessment, to the county for treatment through the DMC-ODS.

ii. Outpatient Services (ASAM Level 1) counseling services are provided to beneficiaries less than 9 hours a week for adults and less than 6 hours a week for adolescents when determined by a Medical Director or Licensed Professional of the Healing Arts to be medically necessary. Services can be provided by a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

The Components of Outpatient are:

- **Intake:** The process of admitting a beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
- **Individual Counseling:** Contacts between a beneficiary and a therapist or counselor. Telehealth, home visits, and hospital visits qualify as Medi-Cal reimbursable units of service.
- **Group Counseling:** Face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served.
- **Patient Education:** A learning experience using a combination of methods such as teaching, counseling, and behavior modification techniques which influence beneficiary knowledge, health and illness behavior.
- **Medication Services:** The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.
- **Collateral Services:** Face-to-face sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.
- **Crisis Intervention Services:** Face-to-face contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation.
- **Treatment Planning:** The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake

and assessment process. The treatment plan will be completed upon intake and then updated every subsequent 90 days unless there is a change in treatment modality which would then require a new treatment plan. The treatment plan shall include: a statement of problems to be addressed, goals to be reached which address each problem, action steps which will be taken by the provider and/or beneficiary to accomplish identified goals, target dates for accomplishment of action steps and goals, and a description of services including the type of counseling to be provided and the frequency thereof. Treatment plans have specific quantifiable goal/treatment objectives related the beneficiary's substance use disorder diagnosis and multidimensional assessment. The treatment plan will identify the proposed type(s) of interventions/modality that includes a proposed frequency and duration. The treatment plan will be consistent with the qualifying diagnosis and will be signed by the beneficiary and the Medical Director or LPHA.

- Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

- iii. Intensive Outpatient Treatment (ASAM Level 2.1) structured programming services are provided to beneficiaries a minimum of nine hours with a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for adolescents when prescribed by a Medical Director or Licensed Professional of the Healing Arts to be medically necessary. Services consist primarily of counseling and education about addiction-related problems. Services can be provided by a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

The Components of Intensive Outpatient are (see Outpatient Services for definitions):

- Intake
- Individual and/or Group Counseling
- Patient Education
- Medication Services
- Collateral Services
- Crisis Intervention Services
- Treatment Planning
- Discharge Services

- iv. Residential Treatment (ASAM Level 3) is a non-institutional, 24-hour non-medical, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when prescribed by a Licensed Professional of the Healing Arts. Residential services are

provided to non-perinatal and perinatal beneficiaries. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. In the residential treatment environment, an individual's functional cognitive deficits may require treatment that is primarily slower paced, more concrete and repetitive in nature. The daily regimen and structured patterns of activities are intended to restore cognitive functioning and build behavioral patterns within a community. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain and apply interpersonal and independent living skills and access community support systems. Providers and residents work collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.

Residential services are provided in DHCS licensed residential facilities that also have DMC certification. The length of residential services range from 1 to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents; unless medical necessity authorizes a one-time extension of up to 30 days. Adolescents require shorter lengths of stay and should be stabilized and then moved down to a less intensive level of treatment.

The components of Residential Treatment Services are (see Outpatient Services for definitions):

- Intake
- Individual and Group Counseling
- Patient Education
- Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.
- Collateral Services
- Crisis Intervention Services
- Treatment Planning
- Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment.
- Discharge Services

- v. Withdrawal Management (Levels 1, 2, 3.2, 3.7 and 4 in ASAM) services are provided in a continuum of WM services as per the five levels of WM in the ASAM Criteria when authorized by a Medical Director or Licensed Professional of the Healing Arts as medically necessary. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, and approved and authorized according to the state of California requirements.

The components of withdrawal management services are:

- Intake: The process of admitting a beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
- Observation: Beneficiaries are monitored every thirty minutes throughout the 24-hour period in accordance with requirements. Monitoring includes but is not limited to the beneficiary's general health status.
- Medication Services: The prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license.
- Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

- vi. Medication Assisted Treatment (ASAM OTP Level 1) services to prescribe all FDA approved medication for alcohol and other drug treatment currently covered under the formulary for pharmacy benefit including but not limited to methadone, buprenorphine products, and naltrexone products. Methadone and buprenorphine products are medications provided as a treatment service directed at serving the treatment of opioid dependence and is covered when prescribed by a physician and deemed medically necessary. Naltrexone is a medication provided as a treatment service directed at serving for the treatment of alcohol or opioid dependence and is covered in oral and injectable form when prescribed by a physician and deemed medically necessary. A patient must receive at least two counseling sessions with a therapist or counselor every 30-day period or less if deemed medically necessary by the Medical Director.

The Components of Medication Assisted Treatment are (see Outpatient Treatment Services for definitions):

- Intake
- Individual and Group Counseling
- Patient Education
- Medication Services
- Collateral Services
- Crisis Intervention Services

- Treatment Planning
- Medical Psychotherapy: Type of counseling services consisting of a face-to-face discussion conducted by the Medical Director of the NTP on a one-on-one basis with the patient.
- Discharge Services

vii. Recovery Residence: Recovery Residence (RR) provide a safe and healthy living environment to initiate and sustain recovery from alcohol and other drug use and improvement in one's physical, mental, spiritual, and social wellbeing. Recovery Residences may be divided into levels of support based on the type as well as the intensity and duration of support that they offer. Recovery Residences will not be a CMS reimbursable service. The State is working with the Substance Abuse and Mental Health Services Administration (SAMSHA) to receive approval to use federal block grant funds for this level of service. If the State does not receive approval from SAMSHA to use SAPT funds, this modality will be removed.

The State requires the counties to ensure, at a minimum, the following:

- RR must meet all zoning, fire clearance and other local requirements for such facilities.
- RR must be short term rather than permanent and may not be permanent housing or rent subsidized. Individuals must receive approval to stay at the maximum of 90 days with SAPT funds, AB 109 or other county funds.
- Services provided may include peer-to-peer recovery support, medical and counseling services, but cannot provide any treatment services which require a residential license.
- Clients residing in a RR are expected to leave each day for SUD activities that support a plan for recovery support services.
- The county must develop, for State approval, a local process of certifying and assuring that the RR services meet the criteria consistent with the National Alliance for Recovery Services standards.
- The county must provide monitoring and oversight of the RR and must describe how it will ensure that the local process is being administered.
- To qualify for RR, it must be defined as a treatment service integral to the person's overall recovery, and so specified in the treatment plan.

viii. Recovery Services: Recovery services are important to the beneficiary's recovery and wellness. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of The ASAM Criteria and during the transfer/discharge planning process, beneficiaries will be linked to applicable recovery services. The treatment community becomes a therapeutic agent through which patients are empowered and prepared to manage their health and health care. Therefore, treatment must emphasize the patient's central role in managing their health, use effective self-

management support strategies, and organize internal and community resources to provide ongoing self-management support to patients. Services are provided as medically necessary for up to three years.

The components of Recovery Services are:

- Recovery Monitoring: Recovery coaching, monitoring via telephone and internet
- Substance Abuse Assistance: Outreach, peer-to-peer services, relapse prevention, and substance abuse education
- Education and Job Skills: Life skills, employment services, job training, and education services
- Family Support: Childcare, parent education, child development support services, family/marriage education
- Support Groups: Self-help and support, spiritual and faith-based support
- Ancillary Services: housing assistance, transportation, case management, individual services coordination

iv. Case Management: Counties will coordinate case management services. Case management services can be provided at DMC provider sites, county locations, regional centers or as outlined by the county in the implementation plan. Services may be provided by a Licensed Practitioner of the Healing Arts or certified or certified eligible counselor. Counties will be responsible for coordinating case management services for the SUD client. Counties will also coordinate a system of case management services with physical and/or mental health in order to ensure appropriate level of care.

Case management services are defined as coordinating additional levels of substance use disorder services including but not limited to, transition to a higher or lower level of care, coordinating with physical health plans and providers, and interaction with the criminal justice system, if needed. Case management services may be provided face-to-face, by telephone, or by telemedicine with the beneficiary and may be provided anywhere in the community.

Case management services include:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services;
- Development and periodic revision of a client plan that includes service activities;
- Communication, coordination, referral and related activities;
- Monitoring service delivery to ensure beneficiary access to service and the service delivery system; and,
- Monitoring the beneficiary's progress.

- v. Physician Consultation Services include physician consultation services with preferably American Society of Addiction Medicine Specialists or other addiction specialist physicians. Physicians may consult, in person or via telemedicine, with trained and certified physicians with the California Society of Addiction Medicine Specialists or other California addiction specialist physicians. Counties may contract with one or more CSAM specialists in order to provide the Medical Director or Licensed Professional of the Healing Arts with consultation services including but not limited to information pertaining to the effectiveness of medication assisted treatment, prescribing medication to treat substance use disorders, dosage recommendations, case recommendations

3. **DMC-ODS Provider Specifications**

DMC-ODS staff shall include:

- a. Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Professional of the Healing Arts includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.
- b. Non-professional staff shall receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff will be supervised by professional and/or administrative staff.
- c. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring.
- d. Registered and certified alcohol and other drug counselors must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

4. **Responsibilities of Counties for DMC-ODS Benefits**

The responsibilities of counties for the DMC-ODS benefit shall be consistent with each counties contract with DHCS and shall include that counties do the following.

- a. Selective Provider Contracting Requirements for Counties: Counties may choose the DMC providers to participate in the DMC-ODS. DMC providers not contracted with by a county cannot receive a direct contract with the State.
 - i. Beneficiary Selection: Beneficiaries will be given a choice of providers in their service area.
 - ii. Access: Access cannot be limited in any way when counties select providers. Access to services must remain at the current level and/or expand upon implementation of the waiver. The county shall maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this Waiver. In

establishing and monitoring the network the county must consider the following:

- a. The anticipated number of Medi-Cal eligible clients.
- b. The expected utilization of services, taking into account the characteristics and substance use disorder needs of beneficiaries.
- c. The expected number and types of providers in terms of training and experience needed to meet expected utilization.
- d. The number of network providers who are not accepting new beneficiaries.
- e. The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disabled beneficiaries.

- iii. Medication Assisted Treatment Services: Counties must describe in their implementation plan how they will guarantee access to medication assisted treatment services. Counties currently with inadequate access to medication assisted treatment services must describe in their implementation plan how they will provide the service modality.

MAT Expansion Ideas

Counties are encouraged to increase medication assisted treatment services by exploring the use of the following models:

- Implement a Federal Office Based Opioid Treatment where private practice physicians utilize buprenorphine products for addiction to opioids. County refer to Primary Care Provider (PCP)s. Referrals by the County would come with agreements between County and PCP on services required.
- Outpatient certified providers could utilize buprenorphine or naltrexone products for addiction to opioids. A Physician's Assistant, Nurse Practitioner or Registered Nurse could be utilized for portions of the medical management.
- Increase the use of Naltrexone. It is not a scheduled narcotic so any physician may prescribe it in pill or injection form in an ODF or PCP setting with managed care.
- A private or county NTP licensed facility could act as the DMC parent with medication units in outlying areas where methadone and buprenorphine products could be used.
- A licensed NTP could have mobile units for outlying areas. If Counties participated and the Counties have their own pharmacies this is another option. Mobile units can have counseling areas and conduct urinalysis collection.

- iv. Selection Criteria: In selecting providers, counties:

- Must have written policies and procedures for selection, retention, credentialing and re-credentialing of providers.

- Must not discriminate against persons who require high-risk or specialized services.
- Must not discriminate against for-profit organizations.
- May not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of their certification.
- Include the following provider requirements in the contract:
 - Provide the six quality aims for health care services outlined by the Institute of Medicine. According to IOM, high quality care is safe, effective, patient-centered, timely, efficient and equitable;
 - Possess the necessary license and/or certification;
 - Maintain a safe facility;
 - Maintain client records in a manner that meets state and federal standards;
 - Meet quality assurance standards and any additional standards established by the county as part of credentialing or other evaluation process;
 - Provide for the appropriate supervision of staff;
 - Meet the definition of a satellite, as needed.

v. Contract Denial: Counties shall serve providers that apply to be a contract provider but are not selected a written decision including the basis for the denial.

i. County Protest: Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision.

1. Counties shall have a protest procedure for providers that are not awarded a contract.
2. The protest procedure shall include requirements outlined in the State/County contract.
3. Providers that submit a bid to be a contract provider, but are not selected, must exhaust the county's protest procedure if a provider wishes to challenge the denial to the Department of Health Care Services (DHCS).

ii. DHCS Appeal Process:

1. A provider may appeal to DHCS, following an unsuccessful contract protest, if the contract was denied because the county has an adequate network of providers to meet beneficiary need.
2. A provider may not appeal to DHCS a county's decision not to contract for any other reason including allegations of violations of Federal or State equal employment opportunity laws.
3. A provider shall have 10 calendar days from the conclusion of the county protest period to submit an appeal to the DHCS. Untimely appeals will not be considered. The provider shall serve a copy of its appeal documentation on the county. The

appeal documentation, together with a proof of service, may be served by certified mail, facsimile, or personal delivery.

4. The provider shall include the following documentation to DHCS for consideration of an appeal:
 - a. Response to the county's solicitation document;
 - b. County's written decision not to contract
 - c. Documentation submitted for purposes of the county protest;
 - d. Decision from county protest; and
 - e. Evidence supporting the basis of appeal.
5. The county shall have 10 calendar days from the date set forth on the provider's proof of service to submit its written response with supporting documentation to DHCS. The county shall serve a copy of its response, together with a proof of service, to the provider by certified mail, facsimile, or personal delivery.
6. Within 10 calendar days of receiving the county's written response to the provider's appeal, DHCS will set a date for the parties to discuss the respective positions set forth in the appeal documentation. A representative from DHCS will be present to facilitate the discussion.
7. If following the facilitated discussion, DHCS determines the county does not have adequate access for the modality at issue, the county must submit a Corrective Action Plan (CAP) to DHCS. The CAP must detail how the county will remedy the access issue. DHCS may remove the county from participating in the Waiver if the CAP is not implemented.
8. If DHCS determines that the county has adequate access for the modality at issue, no further action will be required of the county.
9. The decision issued by DHCS shall be final.

b. Authorization: Counties must authorize residential services within 5 days of the service being provided to the beneficiary. Authorization of other services is optional for the county. If the county chooses to authorize other services, the county must establish specific timeframes for authorization. Counties will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service. Counties shall have written policies and procedures for processing requests for initial and continuing authorization of services.

Counties are to have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. Counties are to meet the established timelines for decisions for service authorization.

c. County Implementation Plan: Counties must submit to the State a plan on their implementation of DMC-ODS. The State will provide the format for the implementation plan. Counties cannot commence services without an approved

implementation plan. County implementation plans must ensure that providers are appropriately certified for the services contracted, implementing at least two evidenced based practices, trained in ASAM Criteria, and participating in efforts to promote culturally competent service delivery. Counties will describe how they will increase adolescent services. Counties will also describe how they will phase in the additional services within the Waiver which the county does not currently have established.

Counties will be provided a transition period of one year after approval of the implementation plan in order to build system capacity, provide training, implement the required services as outlined in 4d and create the necessary county systems as described in the Waiver. Upon State approval of the implementation plan, counties will be able to bill back to the date the implementation plan was submitted to the State.

d. Service Provision:

Counties are required to provide the following services outlined in the chart below. Upon State approval, counties may implement a regional model with other counties in order to provide the required services.

Service	Required	Optional
Early Intervention	<ul style="list-style-type: none"> • SBIRT • DUI 	
Outpatient Services	<ul style="list-style-type: none"> • Outpatient • Intensive Outpatient 	
Residential	<ul style="list-style-type: none"> • At least one level of service 	<ul style="list-style-type: none"> • Additional levels
Withdrawal Management	<ul style="list-style-type: none"> • At least one level of service 	<ul style="list-style-type: none"> • Additional levels
Medication Assisted Tx	<ul style="list-style-type: none"> • Required 	
Recovery Residence		<ul style="list-style-type: none"> • Optional
Recovery Services	<ul style="list-style-type: none"> • Required 	
Case Management	<ul style="list-style-type: none"> • Required 	
Physician Consultation		<ul style="list-style-type: none"> • Optional

e. DMC Certification: Counties, consistent with federal and state requirements, will be responsible for issuing DMC certifications for non-county providers. The process will consist of application review, conducting the initial onsite review and issuing the provisional certification. The State will be responsible for reviewing and approving the DMC Disclosure Statement and issuing the final certification. Once the provisional certification is issued, the provider can begin providing and billing for services. The State will also be responsible for certifying county operated DMC programs.

f. Coordination with DMC-ODS Providers: Counties will include the following provider requirements within their contracts with the providers.

- **Culturally Competent Services:** Providers are responsible to provide culturally competent services. Providers must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations.
- **Medication Assisted Treatment:** Providers will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. Provider staff will regularly communicate with physicians of clients who are prescribed these medications assuming the client has signed a 42 CFR part 2 compliant release of information for this purpose.
- **Evidenced Based Practices:** Providers will implement at least two of the following evidenced based treatment practices (EBPs) based on the timeline established in the county implementation plan. Counties will ensure the providers have implemented EBPs. The State will monitor the implementation of EBP's during reviews. The required Evidenced based practices include:
 - *Motivational Interviewing:* MET is a client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes.
 - *Cognitive-Behavioral Therapy:* Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
 - *Relapse Prevention:* A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. RPT can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
 - *Trauma-Informed Treatment:* Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.
 - *Psycho-Education:* Psycho-educational groups are designed to educate clients about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to clients' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery; and prompt people using substances to take action on their own behalf.

g. Beneficiary Access Number: All counties shall have a toll free number for prospective beneficiaries to call to access DMC-ODS services.

h. Coordination with Managed Care Plans:

The following elements should be implemented at the point of care to ensure clinical integration:

- Comprehensive substance use, physical, and mental health screening;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Care coordination and effective communication among providers;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals between systems.

The participating county shall enter into a memorandum of understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement can be met through an amendment to the MHP-MCP MOU. MOU's should at a minimum include bidirectional referral protocols between plans, the availability of clinical consultation, including consultation on medications, the management of a beneficiary's care, including procedures for the exchanges of medical information and a process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved.

5. DMC-ODS Center State Oversight, Monitoring, and Reporting.

a. Monitoring Plan: The State shall maintain a plan for oversight and monitoring of DMC-ODS providers to ensure compliance and corrective action with provider standards, access, and delivery of quality care and services. The state will ensure that the counties are providing the required services in the DMC-ODS using the evidence based practices through the implementation plan and ongoing county monitoring.

b. Reporting of Activity: The state will report activity consistent with the Quarterly and Annual Progress Reports as set forth in this Waiver, Section IV, General Reporting Requirements. Such oversight, monitoring and reporting shall include all of the following:

- i. Enrollment information to include the number of DMC-ODS beneficiaries served in the DMC-ODS program.
- ii. Summary of operational, policy development, issues, complaints, grievances and appeals. The State will also include any trends discovered, the resolution of complaints and any actions taken or to be taken to prevent such issues, as appropriate.

c. Triennial Reviews: During the triennial reviews, the State will review the status of the QI Plan and the county monitoring activities. This review will include the counties service delivery system, beneficiary protections, access to services, authorization for services, compliance with regulatory and contractual requirements of the waiver, and a beneficiary records review. This triennial

review will provide the State with information as to whether the counties are complying with their responsibility to monitor their service delivery capacity. The counties will receive a final report summarizing the findings of the triennial review and if out of compliance, the county must submit a plan of correction (POC) within 60 days of receipt of the final report.

6. DMC-ODS County Oversight, Monitoring and Reporting.

The contract with the state and counties that opt into the waiver, require counties to have a Quality Improvement Plan that includes the counties plan to monitor the service delivery, capacity as evidenced by a description of the current number, types and geographic distribution of substance use disorder services. For counties that have an integrated mental health and substance use disorders department, this Quality Improvement Plan may be combined with the MHP Quality Improvement Plan.

- a. The county shall have a Quality Improvement committee to review the quality of substance use disorders services provided to the beneficiary. For counties with an integrated mental health and substance use disorders department, the county may use the same committee as required in the MHP contract.
- b. The QI committee shall recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions, ensure follow-up of QI process and document QI committee minutes regarding decisions and actions taken. The monitoring of accessibility of services will include:
 - i. Timeliness of first face to face appointment
 - ii. Timeliness of services for urgent conditions
 - iii. Access to after-hour care
 - iv. Responsiveness of the 24/7 toll-free number
- c. Counties will have a Utilization Management (UM) Program assuring that beneficiaries have appropriate access to substance use disorder services; medical necessity has been established and the beneficiary is at the appropriate ASAM level of care and that the interventions are appropriate for the diagnosis and level of care.
- d. Counties will coordinate with the evaluation required by the Waiver.

7. Access in Service Delivery Non-Participating Counties

Standard DMC services approved through SPA 13-038 will be available to all beneficiaries in all counties. Beneficiaries that reside in a Waiver County will receive Waiver benefits. County eligibility will be based on the MEDs file. Counties that do not opt into the Waiver are only allowed to perform services outlined in the approved state plan amendment for DMC services. Beneficiaries receiving services in counties which do not opt into the Waiver will not have access to the services outlined in the DMC-ODS.

8. Financing

Financial provisions are coming at a later date.