The Department of Health Care Services (DCHS) recently released revised draft special terms and conditions for the Drug Medi-Cal (DMC) Organized Delivery System (ODS) Waiver in October. This brief summarizes the main parts of the special terms and conditions (STCs) and provides comments about the most recent draft as the waiver process moves toward submission to CMS. DCHS’ proposals regarding the financing of waiver services are forthcoming.

**What’s in the DMC waiver?**

**Opting In**

The State has designed the DMC-ODS waiver to allow counties the choice of opting into the waiver or declining to participate. Only Medi-Cal beneficiaries who reside in counties that opt in (and in covered geographic service areas of those counties) will be able to receive new services available under the waiver. Counties will also have the option to jointly opt in and create regional delivery systems to provide one or more of the required treatment modalities included in the waiver services.

**Benefits**

DHCS released an outline of a newly organized delivery system for Drug Medi-Cal, which we believe represents a major step forward for the program, and more importantly for Medi-Cal beneficiaries. The STCs articulate a coordinated continuum of services that the expanded DMC benefit made newly available in 2014. The continuum of services is based on criteria of the American Society for Addiction Medicine (ASAM) criteria and range from early intervention to intensive inpatient services. (The chart below is pasted from the STCs and outlines the continuum of services that would be provided through the waiver.)

<table>
<thead>
<tr>
<th>ASAM Level of Care</th>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>Early Intervention</td>
<td>Assessment and education for at-risk individuals who do not meet diagnostic criteria for SUD</td>
</tr>
<tr>
<td>1</td>
<td>Outpatient Services</td>
<td>Less than 9 hours of service per week for adults and less than 6 hours per week for adolescents for recovery or motivational enhancement therapies or strategies</td>
</tr>
<tr>
<td>2.1</td>
<td>Intensive Outpatient Services</td>
<td>9 or more hours of service per week for adults and 6 or more hours per week for adolescents to treat multidimensional instability</td>
</tr>
<tr>
<td>2.5</td>
<td>Partial Hospitalization Services</td>
<td>20 or more hours of service per week for multidimensional instability not requiring 24-hour care</td>
</tr>
<tr>
<td>3.1</td>
<td>Clinically Managed Low-Intensity Residential Services</td>
<td>24-hour structure with available trained personnel, at least 20 hours of clinical service per week</td>
</tr>
<tr>
<td>3.3</td>
<td>Clinically Managed Population-Specific High-Intensity Residential Services</td>
<td>24-hour care with trained counselors to stabilize multidimensional imminent danger; less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community</td>
</tr>
<tr>
<td>3.5</td>
<td>Clinically Managed High-Intensity</td>
<td>24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for</td>
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</tbody>
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1 California expanded substance use disorder services to include intensive outpatient treatment (also known as day care rehabilitative services) for all beneficiaries (previously only available for pregnant/post-partum women and EPSDT-eligible youth); pending CMS approval, residential SUD services will be available to all beneficiaries (also previously only available for pregnant/post-partum women); and a new elective inpatient detoxification benefit will be created.
### Residential Services

<table>
<thead>
<tr>
<th>Residential Services</th>
<th>outpatient treatment; able to tolerate and use full milieu or therapeutic community</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.7</td>
<td>Medically Monitored Intensive Inpatient Services 24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3; counselors available 16 hours a day</td>
</tr>
<tr>
<td>4</td>
<td>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</td>
</tr>
<tr>
<td>OTP</td>
<td>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</td>
</tr>
</tbody>
</table>

### Residential Treatment

DHCS has proposed a non-institutional, 24-hour, non-medical, short-term residential treatment program that would be limited to a maximum of 90 days for adults and 30 days for adolescents. Treatment services would be provided in facilities that are licensed and have DMC certification, and facilities would not need to have any bed limit.

The State also includes a “Recovery Residence” benefit that will not be reimbursable through Medicaid because of the IMD exclusion. The Recovery Residence would provide “a safe and healthy living environment to initiate and sustain recovery.” The benefit cannot include treatments for which a residential treatment license is necessary, and the service will also be optional for counties that chose to participate in the new ODS waiver. The state proposes to use Substance Abuse Prevention and Control (SAPT) Block Grant funds for the Recovery Residence; however, DHCS would need approval from the federal Substance Abuse and Mental Health Service Administration (SAMHSA) to fund the benefit in this manner. The Recovery Residence benefit will be dropped from the waiver if the State does not receive the required approval.

### Medication-Assisted Treatments

The STCs also explicitly identify medication-assisted treatments (MATs) as an important priority. The ASAM continuum of services includes MATs, and the waiver signifies a goal of increasing access to prescription medications for addiction, which clients cannot receive in a DMC facility. DHCS indicated the possibility that counties could engage more proactively with primary care providers to create referral networks from which clients could receive prescriptions. The waiver also proposes that Narcotic Treatment Program (methadone) providers serve as additional access points for MATs.

### Care Management

The waiver would use the ASAM criteria to determine medical necessity for different kinds of treatment, and to ensure that beneficiaries receive the right level of services, in the right setting, and at the right time. Basing the continuum of benefits on the ASAM criteria allow for client treatment in the least restrictive and most clinically appropriate setting. This foundation for client placement and care management processes would be central to an organized delivery system.

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2 The implementation of residential treatment services has been a difficult piece of the expansion of DMC that the California Legislature and Governor authorized last year. The federal Centers for Medicare and Medicaid Services (CMS) must approve the expanded benefits through a Medicaid State Plan Amendment (SPA) for the state to receive federal matching funds for these services. However, a federal law, the Institutions for Mental Diseases (IMD) exclusion, restricts federal Medicaid funds to inpatient mental health facilities with 16 or fewer beds. In California, the number of available facilities that meet the federal criteria is woefully inadequate to accommodate individuals who may need the newly available benefit. Therefore, DHCS has engaged CMS in a discussion about how to make these services available in a way that adheres to the IMD exclusion.

3 Licensure is required when at least one of the following services is provided: detoxification, group sessions, individual sessions, educational sessions, or alcoholism or drug abuse recovery or treatment planning.
To ensure that care processes follow these guidelines and accommodate clients to the greatest extent possible, the waiver also includes case management as a billable service. Case managers would monitor clients’ response to and engagement in treatment, and ensure that clients are connected to needed providers and services. The waiver also describes these managers as coordinating interactions with other physical and mental health care providers, as well as the criminal justice system when appropriate. In fact, the STCs include a section that specifically addresses the special needs of individuals leaving jail or prison and identifies service coordination with the criminal justice system as a function of these professionals.

Selective Contracting and DMC Provider Certification

Under the waiver, counties that opt in will have the ability to selectively contract with providers, and providers denied a contract with a county may not receive a direct contract from the state. Counties would also have the option to contract with managed care plans to provide waiver services. The waiver stipulates that selective contracting cannot restrict access to services, which must remain at current or greater levels. The STCs include requirements that counties have provider selection criteria with specific metrics (licensing, recordkeeping, quality assurance) that must be considered in the contracting process, and describe the DHCS appeals process for providers that are denied a contract.

Additionally, DHCS will delegate to the counties the responsibility for certifying providers for the DMC program, including responsibility for onsite reviews in that process. The State will then review the counties’ recommended certifications and issue final certification decisions.

County Implementation Plans

The waiver requires all counties that opt in to submit implementation plans for their organized delivery systems, and counties will have one year to execute their plans. The implementation plans must require that providers are:

- Certified to participate in DMC
- Implementing at least two evidence-based practices
- Trained in ASAM criteria
- Participating in efforts to promote culturally competent service delivery

Counties must also articulate how they will increase access to adolescent services and make available the services that would be newly offered as a result of opting into the waiver.

Coordinating Services with Medi-Cal Managed Care Plans

Counties must develop an MOU with local Medi-Cal managed care plans to coordinate the delivery of SUD services with primary care and physical health services. Managed care plans already have MOUs with county mental health plans that deliver specialty mental health services, and the agreements related to DMC waiver services could be an addendum to those existing MOUs. The STCs state that the MOUs should specify procedures for referrals, clinical consultations, care management, information sharing, and dispute resolution.

The waiver names coordination activities that should occur between counties’ SUD provider networks and those of local Medi-Cal managed care plans, although they are not required elements of MOUs with managed care plans. Providers within these networks should ensure comprehensive screening for physical and behavioral health conditions, including both mental health and substance use disorders; unified treatment planning among a beneficiary’s multiple providers; care coordination and navigation; and tracking referrals across systems.

Oversight

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Evidence-based practices include: motivational interviewing, cognitive-behavioral therapy, relapse prevention, trauma-informed treatment, and pyscho-education.
The STCs include provisions regarding oversight of the DMC organized delivery system at both the state and county levels. At the state level, DHCS would submit Quarterly and Annual Progress Reports to CMS, pursuant to the reporting requirements of the waiver. These reports would provide a summary of enrollment, operational and policy developments, and grievances and appeals. The State would also submit a triennial review that outlines a quality improvement plan and the results of county monitoring.

At the county level, the waiver would require a quality improvement plan to monitor the service delivery capacity of the provider network. Since many counties’ mental health and substance use agencies are housed within one department, those counties would have the option to combine their DMC quality improvement plan with that for their mental health plan. Each participating county would also have to have a county quality improvement committee for DMC services, and the committee would review performance and make policy recommendations. Counties’ quality improvement committees would be charged with reviewing the timeliness of first face-to-face appointments and urgent care, access to after-hours care, and responsiveness of the 24/7 toll free help number.

Counties would also be required to have a utilization management program that would ensure access to services, appropriate assignments to different levels of care, and appropriate treatments for individual clients.

**Financing**

Details of the waiver financing are forthcoming.

**How are we doing?**

The draft STCs of the DMC ODS waiver are a large step forward for Drug Medi-Cal, its beneficiaries, and California’s safety net. The benefits that STCs describe are critical for many enrolled in Medi-Cal who struggle with addiction. The State’s plan to increase access to MATs and its attempt to include a residential treatment benefit could allow individuals with some of the most severe substance use disorders to finally be able to access the treatment they need to manage their conditions. Further, allowing counties to selectively contract with providers has the potential to increase accountability for the quality of services and program integrity.

We strongly support the goal of creating an integrated safety net delivery system. We applaud the portions of the waiver that seek to coordinate SUD services with physical and mental health services, and the criminal justice system. The inclusion of case management as a waiver benefit and MOUs between county DMC programs and managed care plans will be central to reaching those goals.

We urge DHCS to provide further clarification and specificity for some elements of the waiver. The content DHCS provides in the current draft STCs provides a very promising foundation for an organized delivery system. However, more guidance would enable counties, providers, and stakeholders to be most effective in realizing these goals. While preserving flexibility for counties to respond to local needs remains very important in a state as large and diverse as California, more specific objectives and benchmarks would allow stakeholders to offer more informed feedback and more easily develop implementation plans.

**State Oversight**

Oversight has been a major problem for the DMC program, and to ensure program integrity and service quality, the portion of the waiver dedicated to this issue should be clear and robust. The STCs’ description of oversight activities includes a DHCS monitoring plan, Quarterly and Annual Progress Reports, and a triennial review. The STCs also list a range of appropriate and important oversight activities (e.g., data analysis, investigations, background checks, and site visits) and personnel (auditors, nurse evaluators, and peace officers) that would be very helpful in ensuring program integrity.
We also urge DHCS to specify the types of financial, utilization, and quality performance data that counties would be required to submit to DHCS to evaluate system and provider performance against best practices and broader historical and national trends—not just indicators of potential program integrity issues. These particulars of the monitoring plan will be very important because they would have a meaningful effect on the quality of services. This additional detail in the draft STCs would also allow counties to create more focused implementation, utilization management, and quality improvement plans.

Selective Contracting

DHCS provided some useful detail in its requirements for counties’ provider selection criteria, and the criteria heavily focused on ensuring beneficiaries’ access to services. We agree that this dimension of program performance must be a high priority. Yet, the STCs were fairly vague about other quality assurance metrics that counties would need to apply. The inclusion of the IOM’s six quality aims sets a good foundation with broad principles for measuring quality performance. The State should also set more specific benchmarks within each of these areas to ensure that counties and providers adhere to best practices in the field, while also allowing counties flexibility in establishing additional quality performance criteria, as the draft STCs currently do. Given the recent issues related to service quality in DMC, DHCS should be more prescriptive in setting statewide performance benchmarks to ensure an equitable level of quality and access to services.

County Implementation Plans

Stipulating that counties have implementation plans for meeting the requirements of the waiver is an important piece of DHCS’ proposal. These documents will be the primary tools for guiding counties’ DMC waiver programs toward the most successful implementation possible. Counties will have to articulate in these documents how they will meet many of the requirements for participating in the waiver. To allow county officials to begin a dialogue with the State about what approaches would be most effective, DHCS should establish the basic required elements of the plans as fully and as soon as possible.

The STCs should provide counties with further guidance regarding the necessary pieces of their implementation plans to make planning processes more focused and efficient, while still allowing flexibility to innovate and be responsive to local needs. In addition to the fundamental pieces that the draft STCs currently mention, it seems likely that counties would outline in this document how they would implement a utilization management program, develop a case management program, coordinate services with criminal justice partners, and craft an MOU with Medi-Cal managed care plans. This guidance would allow counties to expeditiously begin planning processes after the waiver is approved.

Utilization Management Programs

The requirement that counties operate utilization management (UM) programs has the potential to ensure that clients receive the most appropriate and effective care in the least restrictive setting. As a consequence, this component is central to improving quality and controlling program costs. The draft STCs establish clear rules (with the ASAM criteria) for care placement and medical necessity decisions, and effective UM is necessary to ensure that these decisions happen in a timely fashion, not retrospectively after quarterly, annual, or triennial reviews or reports.

Again, we urge DHCS to provide more specificity for the requirements of county UM programs so that the new benefits can have the greatest possible positive impact on clients. It is clear from the STCs that DHCS expects UM programs to ensure access to services and that individuals receive appropriate care in the appropriate setting. The STCs ought to list the required functions of a utilization management program and articulate requirements for the timeliness and frequency of utilization assessments for the range of waiver services. This detail would be useful because some services and facilities may require a different frequency or type of monitoring than others. It would also be important that the activities of UM programs align closely with the processes that counties establish for initial eligibility determinations for waiver services.
County Quality Improvement Strategies

The requirements for counties to submit a quality improvement plan to the State, and to establish a quality improvement committee are valuable additions to the terms of participation in the waiver. While the STCs list access to and timeliness of services as required elements of quality improvement plans, DHCS should require additional dimensions of performance. For example, DHCS could require counties to develop strategies to reduce avoidable hospitalizations, to coordinate physical and mental health services with waiver services at the provider level, to assess patient experiences, or to ensure cultural competency. The waiver could allow counties flexibility to accommodate specific local needs by providing a menu of items from which counties can choose, similar to its approach to incorporating evidence-based practices into providers’ care delivery patterns. In addition, more detail about the structure and timeline of the counties’ quality improvement plans would be helpful to their quality improvement committees as they anticipate future assessment activities and action plans.

Care Coordination with Physical, Mental Health, and Social Services

Case management has the potential to be a valuable tool for coordinating DMC services with physical and mental health services, as well as the criminal justice system. Case managers would be very important to ensuring that clients receive the most appropriate treatment, remain engaged in treatment, and get connected to the full range of services that they need. For individuals with SUDs, their primary contact to the health care system and the Medi-Cal program may be their SUD service provider. These professionals would allow for the SUD treatment delivery system to inform the treatment plans of other physical and mental health care providers, and vice versa. When possible, skillfully coordinating and managing as many of a beneficiary’s needed services as possible has the potential to increase the effectiveness of services.

For all of these reasons, the requirement of an MOU between the county DMC-ODS and the local Medi-Cal managed care plans provides a foundation for coordinated services between the two delivery systems. The STCs name referral protocols, care management, clinical consultation, medication management, and the exchange of medical information between the delivery systems as necessary basic elements of MOUs. Each of these elements is necessary for 1) collaborative treatment planning and 2) an integrated care program. According to the STCs, these two alignments “should be implemented at the point of care.” Yet, DHCS should also require that the county DMC programs and health plans explicitly include these two elements in their MOUs. An expectation that the involved administrative entities create agreements that organize and continuously facilitate these provider-level collaborations would more be more effective in establishing coordinated care and, when possible, unified treatment plans.

Waiver provisions to connect the DMC delivery system to the criminal justice system are also very encouraging and could be very impactful. DMC-supported case managers could provide valuable links between Medi-Cal services and AB 109 programs for individuals serving split sentences or reentering communities from incarceration. DMC case managers can communicate with probation officers to create the most beneficial community reentry and treatment plan for beneficiaries. These professionals could coordinate appointments among different service providers and collaborate with each other and the beneficiary to draft a successful comprehensive community reentry plan involving all needed services. DMC case managers could also support beneficiaries in adhering to the terms of their community supervision, such as maintaining appointments or remaining engaged in a treatment or rehabilitative program. These professionals may be well positioned to serve in this role because they have the potential to build trust with beneficiaries by serving as important primary contacts during treatment and reentry.

Mapping a Path Forward

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6 AB 109 refers to state legislation that enacted Public Safety Realignment of 2011, which transferred responsibility for supervising certain low-level offenders from the state prisons to the county jails.
The STCs outline a very ambitious plan for DMC and would represent a vast improvement from the current program. The added services and program enhancements could make a tremendous difference in the effectiveness of DMC and the lives of beneficiaries. We applaud DHCS for undertaking this project and support its efforts to make it a reality. Many of our comments urge DHCS to provide more detail and clarity for counties in the STCs. With more guidance, the counties, providers, and all stakeholders would have a fuller outline of the objectives that the State intends to reach—and how all stakeholders can work together to reach them. In sum, we are glad to see DHCS to articulate a vision for DMC in this waiver, and we encourage the State to maximize its chances for success by setting a clear path forward to that goal.