

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00193/9

TITLE: California Medi-Cal 2020 Demonstration

AWARDEE: California Health and Human Service Agency

I. PREFACE

The following are the Special Terms and Conditions (STCs) for California’s Medi-Cal 2020 section 1115(a) Medicaid Demonstration (hereinafter “Demonstration”), to enable the California Health and Human Services Agency (State) to operate this Demonstration, The Centers for Medicare & Medicaid Services (CMS) has granted waivers of statutory Medicaid requirements permitting deviation from the approved State Medicaid plan, and expenditure authorities authorizing expenditures for costs not otherwise matchable. These waivers and expenditure authorities are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the Demonstration and the State’s obligations to CMS during the life of the Demonstration.

**THIS IS AN EXCERPT OF THIS DOCUMENT THAT
ONLY INCLUDES THE DRUG MEDI-CAL ORGANIZED
DELIVERY SYSTEM (DMC-ODS) SPECIAL TERMS
AND CONDITIONS SECTION. FOR THE ENTIRE
DOCUMENT PLEASE VISIT:**

http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf

X. DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

127. Drug Medi-Cal Eligibility and Delivery System. The “Drug Medi-Cal Organized Delivery System (DMC-ODS)” is a Pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with substance use disorder (SUD). The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services, increased local control and accountability, greater administrative oversight, creates utilization controls to improve care and efficient use of resources, evidence based practices in substance abuse treatment, and increased coordination with other systems of care. This approach is expected to provide the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery.

128. Drug Medi-Cal Definitions

- a. Delivery System The DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. Any county that elects to opt into DMC-ODS services shall submit an implementation plan to the State for approval by DHCS and CMS pursuant to Attachment Z. Upon approval of the implementation plan, the State shall enter into an intergovernmental agreement with the County to provide or arrange for the provision of DMC-ODS services through a Prepaid Inpatient Hospital Plan (PIHP) as defined in 42 CFR 438.2 DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the State will enter into an intergovernmental agreement with the county to provide DMC-ODS services. The county will, in turn, contract with DMC certified providers or offer county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the State may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design. Counties may act jointly in order to deliver these services.
- b. Short-Term Resident Any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a “short-term resident” of the residential facility in which they are receiving the services.
- c. Tribal and Indian Health Providers A description of how the Tribal operated and urban Indian health providers, as well as American Indians and Alaska Natives Medi-Cal beneficiaries, will participate in the program through a Tribal Delivery System will be outlined in Attachment BB following approval of this amendment. The provisions in Attachment BB will be consistent with the authorities in the Indian Health Care Improvement Act (including the statutory exemption from state

or local licensure or recognition requirements at Section 1621(t) of the Indian Health Care Improvement Act) and will be developed in consultation with the California tribes, and Tribal and Urban Indian health programs located in the state, consistent with the Tribal Consultation SPA and the CMS Tribal Consultation Policy.

- d. DMC-ODS Program Medical Criteria In order to receive services through the DMC-ODS, the beneficiary must be enrolled in Medi-Cal, reside in a participating county and meet the following medical necessity criteria:
- i. 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; or be assessed to be at risk for developing substance use disorder (for youth under 21).
 - ii. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
 - iii. If applicable, must meet the ASAM adolescent treatment criteria. As a point of clarification, beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS Pilot overrides any EPSDT requirements.
- e. DMC-ODS Determination of Medicaid Eligibility Determination of who may receive the DMC-ODS benefit will be performed as follows:
- i. Medicaid eligibility must be verified by the county or county contracted provider. When the county contracted provider conducts the initial eligibility verification, it will be reviewed and approved by the county prior to payment for services, unless the individual is eligible to receive services from tribal health programs operating under the Indian Self Determination and Education Assistance Act (ISDEAA – Pub.L. 93-638, as amended) and urban Indian organizations operating under title V of the IHCA. If so eligible, the determination will be conducted as set forth in the Tribal Delivery System - Attachment BB to these STCs.
 - ii. The initial medical necessity determination for the DMC-ODS benefit must be performed through a face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA) as defined in Section 3(a). After establishing a diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services.
 - iii. Medical necessity qualification 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; except for NTP services which will require reauthorization annually.

- f. Grievances and Appeals 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. The Department of Health Care Services will provide beneficiaries access to a state fair hearing process.
 - i. The grievance and appeals process for the Tribal Delivery System will be outlined in Attachment BB.

- 129. DMC-ODS Benefit and Individual Treatment Plan (ITP)** Standard DMC services approved through the State Plan Benefit will be available to all beneficiaries in all counties.
- a. Beneficiaries that reside in a Pilot County will receive DMC-ODS benefits in addition to other state plan services. County eligibility will be based on the MEDs file.
 - b. In counties that do not opt into the Pilot, beneficiaries receive only those drug and substance use disorder treatment services outlined in the approved state plan (including EPSDT).
 - c. Beneficiaries receiving services in counties which do not opt into the Pilot will not have access to the services outlined in the DMC-ODS.
 - d. The benefits and ITP for the Tribal Delivery System will be discussed in Attachment BB.

Table ONE: State Plan and DMC-ODS Services Available to DMC-ODS Participants (with Expenditure Authority and Units of Service)

DMC-ODS Service	Current State Plan	Allowable 1905(a) services – not covered in State Plan*	Costs Not Otherwise Matchable (CNOM)	Units Of Service
Early Intervention (Note: SBIRT services are paid for and provided by the managed care plans or by fee-for-service primary care providers.)	x (preventive service; physician services)			Annual screen, up to 4 brief interventions
Outpatient Drug Free	x (rehab services)			Counseling: 15 min increments

Intensive Outpatient	x (rehab services)			per day
Partial Hospitalization		X		Diagnosis-related Group (DRG)/Certified Public Expenditures (CPE)
Withdrawal management General Acute Care Hospital (VID, INVID) (non-IMD)	x inpatient services			DRG/CPE
CDRH/Free Standing Psych (IMD)			x	DRG/CPE
Residential (perinatal, non-IMD)	x (rehab services)			Per day/bed rate
(all pop., non-IMD)		X		Per day/bed rate
(IMD)			<u>x</u>	Per day/bed rate
NTP	x (rehab services)			Per day dosing; 10 minute increments

DMC-ODS Service	Current State Plan	Allowable 1905(a) services – not covered in State Plan*	Costs Not Otherwise Matchable (CNOM)	Units Of Service
Additional MAT (drug products)	x (pharmacy)			Drug cost
(physician services)	x (physician services; rehab)			Per visit
Recovery Services		x		Counseling: 15 min increments
Case Management	x (TCM)	x**		15 min increments
Physician Consultation				15 min increments

*Allowable 1905(a) services are all Medicaid services that can be covered upon CMS approval in a State Plan.

**TCM is not available state-wide as per 1915(g) and is not currently covered in all counties.

The following services (Tables TWO and THREE) must be provided, as outlined in Table FOUR, to all eligible DMC-ODS beneficiaries for the identified level of care as follows.

DMC-ODS benefits include a continuum of care that 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.

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

ASAM Level of Care	Title	Description	Provider
0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Managed care or fee-for-service provider
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 5 hours of clinical service/week and prepare for outpatient treatment.	DHCS Licensed and DHCS/ASAM Designated 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	DHCS Licensed and DHCS/ASAM Designated Residential Providers

ASAM Level of Care	Title	Description	Provider
		other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	
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 and DHCS/ASAM Designated 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; Hospital, Free Standing Psychiatric 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; Free Standing Psychiatric hospitals
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 OTP Maintenance Providers, licensed prescriber

Table THREE: 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, licensed prescriber; 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; licensed prescriber; or OTP.
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, licensed prescriber; ability to promptly receive step-downs

Level of Withdrawal Management	Level	Description	Provider
			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.	Hospital, Chemical Dependency Recovery Hospitals; Free Standing Psychiatric 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, Chemical Dependency Recovery Hospitals; Free Standing Psychiatric hospitals
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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 or contract with providers in other counties in order to provide the required services.

TABLE FOUR: Required and Optional DMC-ODS Services

Service	Required	Optional
Early Intervention (SBIRT)	<ul style="list-style-type: none"> • (Provided and funded through FFS/managed care) 	
Outpatient Services	<ul style="list-style-type: none"> • Outpatient (includes oral naltrexone) • Intensive Outpatient 	<ol style="list-style-type: none"> 1. Partial Hospitalization
Residential	<ul style="list-style-type: none"> • At least one ASAM level of service initially • All ASAM levels (3.1, 3.3, 3.5) within three years • Coordination with ASAM Levels 3.7 and 4.0 (provided and funded through FFS/managed care) 	<ul style="list-style-type: none"> • Additional levels
NTP	<ul style="list-style-type: none"> • Required (includes buprenorphine, naloxone, disulfiram) 	
Withdrawal Management	<ul style="list-style-type: none"> • At least one level of service 	<ul style="list-style-type: none"> • Additional levels
Additional Medication Assisted Treatment		<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"> • Required 	

The continuum of care for SUD services outlined in Tables TWO and THREE are modeled after the levels identified in the ASAM Criteria. While counties will be responsible for the oversight and implementation of most of the levels in the continuum, a few of the levels (Early Intervention Services, Partial Hospitalization and Levels 3.7 and 4.0 for Residential and Withdrawal Management) are overseen and funded by other sources not under the DMC-ODS.

These services are contained in the DMC-ODS Pilot in order to show the entire continuum of care of SUD services available to California's MediCal population.

- 130. Early Intervention Services** (ASAM Level 0.5) Screening, brief intervention and referral to treatment (SBIRT) services are provided by non-DMC providers to beneficiaries at risk of developing a substance use disorder.
- a. SBIRT services are not paid for under the DMC-ODS system.
 - b. SBIRT services are paid for and provided by the managed care plans or by fee- for-service primary care providers.
 - c. 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.

Referrals by managed care providers or plans to treatment in the DMC-ODS will be governed by the Memorandum of Understanding (MOU) held between the participating counties and managed care plans. The components of the MOUs governing the interaction between the counties and managed care plans related to substance use disorder will be included as part of the counties' implementation plan and waiver contracts.

- d. The components of Early Intervention are:
 - a. Screening: Primary Care physicians screen adults ages 18 years or older for alcohol misuse.
 - b. Counseling: Persons engaged in risky or hazardous drinking receive brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services, as medically necessary.
 - c. Referral: Managed Care Plans and fee-for-service primary care providers will make referrals from SBIRT to the county for treatment through the DMC-ODS.

- 131. Outpatient Services** (ASAM Level 1) Counseling services are provided to beneficiaries (up to 9 hours a week for adults, and less than 6 hours a week for adolescents) when determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary and in accordance with an individualized client plan. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

- a. The Components of Outpatient Services are:
 - i. Intake: The process of determining that a beneficiary meets the medical necessity criteria and a beneficiary is admitted 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.
 - ii. Individual Counseling: Contacts between a beneficiary and a therapist or

counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.

- iii. 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.
- d. Family Therapy: The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery as well as their own recovery can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.
- e. Patient Education: Provide research based education on addiction, treatment, recovery and associated health risks.
- f. 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.
- g. Collateral Services: 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.
- h. Crisis Intervention Services: 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.
- i. 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 or significant event that would then require a new treatment plan. The treatment plan shall include:
 - A. A statement of problems to be addressed,
 - B. Goals to be reached which address each problem
 - C. Action steps which will be taken by the provider and/or beneficiary to accomplish identified goals,
 - D. 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.

- E. Treatment plans have specific quantifiable goal/treatment objectives related the beneficiary’s substance use disorder diagnosis and multidimensional assessment.
- F. The treatment plan will identify the proposed type(s) of interventions/modality that includes a proposed frequency and duration.
- G. The treatment plan will be consistent with the qualifying diagnosis and will be signed by the beneficiary and the Medical Director or LPHA.
- j. 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.

132. 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 determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary and in accordance with an individualized client plan. Lengths of treatment can be extended when determined to be medically necessary. Services consist primarily of counseling and education about addiction-related problems. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

- a. The Components of Intensive Outpatient are (see Outpatient Services for definitions):
 - i. Intake
 - ii. Individual and/or Group Counseling
 - iii. Patient Education
 - iv. Family Therapy
 - v. Medication Services
 - vi. Collateral Services
 - vii. Crisis Intervention Service
 - viii. Treatment Planning
 - ix. Discharge Services

133. Partial Hospitalization (ASAM Level 2.5) services feature 20 or more hours of clinically intensive programming per week, as specified in the patient’s treatment plan. Level 2.5 partial hospitalization programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting. Providing this level of service is optional for participating counties.

134. 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 determined by a Medical Director or Licensed

Practitioner of the Healing Arts as medically necessary and in accordance with an individualized treatment plan. 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.

- a. Residential services are provided in a DHCS, or for adolescents Department of Social Services, licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.
- b. Residential services can be provided in facilities of any size.
- c. 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 on an annual basis. Only two non-continuous 90-day regimens will be authorized in a one-year period. The average length of stay for residential services is 30 days. Peri-natal clients may receive a longer length of stay based on medical necessity. Peri-natal clients may receive lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends.)
- d. Residential Services for Adults- Residential services for adults may be authorized for up to 90 days in one continuous period. Reimbursement will be limited to two non-continuous regimens for adults in any one-year period (365 days). One extension of up to 30 days beyond the maximum length of stay of 90 days may be authorized for one continuous length of stay in a one-year period (365 days)
- e. Residential Services for Adolescents Residential services for adolescents may be authorized for up 30 days in one continuous period. Reimbursement will be limited to two non-continuous 30-day regimens in any one-year period (365 days). One extension of up to 30 days beyond the maximum length of stay may be authorized for one continuous length of stay in a one-year period (365 days).
- f. One ASAM level of Residential Treatment Services is required for approval of a county implementation plan in the first year. The county implementation plan must demonstrate ASAM levels of Residential Treatment Services (Levels 3.1-3.5) within three years of CMS approval of the county implementation plan and state-county intergovernmental agreement (managed care contract per federal definition). The county implementation plan must describe coordination for ASAM Levels 3.7 and 4.0.
- g. The components of Residential Treatment Services are (see Outpatient Services for definitions):

- i. Intake
- ii. Individual and Group Counseling
- iii. Patient Education
- iv. Family Therapy
- v. Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.
- vi. Collateral Services
- vii. Crisis Intervention Services
- viii. Treatment Planning
- ix. Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment.
- x. Discharge Services

135. 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 determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with an individualized client plan. 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 treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the state of California requirements.

The components of withdrawal management services are:

- a. 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.
- b. Observation: The process of monitoring the beneficiary's course of withdrawal. To be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary's health status.
- c. 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.
- d. 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.

136. Opioid (Narcotic) Treatment Program (ASAM OTP Level 1)_services are provided in NTP licensed facilities. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber

and approved and authorized according to the State of California requirements. NTPs/OTPs are required to offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone and disulfiram.

- a. A patient must receive at minimum fifty minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.
- b. The components of Opioid (Narcotic) Treatment Programs are (see Outpatient Treatment Services for definitions):
 - i. Intake
 - ii. Individual and Group Counseling
 - iii. Patient Education
 - iv. Medication Services
 - v. Collateral Services
 - vi. Crisis Intervention Services
 - vii. Treatment Planning
 - viii. Medical Psychotherapy: Type of counseling services consisting of a face-to-face discussion conducted by the Medical Director of the NTP/OTP on a one-on-one basis with the patient.
 - ix. Discharge Services

137. Additional Medication Assisted Treatment (ASAM OTP Level 1) includes the ordering, prescribing, administering, and monitoring of all medications for substance use disorders. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

- a. Opioid and alcohol dependence, in particular, have well-established medication options.
- b. The current reimbursement mechanisms for medication assisted treatment (MAT) will remain the same except for the following changes for opt-in counties: buprenorphine, naloxone and disulfiram will be reimbursed for onsite administration and dispensing at NTP programs; additionally, physicians and licensed prescribers in DMC programs will be reimbursed for the ordering, prescribing, administering, and monitoring of medication assisted treatment.
- c. The components of Additional Medication Assisted Treatment are ordering, prescribing, administering, and monitoring of medication assisted treatment.
- d. The goal of the DMC-ODS for MAT is to open up options for patients to receive MAT by requiring MAT services in all opt-in counties, educate counties on the various options pertaining to MAT and provide counties with technical assistance to implement any new services. These medications are available through the DMC- ODS and outside of Drug Medi-Cal programs. Further details explaining the financing and availability of MAT services in the Medi-Cal system are contained in Attachment CC.
- e. Counties may also choose to utilize long-acting injectable naltrexone in allowable DMC facilities under this optional provision. Long-acting injectable naltrexone will be reimbursed for onsite administration and physicians and licensed prescribers in DMC-ODS programs will be reimbursed for the ordering, prescribing, administering and monitoring.

- f. Counties that choose to provide long-acting injectable naltrexone through this option must cover the non-federal share cost. While a treatment authorization request will not be required at the State level, under this option the county may choose to implement an approval process at the county level.

- 138. 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/transition 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.
- a. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed or as a preventative measure to prevent relapse.
 - b. Recovery services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.
 - c. The components of Recovery Services are:
 - i. Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;
 - ii. Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;
 - iii. Substance Abuse Assistance: Peer-to-peer services and relapse prevention;
 - iv. Education and Job Skills: Linkages to life skills, employment services, job training, and education services;
 - v. Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;
 - vi. Support Groups: Linkages to self-help and support, spiritual and faith-based support;
 - vii. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

- 139. 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; however, the county will be responsible for determining which entity monitors the case management activities. Services may be provided by a Licensed Practitioner of the Healing Arts or certified counselor.
- a. 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.

- b. Case management services are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed.
- c. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.
- d. Case management services include:
 - i. Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services;
 - ii. Transition to a higher or lower level SUD of care;
 - iii. Development and periodic revision of a client plan that includes service activities;
 - iv. Communication, coordination, referral and related activities;
 - v. Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
 - vi. Monitoring the beneficiary's progress;
 - vii. Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services; and,
 - viii. Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

140. Physician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries.

- a. Physician consultation services are to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.
- b. Counties may contract with one or more physicians or pharmacists in order to provide consultation services. Physician consultation services can only be billed by and reimbursed to DMC providers.

141. 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:

- a. 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 probationers are eligible. Currently incarcerated inmates are not eligible to receive FFP for DMC-ODS

- services.
- b. Lengths of Stay: Counties may provide extended lengths of stay for withdrawal and residential services for criminal justice offenders if assessed for need (e.g. up to 6 months residential; 3 months FFP with a one-time 30-day extension if found to be medically necessary and if longer lengths are needed, other county identified funds can be used).
- c. Promising Practices: Counties utilize promising practices such as Drug Court services.

142. DMC-ODS Provider Specifications The following requirements will apply to DMC-ODS staff:

- 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 Practitioner of the Healing Arts includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), 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.

143. Responsibilities of Counties for DMC-ODS Benefits

The responsibilities of counties for the DMC-ODS benefit shall be consistent with each county's intergovernmental agreement 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 certified providers that do not receive a county contract cannot receive a direct contract with the State in counties which opt into the Pilot. If a county does not participate in the Pilot or is removed from participation in the Pilot by the State, the county will continue to cover state plan services.
- b. Access: Each county must ensure that all required services covered under the DMC-ODS Pilot are available and accessible to enrollees of the DMC-ODS. NTP services are an important modality within the continuum of care. Counties are required to provide this service. Access to medically necessary NTP services cannot be denied for DMC-ODS eligible beneficiaries. Eligible DMC-ODS beneficiaries will receive medically necessary services at a DMC certified NTP provider. All DMC-ODS services, including Medi-Cal NTP services, shall be furnished with reasonable promptness in accordance with

federal Medicaid requirements and as specified in the county implementation plan and state/county intergovernmental agreement (managed care contracts per federal definition). Medical attention for emergency and crisis medical conditions must be provided immediately. If the DMC-ODS network is unable to provide services, the county must adequately and timely cover these services out-of-network for as long as the county is unable to provide them.

- c. All counties must ensure that beneficiaries who live in an opt-out county, but receive NTP services in an opt-in county do not experience a disruption of services. The opt-out county will claim state plan expenditures for the reimbursement made to the out-of-county NTP providers in accordance with the approved state plan methodology for services furnished to beneficiaries. No persons eligible for DMC-ODS services, including Medi-Cal funded NTP treatment services, will be placed on waiting lists for such services due to budgetary constraints.
- d. The DMC-ODS Pilot program is administered locally by each demonstration county and each county provides for, or arranges for, substance use disorder treatment for Medi-Cal beneficiaries. Access cannot be limited in any way when counties select providers. Access to State Plan services must remain at the current level or expand upon implementation of the Pilot. The county shall maintain and monitor a network of appropriate providers that is supported by contracts with subcontractors and that is sufficient to provide adequate access to all services covered under this Pilot. Access for this purpose is defined as timeliness to care as specified below. In establishing and monitoring the network, the county must consider the following:
 - i. Require its providers to meet Department standards for timely access to care and services as specified in the county implementation plan and state-county intergovernmental agreements (managed care contracts per federal definition). Medical attention for emergency and crisis medical conditions must be provided immediately.
 - ii. The anticipated number of Medi-Cal eligible clients.
 - iii. The expected utilization of services, taking into account the characteristics and substance use disorder needs of beneficiaries.
 - iv. The expected number and types of providers in terms of training and experience needed to meet expected utilization.
 - v. The number of network providers who are not accepting new beneficiaries.
 - vi. 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 disable beneficiaries.

144. Medication Assisted Treatment Services: Counties must describe in their implementation plan how they will guarantee access to medication assisted treatment

services.

- a. Counties currently with inadequate access to medication assisted treatment services must describe in their implementation plan how they will provide the service modality.
- b. Counties are encouraged to increase medication assisted treatment services by exploring the use of the following interventions:
 - i. Extend NTP/OTP programs to remote locations using mobile units and contracted pharmacies which may have onsite counseling and urinalysis.
 - ii. Implement medication management protocols for alcohol dependence including naltrexone, disulfiram, and acamprosate. Alcohol maintenance medications may be dispensed onsite in NTPs/OTPs or prescribed by providers in outpatient programs.
 - iii. Provide ambulatory alcohol detoxification services in settings such as outpatient programs, NTPs/OTPs, and contracted pharmacies.
- c. Selection Criteria and Provider Contracting Requirements: In selecting providers to furnish services under this Pilot, counties must:
 - i. Must have written policies and procedures for selection and retention of providers that are in compliance with the terms and conditions of this amendment and applicable federal laws and regulations.
 - ii. Apply those policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services.
 - iii. Must not discriminate against persons who require high-risk or specialized services.
 - iv. May contract with providers in another state where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances.
 - v. Select only providers that have a license and/or certification issued by the state that is in good standing.
 - vi. Select only providers that, prior to the furnishing of services under this pilot, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations, have been screened in accordance with 42 CFR 455.450(c) as a “high” categorical risk prior to furnishing services under this pilot, have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104. DHCS shall deny enrollment and DMC certification to any provider (as defined in Welfare & Institutions Code section 14043.1), or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101),

that, at the time of application, is under investigation for fraud or abuse pursuant to Part 455 of Title 42 of the Code of Federal Regulations, unless DHCS determines that there is good cause not to deny enrollment upon the same bases enumerated in 42 CFR 455.23(e) If a provider is under investigation for fraud or abuse, that provider shall be subject to temporary suspension pursuant to Welfare & Institutions Code section 14043.36. Upon receipt of a credible allegation of fraud, a provider shall be subject to a payment suspension pursuant to Welfare & Institutions Code section 14107.11 and DHCS may thereafter collect any overpayment identified through an audit or examination. During the time a provider is subject to a temporary suspension pursuant to Welfare & Institutions Code section 14043.36, the provider, or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101), may not receive reimbursement for services provided to a DMC-ODS beneficiary. A provider, shall be subject to suspension pursuant to Welfare and Institutions Code section 14043.61 if claims for payment are submitted for services provided to a Medi-Cal beneficiary by an individual or entity that is ineligible to participate in the Medi-Cal program. A provider will be subject to termination of provisional provider status pursuant to Welfare and Institutions Code section 14043.27 if the provider has a debt due and owing to any government entity that relates to any federal or state health care program, and has not been excused by legal process from fulfilling the obligation. Only providers newly enrolling or revalidating their current enrollment on or after January 1, 2015 would be required to undergo fingerprint- based background checks required under 42 CFR 455.434.

- vii. Select only providers that have a Medical Director who, prior to the delivery of services under this pilot, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a “limited” categorical risk within a year prior to serving as a Medical Director under this pilot, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.
- viii. Counties may contract individually with licensed LPHAs to provide services in the network.
- ix. Must not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of their certification.
- x. Must enter into contracts with providers that they have selected to furnish services under this pilot program. All contracts with providers must include the following provider requirements:
 - A. Services furnished to beneficiaries by the provider under this amendment are safe, effective, patient-centered, timely,

culturally competent, efficient and equitable, as defined by the Institute of Medicine;

- B. Possess the necessary license and/or certification;
 - C. Maintain a safe facility by adhering to the state licensing and certification regulations;
 - D. Maintain client records in a manner that meets state and federal standards;
 - E. Shall meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation, for residential services only, prior to providing Pilot services;
 - F. Be trained in the ASAM Criteria prior to providing services;
 - G. Meet quality assurance standards and any additional standards established by the county or other evaluation process; and
 - H. Provide for the appropriate supervision of staff.
- xi. If a county elects to contract with a managed care plan to furnish services under this pilot, the contract must ensure that any provider furnishing services under this pilot on behalf of the managed care plan meets all of the requirements that apply to a provider (and any Medical Director) that is selected by a county under this section to furnish services under this Pilot.

145. 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.

- a. County Protest: Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision.
 - i. Counties shall have a protest procedure for providers that are not awarded a contract.
 - ii. The protest procedure shall include requirements outlined in the State/County contract.
 - iii. 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). If the county does not render a decision within 30 calendar days after the protest was filed with the county, the protest shall be deemed denied and the provider may appeal the failure to DHCS.
- b. DHCS Appeal Process: A provider may appeal to DHCS as outlined in Attachment Y.

146. Authorization: Counties must provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider. 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. Counties are required to track the number, percentage of denied and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved and denied. This prior authorization for residential services is compliant with the Medicaid-applicable parity requirements established by the Mental Health Parity and Addiction Equity Act. Non-residential services shall not require prior authorization.

- a. County Implementation Plan: Counties must submit to the State a plan on their implementation of DMC-ODS. The State will provide the template for the implementation plan, which is included here as Attachment Z. Counties cannot commence services without an implementation plan approved by the state and CMS. Counties must also have an executed State/County intergovernmental agreement (managed care contract per federal definition) with the county Board of Supervisors and approved by CMS. 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.
- b. One ASAM level of Residential Treatment Services is required for approval of a county implementation plan in the first year. The county implementation plan must demonstrate ASAM levels of Residential Treatment Services (Levels 3.1- 3.5) within three years of CMS approval of the county implementation plan and state-county intergovernmental agreement (managed care contract per federal definition). The county implementation plan must describe coordination for ASAM Levels 3.7 and 4.0.
- c. Upon CMS approval of the implementation plan and an executed contract, counties will be able to bill prospectively for services provided through this Pilot.
- d. Below is a summary of the requirements that must be submitted with the county implementation plan:

Care coordination strategy

- MOU with managed care plan
- DMC transitions, especially aftercare and recovery supports

<p>Service descriptions</p> <ul style="list-style-type: none"> • Withdrawal Management • Outpatient • Intensive Outpatient • NTP/OTP • Additional MAT • Residential • Recovery Services • Case Management • Physician Consultation • Two evidence-based practices • Any optional services (including partial hospitalization)
<p>Provider network development plan</p> <ul style="list-style-type: none"> • By service • With timeline pegged to specified timeliness standard • Network adequacy requirements (will vary by county)
<p>Phase-in description for a one-year provisional period*</p> <ul style="list-style-type: none"> • By service • With timeline and deliverables pegged to timeliness measure

*Only applies to counties unable to meet all mandatory requirements.

- 147. Provisional Option:** For counties that are unable to comply fully with the mandatory requirements upon implementation of this Pilot, at the time of approval by DHCS and CMS, there exists the option for a one-year provisional period. A one year-provisional option will provide counties the opportunity to participate in the DMC-ODS Pilot while taking the necessary steps to build system capacity, provide training, ensure appropriate care coordination, and implement a full network of providers as described in the Pilot.
- a. In order to apply for the one-year provisional option, a county must include with their implementation plan a strategy for coming into full compliance with the terms of this Pilot. Specifically, each county must describe the steps it will take to provide all required DMC-ODS services that it cannot provide upon initial DMC-ODS implementation. The county will assure that all DMC-ODS services will be available to beneficiaries (whether the services are provided in-network, out-of-network, or using telehealth) while meeting the timeliness requirement during the course of the one-year probation option.
 - b. At least sixty (60) days prior to the expiration of the one-year provisional period, counties must resubmit their revised implementation plans for renewal. The plans will describe how the county has implemented the requirements which they originally could not provide. DHCS and CMS will review the revised implementation plans, in conjunction with the state and county monitoring reports as described in Sections 5 and 6 of this amendment, to assess if the county is progressing towards complying fully with the terms of this Pilot. If a county originally awarded a one-year provisional option is able to fully comply with the terms of this Pilot upon

renewal, they will be eligible to receive approval to participate in the remainder of the Pilot. If a county originally awarded a one-year provisional option is not able to fully comply with the terms of this Pilot, DHCS and CMS may approve a renewal pursuant to a Corrective Action Plan (CAP). The CAP will describe how the county will continue to implement its phase-in approach pursuant to its implementation plan, and will assure that all DMC-ODS services are available to beneficiaries in the interim (whether the services are provided are in-network, out-of-network, or using telehealth) within the timeliness requirement.

- 148. State-County Intergovernmental Agreement (Managed Care Contract per federal definition):** DHCS will require a State-County intergovernmental agreement (managed care contract per federal definition) to be signed between the state and the county in opt-in counties, subject to CMS approval. The intergovernmental agreement will provide further detailed requirements including but not limited to access, monitoring, appeals and other provisions. Access standards and timeliness requirements that are specified and described in the county implementation plans will be referenced in the state/county intergovernmental agreements (managed care contract per federal definition). CMS will review and approve the State-County intergovernmental agreement (managed care contract per federal definition) to ensure that the DMC-ODS program is operated in a manner that reduces the risk of fraud and abuse to the maximum extent feasible.
- 149. Coordination with DMC-ODS Providers:** Counties will include the following provider requirements within their contracts with the providers.
- a. **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. Translation services must be available for beneficiaries, as needed.
 - b. **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 unless the client refuses to consent to sign a 42 CFR part 2 compliant release of information for this purpose.
 - c. **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. The two EBPs are per provider per service modality. Counties will ensure the providers have implemented EBPs. The State will monitor the implementation of EBP's during reviews. The required EBP include:
 - i. **Motivational Interviewing:** 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.

- ii. **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.
- iii. **Relapse Prevention:** A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention 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.
- iv. **Trauma-Informed Treatment:** Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.
- v. **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.

- 150. Beneficiary Access Number:** All counties shall have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services. Oral interpretation services must be made available for beneficiaries, as needed.
- 151. Beneficiary Informing:** Upon first contact with a beneficiary or referral, counties shall inform beneficiaries about the amount, duration and scope of services under this waiver in sufficient detail to ensure that the beneficiaries understand the benefits to which they are entitled.
- 152. Care Coordination:** Counties' implementation plans and state/county contracts (managed care contracts per federal definition) will describe their care coordination plan for achieving seamless transitions of care. Counties are responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the county will describe in the implementation plan and state/county intergovernmental agreement (managed care contracts per federal definition) how beneficiaries will access recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.
- a. The county implementation plan and state/county intergovernmental agreement (managed care contract per federal definition) will indicate whether their care transitions approach will be achieved exclusively through case management services or through other methods. The county implementation plan and state/county intergovernmental agreement (managed care contract per federal definition) will indicate which beneficiaries receiving SUD

services will receive care coordination.

- b. 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 Specialty Mental Health Managed Care Plan MOU. The components of the MOUs governing the interaction between the counties and managed care plans related to substance use disorder will be included as part of the counties' implementation plan. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s). Any MOU shall be consistent with the confidentiality provisions of 42 CFR Part 2.
- c. The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:
 - i. Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;
 - ii. Beneficiary engagement and participation in an integrated care program as needed;
 - iii. Shared development of care plans by the beneficiary, caregivers and all providers;
 - iv. Collaborative treatment planning with managed care;
 - v. Delineation of case management responsibilities;
 - vi. 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;
 - vii. Availability of clinical consultation, including consultation on medications;
 - viii. Care coordination and effective communication among providers including procedures for exchanges of medical information;
 - ix. Navigation support for patients and caregivers;
and
 - x. Facilitation and tracking of referrals between systems including bidirectional referral protocols.

153. Integration with Primary Care: DHCS is committed to participate in the Medicaid Innovation Accelerator Program initiative for substance use disorder, specifically in the Targeted Learning Opportunity topics on primary care and SUD integration.

DHCS is embarking on a strategy to integrate physical and behavioral health care services delivered to beneficiaries in order to improve health outcomes for beneficiaries with SUD and reduce costs in the Medi-Cal program. DHCS will explore options for identifying the best integration strategy upon approval of this waiver amendment and

will commit to specifying an integration approach by April 1, 2016. DHCS will produce a concept design for an integrated care model by October 1, 2016, with the goal of implementing physical and behavioral health integration by April 1, 2017.

- 154. ASAM Designation for Residential Providers:** In order to enroll in Medi-Cal and bill for services under the auspices of this waiver, all residential providers must be designated to have met the ASAM requirements described in STC 144. DHCS will develop a designation program by July 1, 2015 to certify that all providers of Adult and Adolescent Level 3.1-3.5 Residential/Inpatient Services are capable of delivering care consistent with ASAM criteria. As part of this designation program, DHCS will use an existing tool or develop a tool that includes the elements that define each sublevel of Level 3 services for Levels 3.1- 3.5, develop standard program audit materials and protocols, and implement the ASAM designation program. The timeline for this designation program is outlined in an attachment and will be technically amended after the program has been developed.
- 155. Services for Adolescents and Youth:** At a minimum, assessment and services for adolescents will follow the ASAM adolescent treatment criteria. In addition, the state will identify recovery services geared towards adolescents, such as those described in the January 26, 2015 CMS Informational Bulletin “Coverage for Behavioral Health Services for Youth with Substance Use Disorder”.
- 156. DMC-ODS State Oversight, Monitoring, and Reporting.**
 - a. **Monitoring Plan:** The State shall maintain a plan for oversight and monitoring of DMC- ODS providers and counties to ensure compliance and corrective action with standards, access, and delivery of quality care and services. The state/county intergovernmental agreement (managed care contracts per federal definition) will require counties to monitor providers at least once per year, and the state to monitor the counties at least once per year through the External Quality Review Organizations (EQRO). If significant deficiencies or significant evidence of noncompliance with the terms of this waiver, the county implementation plan or the state/county intergovernmental agreement are found in a county, DHCS will engage the county to determine if there challenges that can be addressed with facilitation and technical assistance. If the county remains noncompliant, the county must submit a corrective action plan (CAP) to DHCS. The CAP must detail how and when the county will remedy the issue(s). DHCS may remove the county from participating in the Pilot if the CAP is not promptly implemented.
 - b. **Timely Access.** The state must ensure that demonstration counties comply with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to Medi-Cal population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed. Access standards and timeliness requirements that are specified and described in the county implementation plans will be referenced in the state/county intergovernmental agreements (managed care contract per federal definition). Medical attention for emergency and crisis medical conditions must be provided immediately.

- c. **Program Integrity.** The State has taken action to ensure the integrity of oversight processes and will continue to closely monitor for any wrongdoing that impacts the DMC-ODS. The State will continue to direct investigative staff, including trained auditors, nurse evaluators and peace officers to continue to discover and eliminate complex scams aimed at profiting from Medi-Cal. Efforts include extensive mining and analyzing of data to identify suspicious Drug Medi-Cal providers; designating DMC providers as “high” risk which requires additional onsite visits, fingerprinting and background checks (except for county providers); and regulations that strengthen DMC program integrity by clarifying the requirements and responsibilities of DMC providers, DMC Medical Directors, and other provider personnel. In conducting site visits of providers seeking to furnish services under this Pilot, the State shall conduct a site visit monitoring review of every site through which the provider furnishes such services. In addition, providers that have not billed DMC in the last 12 months have been and will continue to be decertified. Counties are required to select and contract with providers according to the requirements specified in section 4(iv) of this amendment

The State will ensure that the counties are providing the required services in the DMC- ODS, including but not limited to the proper application of the ASAM Criteria, through the initial approval in the county implementation plan and through the ongoing county monitoring. The State will conduct a state monitoring review for residential facilities to provide an ASAM designation prior to facilities providing Pilot services. This review will ensure that the facility meets the requirements to operate at the designated ASAM level (as explained in 4(k)).

- d. **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.
 - iii. Number of days to first DMC-ODS service at appropriate level of care after referral
 - iv. Existence of a 24/7 telephone access line with prevalent non-English language(s)
 - v. Access to DMC-ODS services with translation services in the prevalent non- English language(s)
 - vi. Number, percentage and time period of authorization requests approved or denied
- e. **Triennial Reviews:** During the triennial reviews, the State will review the status of the Quality Improvement 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. The State will follow-up with the POC to ensure compliance.

157. DMC-ODS County Oversight, Monitoring and Reporting. The intergovernmental agreement with the state and counties that opt into the waiver must require counties to have a Quality Improvement Plan that includes the county's 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 Mental Health Plan (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 with SUD participation 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 outlined in the Quality Improvement Plan will at a minimum include:
 - i. Timeliness of first initial contact to face-to-face appointment
 - ii. Timeliness of services of the first dose of NTP services
 - iii. Access to after-hours care
 - iv. Responsiveness of the beneficiary access line
 - v. Strategies to reduce avoidable hospitalizations
 - vi. Coordination of physical and mental health services with waiver services at the provider level
 - vii. Assessment of the beneficiaries' experiences
 - viii. Telephone access line and services in the prevalent non-English languages.
- c. Each county's QI Committee should review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol.
 - i. Number of days to first DMC-ODS service at appropriate level of care after referral
 - ii. Existence of a 24/7 telephone access line with prevalent non-English language(s)
 - iii. Access to DMC-ODS services with translation services in the prevalent

- non- English language(s)
 - iv. Number, percentage of denied and time period of authorization requests approved or denied
- d. 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. Counties shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at an appropriate level of care following initial request or referral for all DMC- ODS services.
- e. Counties will provide the necessary data and information required in order to comply with the evaluation required by the DMC-ODS.

158. DMC-ODS Financing For claiming federal financial participation (FFP), Counties will certify the total allowable expenditures incurred in providing the DMC-ODS waiver services provided either through county-operated providers (based on actual costs, consistent with a cost allocation methodology if warranted), contracted fee-for-service providers or contracted managed care plans (based on actual expenditures). For contracted FFS providers, counties will propose county-specific rates except for the NTP/OTP modality and the State will approve or disapprove those rates. NTP/OTP reimbursement shall be set pursuant to the process set forth in Welfare and Institutions Code Section 14021.51. All NTP/OTP providers contracting with counties shall provide their county with financial data on an annual basis. This data is to be collected for the purpose of setting the rates after the expiration of the waiver. The DHCS Rates Setting Workgroup shall propose a recommended format for this annual financial data and the State will approve a final format. Counties shall provide this financial data to the DHCS Rates Setting Workgroup upon its request. The provision in the Welfare and Institutions Code, Section 14124.24(h)) remains in effect and NTPs/OTPs will not be required to submit cost reports to the counties for the purpose of cost settlement.

- a. If during the State review process, the State denies the proposed rates, the county will be provided the opportunity to adjust the rates and resubmit to the State. The State will retain all approval of the rates in order to assess that the rates are sufficient to ensure access to available DMC-ODS waiver services. Rates will be set in the State and County intergovernmental agreement. For contracted managed care plans, counties will reimburse the managed care organizations the contracted capitation rate. A CMS-approved CPE protocol, based on actual allowable costs, is required before FFP associated with waiver services is made available to the state. This approved CPE protocol (Attachment AA) must explain the process the State will use to determine costs incurred by the counties under this demonstration.
- b. Only state plan DMC services will be provided prior to the DHCS and CMS approval of the State/County intergovernmental agreement (managed care

- contract per federal definition) and executed by the County Board of Supervisors. State plan DMC services will be reimbursed pursuant to the state plan reimbursement methodologies until a county is approved to begin DMC-ODS services.
- c. SB 1020 (Statutes of 2012) created the permanent structure for 2011 Realignment. It codified the Behavioral Health Subaccount which funds programs including Drug Medi- Cal. Allocations of Realignment funds run on a fiscal year of October 1-September 30. The monthly allocations are dispersed to counties from the State Controller's Office. The Department of Finance develops schedules, in consultation with appropriate state agencies and the California State Association of Counties (CSAC), for the allocation of Behavioral Health Subaccount funds to the counties. The base has not yet been set, as the State assesses the expenditures by county for these programs. The state will continue to monitor the BH subaccount and counties to ensure that SUD is not artificially underspent.
 - d. Subject to the participation standards and process to be established by the State, counties may also pilot an alternative reimbursement structure, including but not limited to, for a DMC-ODS modality if both the provider of that modality and the county mutually and contractually agree to participate. This may include use of case rates. The State and CMS will have the final approval of any alternative reimbursement structure pilot proposed by the county, and such pilot structure must continue to meet the terms and conditions expressed herein, including but not limited to, the rate approval process described above.

159. DMC-ODS Evaluation Through an existing contract with DHCS, University of California, Los Angeles, (UCLA) Integrated Substance Abuse Programs will conduct an evaluation to measure and monitor the outcomes from the DMC-ODS Waiver. The design of the DMC-ODS evaluation will focus on the four key areas of access, quality, cost, and integration and coordination of care. Specifically, the data collection, reporting and analysis strategy for this waiver program will be designed to assess:

- a. The impact of providing intensive outpatient SUD services in the community;
- b. The effectiveness of drug based SUD treatments;
- c. The impact of providing residential SUD services;
- d. Whether the length of stay of residential SUD services affects the impact of such services; and
- e. 5) Whether the residential treatment methods affect the impact of such services.

These impacts will be assessed in terms of beneficiary access, health care costs, outcomes and service utilization, and will utilize a comparison between comparable populations in opt-in counties and other counties. The measurement strategy will track readmission rates to the same level of SUD care or higher, emergency department utilization and inpatient hospital utilization. The measurement strategy will also evaluate successful care transitions to outpatient care, including hand-offs between levels of care within the SUD continuum as well as linkages with primary care upon discharge.

California will utilize the SUD data system currently in place known as the California Outcomes Measurement System (CalOMS). CalOMS captures data from all SUD treatment providers which receive any form of government funding. The CalOMS data set, along with additional waiver specific data, will enable the State to evaluate the effectiveness of the DMC-ODS. The design of the evaluation is contained in Attachment DD, UCLA Evaluation. The state will submit the complete design of the evaluation within 60 days of the approval of the amendment.

One of the focuses of the first year of the evaluation will be that each opt-in county has an adequate number of contracts with NTP providers, access to NTP services has remained consistent or increased and that no disruption to NTP services has occurred as a result of the DMC-ODS.

160. Federal 42 CFR 438 and other Managed Care Requirements

- a. Any entity that receives a prepayment from the state to provide services to beneficiaries will be considered by federal definition, a managed care plan and held to all federal 42 CFR 438 requirements and requirements in this section. Accordingly, counties participating in this DMC-ODS Pilot program will be considered managed care plans. CMS will waive the following 438 requirement(s):
 - i. 438.310-370 (External Quality Review Organizations, or EQROs). Opt-in counties will include in their implementation plan a strategy and timeline for meeting EQR requirements. EQR requirements must be phased in within 12 months of having an approved implementation plan. EQRO monitoring visits will begin in March 2016 in Phase One counties and Phase Two counties will begin in September 2016. By January 2017, the EQRO will begin monitoring all Pilot counties phased into the DMC-ODS.
 - ii. Implementation cannot begin prior to CMS review and approval of the State/County intergovernmental agreement (managed care plan contracts per federal definition).
 - iii. At least sixty (60) days prior to CMS contract approval the state shall submit for each opt-in county the applicable network adequacy requirements as part of the county implementation plan. CMS concurrence with standards is required.
 - iv. At least sixty (60) days prior to CMS contract approval the state shall provide all deliverables necessary to indicate compliance with network adequacy requirements.

Attachment X
Drug Medi-Cal Organized Delivery System (DMC-ODS)
Operational Protocol

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. With assistance from the State, counties will facilitate ASAM provider trainings.

All residential providers must be designated to have met the ASAM requirements and receive a DHCS issued ASAM designation. DHCS will develop a designation program to certify that all providers of Adult and Adolescent Level 3.1-3.5 Residential/Inpatient Services are capable of delivering care consistent with ASAM Criteria. As part of this designation program, DHCS will develop a tool that includes the elements that define each sublevel of Level 3 services for Levels 3.1-3.5, develop standard program monitoring materials and protocols, and implement the ASAM designation program. After developing the protocol and monitoring tool, DHCS will designate all current residential providers which will require initial paperwork and a DHCS designation. DHCS will then fold the ASAM designation process into the initial licensing process so all new residential providers will have an ASAM designation.

Attachment Y
Drug Medi-Cal Organized Delivery System (DMC-ODS)
Department of Health Care Services (DHCS) Appeals Process

1. Following a county's contract protest procedure, a provider may appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.
2. A provider may appeal to DHCS, following an unsuccessful contract protest, if the provider meets all objective qualifications and it has reason to believe the county has an inadequate network of providers to meet beneficiary need and the provider can demonstrate it is capable of providing high quality services under current rates, and:
 - A. It can demonstrate arbitrary or inappropriate county fiscal limitations; or
 - B. It can demonstrate that the contract was denied for reasons unrelated to the quality of the provider or network adequacy.
3. DHCS does not have the authority to enforce State or Federal equal employment opportunity laws through this appeal process. If a provider believes that a county's decision not to contract violated Federal or State equal employment opportunity laws, that provider should file a complaint with the appropriate government agency.
4. A provider shall have 30 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.
5. The provider shall include the following documentation to DHCS for consideration of an appeal:
 - a) County's solicitation document;
 - b) County's response to the county's solicitation document;
 - c) County's written decision not to contract
 - d) Documentation submitted for purposes of the county protest;
 - e) Decision from county protest; and
 - f) Evidence supporting the basis of appeal.
6. The county shall have 10 working days from the date set forth on the provider's proof of service to submit its written response with supporting documentation to DHCS. In its response, the County must include the following documentation: 1) the qualification and selection procedures set forth in its solicitation documents; 2) the most current data pertaining to the number of providers within the county, the capacity of those providers, and the number of beneficiaries served in the county, including any anticipated change in need and the rationale for the change; and 3) the basis for asserting that the appealing Provider should not have been awarded a contract based upon the County's solicitation procedures. 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.

Attachment Y
Drug Medi-Cal Organized Delivery System (DMC-ODS)
Department of Health Care Services (DHCS) Appeals Process

7. 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 with subject matter knowledge will be present to facilitate the discussion.
8. Following the facilitated discussion, DHCS will review the evidence provided and will make a determination.
9. Following DHCS' determination that the county must take further action pursuant to Paragraph 8 above, the county must submit a Corrective Action Plan (CAP) to DHCS within 30 days. The CAP must detail how and when the county will follow its solicitation procedure to remedy the issues identified by DHCS. DHCS may remove the county from participating in the Waiver if the CAP is not promptly implemented. If the county is removed from participating in the Waiver, the county will revert to providing State Plan approved services.
10. The decision issued by DHCS shall be final and not appealable.