Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL

Drug Medi-Cal
Organized Delivery System
(DMC-ODS)

Stakeholder Process
Kick-Off Meeting
August 13, 2015

Public Health

How the Affordable Care Act (ACA) is Transforming Delivery of Substance Use Disorder (SUD) Services

Wesley L. Ford, M.A., M.P.H.
Director
Substance Abuse Prevention and Control

Public Health

Expansion of Substance SUD Services under ACA

August 13, 2015
SAPC Launches DMC-ODS Stakeholder Process to Officially Launch Efforts to Expand and Improve SUD Services in LAC

November 21, 2014
DHCS Submits DMC-ODS Waiver Amendment to CMS
Expands available levels of care, adopts ASAM criteria, supports quality assurance/utilization management

January 1, 2014
Medi-Cal Eligibility Expansion
New beneficiaries now include single adults without children, with income up to 138% Federal Poverty Level (FLP)

March 23, 2010
President Obama Signs the Affordable Care Act (ACA) to Achieve the "Triple Aim"
1. Improving the Individual Experience of Care
2. Improving the Health of Populations
3. Reducing the Per Capita Costs of Care for Populations

The healthcare system has been in transition since adoption of the Affordable Care Act (ACA) in 2010. With expansion of the Medi-Cal eligible population in January 2014 and the State's submission of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver to the Centers for Medicare and Medicaid (CMS) in November 2014, the substance use disorder (SUD) system is on the pathway to parity with the physical and mental health systems. This will be a long, and at times challenging transition for our field, but necessary to improve the quality and availability of services that will lead to better health and social outcomes for our clients.

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New Opportunities for SUD System and its Clients

- A full continuum of care for Medi-Cal eligible clients
- New reimbursable services to improve quality of care
- Integration of care with physical and mental health
- Solidify SUD's status as a chronic health condition rather than an acute health condition

This is a time of new opportunities for our system of services and the clients it serves:

- The DMC-ODS Waiver will contribute to a more robust system of care due to expansion in DMC funded levels of care (formerly modalities) that now include withdrawal management (formerly known as detox) and residential services, as well as improved outcomes because services can better match the client's real level of need.
- It will also be an opportunity for us to significantly expand services for youth and young adults, and implement more programs that are developmentally appropriate.
- Both the County and providers will need to prioritize integration and coordination of SUD services with those of physical and mental health to improve client level outcomes and achieve system level change.
- Overall, this transformation will solidify SUD as a chronic health condition like diabetes which is managed over the long-term through appropriate services and care management rather than as an acute condition like an asthma attack where services are available based on an immediate or life-threatening need. With this, it is time for the SUD system's time to embrace its new role as an integral member of a coordinated health care system.

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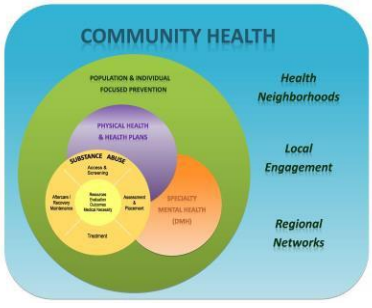
Integrated SUD – MH – HS Services: Essential Components in Supporting Community Health



This transformation not only necessitates increased collaboration and care coordination with the Departments of Health Services and Mental Health that have more traditionally served our clients but also with health plans such as LA Care and Health Net who with expansion of insurance benefits now manage the preventative health, sub-acute mental health and other general health services for a greater proportion of our population.

Increased collaboration and coordination, however, does not stop with these three systems (health, mental health, substance use) but instead must extend to the communities where individuals live and work to more fully achieve the prevention and community health goals of ACA. We will need to look to communities and other stakeholders to help identify key elements and considerations for achieving health and wellness at the local level, and how best to appreciate and address the varied needs and preferences of residents throughout Los Angeles County.

One way to do this is through developing, implementing, and coordinating services and projects locally through health neighborhoods or regional networks. We will be exploring how to best achieve this in the coming months.

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One Los Angeles County Health Agency

- On August 11, 2015 the Los Angeles County Board of Supervisors approved a motion to integrate the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) into a single health agency structure.
- Immediate steps include:
  - Draft a new County ordinance to allow implementation
  - Appoint an Interim Health Agency Director
  - Create a temporary oversight body that includes DHS, DMH, and DPH
  - Create an Integration Advisory Board
  - Draft a strategic plan
  - Create a community prevention and population taskforce

Efforts to improve coordination of health, mental health, and public health services may be enhanced through the integration of these three County departments. Some immediate steps are now underway but this too will be an extensive planning an implementation process and will impact SAPC development of its SUD prevention and treatment services.

As you will see in the presentations to follow, the SUD system will look very different from what we know today, but through collaboration, dedication, and time we will develop a system of care that better addresses the needs of our clients and contributes to improved health for all individuals residing in Los Angeles County.

Public Health

The Expanding DMC Eligible Population

Gary Tsai, M.D.
Medical Director and Science Officer
Substance Abuse Prevention and Control

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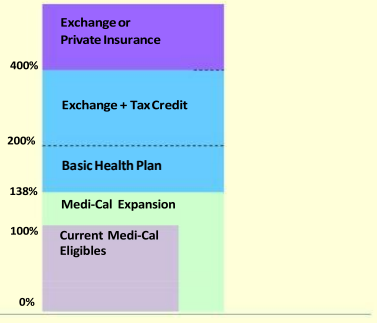
Who Will be at Our Door under the ACA?



Source: Alcohol and Drug Policy Institute Webinar Series (2013)

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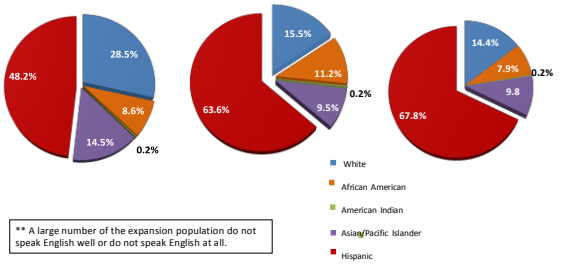
General, Current DMC, and Expansion Population, LAC 2013 (Adults)

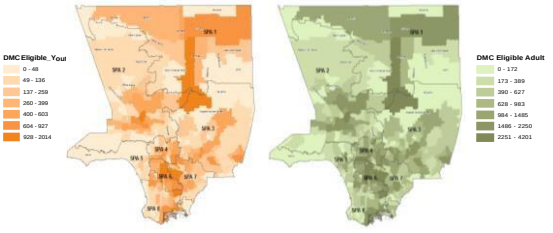
- General Population
- Current DMC Population (<100% FPL)
- Expansion Population (100-138% FPL)



** A large number of the expansion population do not speak English well or do not speak English at all.

Public Health

Drug Medi-Cal Eligible Youth and Adults (138% FPL)

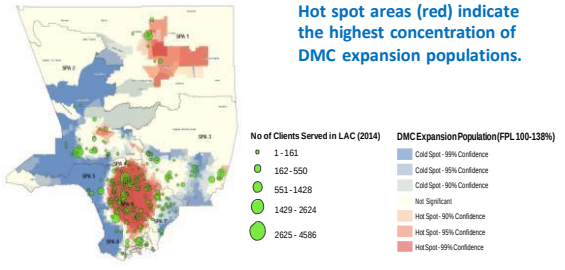


DMC Eligible Youth: No of youth at or below 138% (Numbers reflect 7.4% SUD prevalence)

DMC Eligible Adults: No of youth at or below 138% (Numbers reflect 13% SUD prevalence)

Public Health

Number of Clients Served and DMC Expansion Population Hot Spot Analysis (FPL 100 to 138%)



Hot spot areas (red) indicate the highest concentration of DMC expansion populations.

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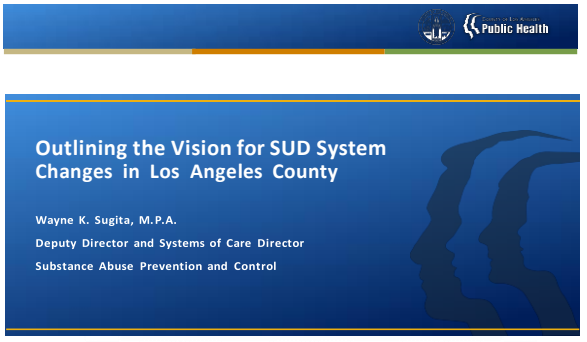
Populations NOT Served by Drug Medi-Cal

- Those who do not meet requirements of medical necessity, which is composed of diagnosis and intervention:
  - Meet current DSM diagnosis for a Substance Use Disorder
  - Recommended service meets level of intervention consistent with the current edition of the ASAM Criteria
- Undocumented individuals
- In-custody populations



It is clear through implementation of the Affordable Care Act (ACA), the California Department of Health Care Services (DHCS) Waiver application, and the recently released letter from the Centers for Medicare and Medicaid (CMS) titled *New Service Opportunities for Individuals with a Substance Use Disorder* that SUD services will be expanded and improved in the coming years. Therefore, SAPC drafted a document titled *Vision Description: Transforming the Los Angeles County Substance Use Disorder System of Care* to begin the dialogue with our contractors and stakeholders on what this could look like in our County.

While many of DHCS' DMC-ODS Standard Terms and Conditions are required as a condition of participation, there will be room to develop how these requirements will be implemented at the County level. Therefore, today we will go over key elements of SAPC's vision for the new system of care, and will look forward to continued input during the regional stakeholder process to be conducted in the next several weeks.

The Affordable Care Act and "Triple Aim" Prompted How the Healthcare System is Changing to Expand Access to Care and Improve Overall Health Outcomes.

SIMILARLY

California's DMC-ODS Waiver will Expand Access and the Variety of SUD Services Covered, and Prioritize Quality of Care that Meets the Clients' Level of Need while Improving SUD Outcomes and Overall Health.

Like what ACA has, and is, doing for the improving healthcare overall, California's DMC-ODS Waiver is intended to do for SUD system of care. With this process comes opportunity to expand the types of services available (what ASAM calls "levels of care") to clients, and thereby better ensure availability of services that meet the clients level of need rather than simply those that are immediately available or funded based on the clients insurance or referral source.

Foundational Principles for LAC's SUD Transformation

1. Treat substance use disorders as a chronic health condition
2. Provide coordinated and integrated care
3. Establish a single benefit package
4. Establish a patient-centered system
5. Maintain partnerships between SAPC and its community-based provider network
6. Educate, empower, and inform people and their communities
7. Establish a continuous improvement process for treatment services

These are the 7 foundational principles on which Los Angeles County will build the new SUD system of care for youth and adults. These principles will guide all of our planning, implementation and evaluation work done over the coming years. These concepts will be touched on throughout the presentation as we discuss our transformation into a specialty health plan.

See the *Vision Description: Transforming the Los Angeles County Substance Use Disorder System of Care* for more detail.

The Transition to a Specialty Health Plan Model

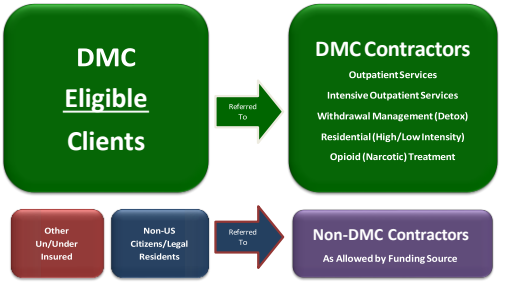
- Establishment of a SUD treatment and recovery continuum of care that integrates all of its revenue streams into a single benefit package. This would mean:
  - All SUD clients will have access to the same services regardless of referral source (e.g., CalWORKs, GR).
  - The DMC-ODS waiver application impacts all SAPC services not just the DMC system as it exists now.
  - DMC becomes the first payer for most treatment clients/services.
  - Type or level of coverage (e.g., DMC, un/under insured) will determine where clients are referred.

Los Angeles County's system will be transforming from a network of largely independent treatment providers to a well-coordinated system of care that functions as a specialty health plan.

One of the first steps in this process is establishing a single benefit package that integrates all revenue streams – Block Grant, DMC, CalWORKs, AB 109 etc. Moving forward, all clients will be eligible for the same services regardless of referral or funding source. In other words, persons receiving services will see themselves as an SUD client and not for example an AB109 or CalWORKs client. It will then be up to the County and providers to ensure funding sources are accurately billed and regulations complied with based on client eligibility.

Therefore, even though this is titled the "DMC-ODS" Waiver, is does not just impact the DMC system as we know it today but rather our entire system. The vast majority of our SUD clients will be Medi-Cal eligible and thus will need to be referred to DMC certified providers when a service is reimbursable by DMC funds. The type or level of coverage (e.g., DMC, un/under insured) will soon determine where a client can be referred.

Referrals/Admissions Based on Insurance Coverage



This change is demonstrated by the graphic shown. We expect that most of our clients will now be DMC eligible, requiring referral to a DMC certified outpatient, intensive outpatient, withdrawal management (formerly detox), residential and opioid (narcotic) treatment provider for services. Providers who do not have a DMC contract will soon only be able to receive referrals for the un- or under-insured or non-US citizens/legal residents as allowed by the funding source. Ideally, contractors will continue to have funding from multiple sources (e.g., DMC, AB109, Block Grant) to allow for the most comprehensive services for SUD clients as DMC funding still will not cover some necessary or required services such as recovery support.

Remember, this change will not be immediate as DHCS still needs to develop certification criteria for some levels of care (e.g., residential and withdrawal management). However, we encourage contract agencies to discuss the feasibility and desirability of applying for DMC certification if you have not already done so. SAPC will continue to provide information on DHCS' application process as it becomes available.

The Transition to a Specialty Health Plan Model (Cont.)

- Improve collaboration with physical and mental health to ensure care coordination and service integration for clients with SUD and other health conditions. This would mean:
  - Not only ensuring that clients receive appropriate and effective SUD services but also that physical and mental health conditions are well addressed and/or coordinated to support overall improved health.
  - SUD is a key component in the County healthcare system and not simply a separate carved-out service.

Another important component of the transition to a specialty health plan is improved collaboration with physical and mental health services. While it has always been important to ensure that a client's health and social needs are addressed to improve the likelihood of treatment success, it is now an even more integral component to service delivery. Counselors or case-managers will need to identify when a health, mental health, or other referral needs to be made throughout the treatment episode *and* follow-through to make sure the client accessed those desired services, or was encouraged to connect if ambivalent.

SUD is an integral part of the "three legged stool" that is healthcare and we need to grow into this new responsibility, our clients and partners in this transition.

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The Transition to a Specialty Health Plan Model (Cont.)

- Ensure delivery of services at the appropriate level of care and based on current client needs. This would mean:
  - Placing clients in the ASAM level of care (formerly modality) based on actual and current need, not what is available at that time or location.
  - Transitioning clients from one level of care to another based on progress or need, not a certain duration of service or to meet a standard benchmark.
  - Regularly evaluating the client for placement suitability, and providing case-management and recovery support services.

Perhaps most importantly is ensuring individualized and client centered services. This means that the provider will identify the appropriate level of care, frequency and duration of services that will be individualized for each client. For example, a common practice may be graduation from residential treatment being based on adhering to a 90-day stay, or 2 group session per week for 6-months for outpatient services, now an individual may complete services and transition to recovery support services or to a different level of care based on medical necessity and client need.

The American Society of Addiction Medicine (ASAM) Criteria will now be the guide to determine what level of care is most appropriate based on medical necessity. Qualified staff such as a licensed practitioners of the healing arts (LPHA) or certified counselors will need to regularly evaluate (not to be understood as a full clinical assessment) whether the current placement is most appropriate. Case-management and recovery support services will also be integral components throughout the treatment process.

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Draft Implementation Timeline

PHASE 1 1 Year from DHCS Approval*	PHASE 2 2 Years from DHCS Approval*	PHASE 3 3 Years from DHCS Approval*
Outpatient (Adults and Youth)	Low Intensity Residential (Youth and Adults)	High Intensity Residential Population Specific (Adults Only)
Intensive Outpatient (Adults and Youth)	Ambulatory Withdrawal Mgmt without extended on-site monitoring	
High Intensity Residential (Youth and Adults)	Ambulatory Withdrawal Mgmt with extended on-site monitoring	
Residential Withdrawal Mgmt (Adults Only)		
Opioid (Narcotic) Treatment (Adults Only)		
ASAM Criteria		
Evidence-Based Practices		
Beneficiary Call Line		
QA/UM Procedures		
Residential Authorization		
Case-Management		
Recovery Support Services		
Physician Consultation		

* The timeline is contingent on DHCS and CMS final guidelines and requirements, DHCS' certification approval process, SAPC solicitation requirements, and input from the stakeholder process. In general, items listed in phase one are required to be implemented in year one of the waiver.

Once the Board of Supervisors, DHCS and CMS approves Los Angeles County's DMC-ODS implementation plan, the expansion will be phased in over the next three years. The pilot project period is a total of five years and may be extended based on demonstrated outcomes.

The timeline is contingent on DHCS and CMS final guidelines and requirements, DHCS' certification approval process, SAPC solicitation requirements, and input from the stakeholder process.

In general, items listed in phase one are required to be implemented in year one of the waiver.

Public Health

ASAM Levels of Care - Adults

ADULT SUBSTANCE USE DISORDER (SUD) BENEFIT PACKAGE			
Level Of Care (LOC)	ASAM Level	DHCS ASAM Description	DMC-ODS LOC
Early Intervention	0.5	Screening, brief intervention, and referral to treatment.	No
Outpatient	1	Less than 9 hours of service per week for recovery or motivational enhancement therapies and strategies.	Yes
Intensive Outpatient	2.1	Nine (9) or more hours of service per week to treat multidimensional instability.	Yes
Partial Hospitalization	2.5	20+ hours of service per week for multidimensional instability. No 24-hour care.	No
Low Intensity Residential	3.1	24-hour structure with available trained personnel and at least 5 hours of clinical service per week. Prepare for outpatient treatment.	Yes
High Intensity Residential Population Specific	3.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive and other impairments unable to use full active milieu. Prepare for outpatient treatment.	Yes
High Intensity Residential Non-Population Specific	3.5	24-hour care with trained counselors to stabilize multidimensional imminent danger for individualsable to use full active milieu. Prepare for outpatient treatment.	Yes
Intensive Inpatient Services Medically Monitored	3.7	24-hour nursing care with physician availability for significant problems with ASAM Dimensions 1, 2, or 3. Includes counselor availability for 16 hours per day.	No
Intensive Inpatient Services Medically Managed	4.0	24-hour nursing care and daily physician care for severe, unstable problems with ASAM Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.	No
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	Yes
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.	Yes
Residential Withdrawal Management Clinically Managed	3.2-WM	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment and recovery.	Yes
Inpatient Withdrawal Management Clinically Managed	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.	No
Inpatient Withdrawal Management Medically Managed and Intensive Services	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	No
Opioid (Narcotic) Treatment Program	1-OTP	Daily or several time weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.	Yes

The next two slides outline in more detail what levels of care will be funded by DMC. These are also included as handouts.

The blue shaded levels of care is what will be expanded or become available under the adult service system. This includes various ASAM levels for outpatient, residential, withdrawal management (formerly detox), and opioid (narcotic) treatment programs. These services will soon be funded by DMC for Medi-Cal eligible beneficiaries.

Blue – Funded under DMC for eligible beneficiaries
Gray – Per DHCS, funded under another component of the system

Public Health

ASAM Levels of Care - Adolescents

ADOLESCENT SUBSTANCE USE DISORDER (SUD) BENEFIT PACKAGE

Level Of Care (LOC)	ASAM Level	DHCS ASAM Description	DMC-ODS LOC
Early Intervention	0.5	Screening, brief intervention, and referral as needed.	No
Outpatient	1	Less than 6 hours of service per week for recovery or motivational enhancement therapies and strategies.	Yes
Intensive Outpatient	2.1	Six (6) or more hours of service per week to treat multidimensional instability.	Yes
Partial Hospitalization	2.5	20+ hours of service per week for multidimensional instability. No 24-hour care.	No
Low Intensity Residential	3.1	24-hour structure with available trained personnel and at least 5 hours of clinical service per week. Prepare for outpatient treatment.	Yes
High Intensity Residential Population Specific	3.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive and other impairments unable to use full active milieu. Prepare for outpatient treatment.	N/A
High Intensity Residential Non-Population Specific	3.5	24-hour care with trained counselors to stabilize multidimensional imminent danger for individuals able to use full active milieu. Prepare for outpatient treatment.	Yes
Intensive Inpatient Services Medically Monitored	3.7	24-hour nursing care with physician availability for significant problems with ASAM Dimensions 1, 2, or 3. Includes counselor availability for 16 hours per day.	No
Intensive Inpatient Services Medically Managed	4.0	24-hour nursing care and daily physician care for severe, unstable problems with ASAM Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.	No
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	N/A
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.	N/A
Residential Withdrawal Management Clinically Managed	3.2-WM	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment and recovery.	N/A
Inpatient Withdrawal Management Clinically Managed	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.	N/A
Inpatient Withdrawal Management Medically Managed and Intensive Services	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	N/A
Opioid (Narcotic) Treatment Program	1-OTP	Daily or several time weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.	N/A

The pink shaded levels of care is what will be expanded or become available under the adolescent service system. This includes outpatient, intensive outpatient, low intensity residential, and high intensity residential. These services will soon be funded by DMC for Medi-Cal eligible beneficiaries. EPSDT (Early and Periodic Screening, Diagnosis and Treatment) will also play a role in the adolescent system of care but this will be further developed over time.

Pink – Funded under DMC for eligible beneficiaries
Gray – Per DHCS, funded under another component of the system
Black – Not an ASAM level for adolescents thus not a part of DMC-ODS

Public Health

DMC SERVICES THEN AND NOW

Primary Population Served	THEN	NOW (DMC-ODS)
Outpatient	All Eligible Beneficiaries <100% FPL	Adults up to 138% Federal Poverty Level (FPL) Children in Households up to 250% FPL
Intensive Outpatient (formerly Day Care Habilitative)	Pregnant/Post-Partum/Youth up to 21	Adults up to 138% FPL Children in Households up to 250% FPL
Narcotic Treatment Programs	All Eligible Beneficiaries based on Income	Adults up to 138% FPL

Select Services	THEN	NOW (DMC-ODS)
Individual Counseling	Admit/Discharge/Tx Plan/Crisis/Collateral	Yes
Family Counseling	No	Yes
Group Counseling	Yes	Yes
Patient Education	No	Yes
Case Management	No	Yes – Required but Funding Source TBD
Recovery Services	No	Yes – Required but Funding Source TBD

Level Of Care (LOC)	THEN	NOW (DMC-ODS)
Outpatient	Yes – Youth/Adults	Yes – Youth/Adults
Intensive Outpatient	Yes – Youth/Adults	Yes – Youth/Adults
Low Intensity Residential	No	Yes – Youth/Adults
High Intensity Residential: Population Specific	No	Yes - Adults
High Intensity Residential: Non-Population Specific	No	Yes – Youth/Adults
Ambulatory Withdrawal Management: Without Extended On-Site Monitoring	No	Yes - Adults
Ambulatory Withdrawal Management: With Extended On-Site Monitoring	No	Yes - Adults
Residential Withdrawal Management: Clinically Managed	No	Yes – Adults
Opioid (Narcotic) Treatment Program	Yes - Adults	Yes – Adults

For comparison, this table demonstrates what is currently funded by DMC and what is expected to be funded by DMC upon implementation of the DMC-ODS for participating Counties.

Eligibility has been significantly expanded for single adults, especially males.

Both the levels of care and the services are more robust and comprehensive. Until final guidelines and financing information is provided by DHCS and CMS, however, it is still unclear how certain mandated services such as recovery support will be reimbursed.

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Transformation Components of the SUD Redesign

- **System Capacity Building**
  - Network service capacity
  - Coordinated SUD continuum across levels of care
  - Care coordination with physical and mental health networks
- **Infrastructure Capacity Building**
  - Electronic health record and billing system
  - Quality assurance and utilization management

As indicated in the preceding slides, the system will be quickly expanding in the next one to two years. With this transformation, there are additional system and workforce capacity building efforts that need to occur concurrently. SAPC is committed to collaborating with its network partners to make the transition to a specialty health plan successful.

System Capacity Building – First, the system itself needs to expand - both in levels of care for youth and adults and also the locations where services are provided. Mechanisms need to be developed to ensure clients can move successful between the levels of care - both within a provider agency and across provider agencies. Care coordination with physical and mental health services needs to be effective, efficient, and consistent to ensure all the clients needs are well addressed.

Infrastructure Capacity Building – All providers need to implement an electronic health record, and the County is working to assist in this for agencies who do not already have a system in place. SAPC's billing system needs to be enhanced to manage and effectively utilize multiple funding sources. The County's Quality Assurance (QA) and Utilization Management (UM) program needs to be fully implemented, and contractor sites will need to ensure similar protocols within their programs.

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Transformation Components of the SUD Redesign

- **Workforce Development**
  - Patient centered treatment services approach
  - Determination of medical necessity/ASAM placement
  - Evidence based practices
  - Cultural and linguistic competence
  - Cross-system care coordination with mental health and primary care
- **Financing**
  - Financing a full continuum of services centered on DMC and supported by all other revenue streams

Workforce Development – Training and capacity building for our direct service staff and managers on these core topics is essential for effective implementation of this client centered and need based system. SAPC has begun training efforts on topics such as the ASAM criteria and Motivational Interviewing, and more will be done throughout the coming years. Given the size of our workforce, however, an emphasis will also need to be on train-the-trainer programs and provider funded trainings for staff.

Financing – The primary foundational principle of the Waiver is that through the expansion of the levels of care, a focus on evidence-based and client centered services, effective quality assurance and utilization management efforts, and with consideration to savings in other systems that this effort will be budget neutral statewide. It is the addition of these system improvements, however, that contributes to County abilities to negotiate rates, therefore, SAPC intends to propose DMC rates above current DMC levels and in closer alignment with our Rate Study. Some financial questions still need to be answered, but given the future direction of the health care system, and a desire to provide the most comprehensive and effective services for SUD clients, DPH is moving ahead with the planning process, and will continue to engage stakeholders in this process as we move forward.

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Designing and Implementing the Transformation

Each of these *Transformational Components* will require extensive planning, development and community collaboration for effective yet timely implementation. While the anticipated launch date is July 2016, full transformation will be phased in over the next several years.

The stakeholder process taking place between now and October to specifically review the DMC-ODS implementation plan/application is the first of many stakeholder/workgroup processes planned as part of this process.

Each of the *Transformational Components* described, and certainly others that arise throughout this process, will require extensive planning, development and community collaboration for effective yet timely implementation. We are targeting a launch date of July 2016, with the full system transformation phased in over the next several years.

The stakeholder process taking place between now and October to specifically review the DMC-ODS implementation plan/application is the first of many stakeholder/workgroup processes planned as part of this process.

Public Health

California's DMC-ODS Waiver Requirements and LA's Draft Plan, and New Responsibilities for Counties and Providers

Victor Kogler
Vice President
California Institute for Behavioral Health Solutions

The Broader Context

- Affordable Care Act
- Mental Health 1915(b) Waiver Renewal
- Medi-Cal 2020 1115 Waiver

What is an Organized Delivery System?

- It's not what we have now.
- What it is –
  - Continuum of Care – ASAM.
  - Integrated Services – Primary Care, Mental Health.
  - Coordinated multi-modality episodes of care.
  - Greater emphasis on compliance and quality.
  - Truly client focused.

Getting from Here to There

1. The rulebook is being rewritten.
2. We're all in this together.
3. Stakeholder and community involvement are essential.
4. Ultimately, it's all about helping more people achieve persistent benefit from treatment and experience lasting recovery.

Sources of New Requirements

1. Waiver Terms & Conditions
2. County Implementation Plan
3. State-County DMC/NNA Contract
4. Federal Regulations

DHCS DMC-ODS Standard Terms & Conditions:

New Program and Administrative Provisions

Medical Necessity

- Can be established by any licensed practitioner of the healing arts (LPHA).
  - MD, Nurse Practioner, Physician Assistant, Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor and appropriately supervised license-eligible practitioner.
- May be determined via telehealth technology.

Youth Treatment & EPSDT

- Not an adaptation of adult treatment models and must be developmentally appropriate.
- Youth treatment is family treatment.
- EPSDT
  - Beneficiaries under age 21 who are at risk for or have a substance use disorder are eligible to receive DMC-ODS waiver services.
  - 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.
  - No requirements in the DMC-ODS pilot override any EPSDT services.

The Role of Non-DMC Services

- SBIRT
- Recovery Residences
- Inpatient Detoxification
  - Acute Care Hospital
  - Chemical Dependency Recovery Hospital
- Services for the residually uninsured and undocumented people.
- Some Medications
  - Camprol
  - Vivitrol

Rehab Model Service Delivery

- Under DMC (Clinic Model) services must be provided at the certified location.
- Under Rehab Model, services can be provided just about anywhere.
- Also opens the door to Telehealth service delivery.

Additional Residential Levels of Care

- ASAM 3.1 – Clinically Managed Low-Intensity Services
- ASAM 3.3 – Clinically Managed Population-Specific High-Intensity Services (adults only)
- ASAM 3.5 – Clinically Managed High-Intensity Services

Evidence Based Practices

- Providers must implement at least 2 of the following:
  - Motivational Interviewing
  - Cognitive-Behavioral Therapy
  - Relapse Prevention
  - Trauma-Informed Treatment
  - Psycho-Education
- Expanded use of medications.
  - NTP
  - MAT

New Services

- Case Management
  - Counties will coordinate, both within the SUD system and with Mental Health and Primary Care.
- Recovery Services
  - Post treatment
  - Pre- or Post-Relapse
- Physician Consultation
  - Intended to assist DMC physicians with designing treatment plans for DMC-ODS beneficiaries.
  - Consultation services may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

County Responsibilities

- Selective Contracting
  - No more state-direct contracts.
- Access
  - To NTP
  - Reasonable promptness
- Prior authorization for residential services
  - Must be acted on within 24 hours of request submission by provider.

County Responsibilities

- **Rate Setting**
  - ". . . counties will propose county-specific rates . . . and the State will approve or disapprove those rates."
  - "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."
  - ". . . counties may also pilot an alternative reimbursement structure . . . . This may include use of case rates."

DHCS DMC-ODS Implementation Plan:

County Plans Must Include Responses in the Following Key Areas

Implementation Plan Elements

1. **Collaborative Planning Process**

- Describe the collaborative process used to plan DMC-ODS services.
- Describe how county entities, community parties, and others participated in the development of this plan and how ongoing involvement will occur.

Implementation Plan Elements

2. **Client Flow**

- Describe how clients move through the different levels identified in the continuum of care.
- How are seamless transitions achieved?
- For which clients?
- What is the mechanism – case management or other methods?

Implementation Plan Elements

3. **Beneficiary Access Line**

- "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."

Implementation Plan Elements

4. Treatment Services
   - What services will be provided – required and optional.
5. Expansion of Services
   - Plan to provide all ASAM levels listed in the STCs over the term of the Waiver.
6. Integration with Mental Health
7. Integration with Physical Health
8. Coordination Assistance - What are TA needs to help meet challenges, e.g.
   - Development of shared care plans and tTracking referrals across systems.

Implementation Plan Elements

9. **Access**

Describe how the county will ensure access to all service modalities. Describe the county's efforts to ensure network adequacy. Describe how the county will establish and maintain the network by addressing the following:

a. The anticipated number of Medi-Cal clients.
b. The expected utilization of services.
c. The numbers and types of providers required to furnish the contracted Medi Cal services.
d. Hours of operation of providers.
e. Language capability for the county threshold languages.
f. Timeliness of first face-to-face visit, timeliness of services for urgent conditions and access to afterhours care.
g. The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities.

California Cultural & Linguistic Capacity

Language	Number of Counties Where Primary Language Frequency Reaches Threshold Level	Number of Eligibles Speaking Threshold Language	Percent of Total Medi Cal Eligibles
Spanish	49	3,057,209	34.5%
Vietnamese	7	143,919	1.6%
Cantonese	5	94,104	1.1%
Armenian	1	60,909	0.7%
Russian	3	32,598	0.4%
Mandarin	4	38,485	0.4%
Tagalog	4	26,552	0.3%
Korean	2	30,788	0.3%
Arabic	2	20,080	0.2%
Hmong	2	19,578	0.2%
Farsi	2	16,667	0.2%
Cambodian	1	8,103	0.1%
Other Chinese	1	8,759	0.1%
Grand Total	**49**	**3,557,751**	**40.2%**

LA County Cultural & Linguistic Capacity

Language	Medi-Cal Eligibles - N	Medi-Cal Eligibles - %
Spanish	1,135,732	42.0%
Armenian	60,909	2.3%
Cantonese	29,744	1.1%
Korean	25,707	1.0%
Vietnamese	23,040	0.9%
Mandarin	23,197	0.9%
Farsi	12,306	0.5%
Tagalog	11,509	0.4%
Russian	10,726	0.4%
Cambodian	8,103	0.3%
Other Chinese	8,759	0.3%
Arabic	5,066	0.2%
Total Non-English Speakers	1,354,798	50%
All Eligibles	2,705,779	100.0%

Implementation Plan Elements

10. Training Provided.

What training will be offered to providers chosen to participate in the waiver?

11. Technical Assistance.

What technical assistance will the county need from DHCS?

Implementation Plan Elements

12. Quality Assurance

- Describe the quality assurance activities the county will conduct.
- Include the county monitoring process (frequency and scope), Quality Improvement plan and Quality Improvement committee activities.

Implementation Plan Elements

13. Evidence Based Practices.

- How will counties ensure that providers are implementing at least two of the identified evidence based practices?
- What action will the county take if the provider is found to be in non-compliance?

Implementation Plan Elements

14. Assessment

- Describe how and where counties will assess beneficiaries for medical necessity and ASAM Criteria placement.
- How will counties ensure beneficiaries receive the correct level of placement?

Implementation Plan Elements

15. Multi-County Regional Service Model

16. Memorandum of Understanding.

- MOUs county and managed care plans.
- Must be reviewed by DHCS.

17. Telehealth Services

- If applicable.

Implementation Plan Elements

18. Contracting

- Describe the county's selective provider contracting process.
- What length of time is the contract term?
- Describe the local appeal process for providers that do not receive a contract.
- If current DMC providers do not receive a DMC-ODS contract, how will the county ensure beneficiaries will continue receiving treatment services?

Implementation Plan Elements

19. Additional Medication Assisted Treatment (MAT)

If the county chooses to implement additional MAT beyond the requirement for NTP services, describe the MAT and delivery system.

20. Residential Authorization

Describe the county's authorization process for residential services.

State-County Contract

- Revisions to the state-county DMC/NNA contract will outline further details for implementation.
- Incorporates compliance with new set of federal regulations.
  - For example, beneficiary problem resolution process.
  - Cultural competence plan
  - Beneficiary brochure and provider list

Federal Regulations

- 42 CFR Part 438, titled "Managed Care"
- Includes sections on –
  - – Enrollee Rights and Protections
  - – Quality Assessment and Performance Improvement
    - Access Standards
    - Structure and Operations Standards
    - Measurement and Improvement Standards
  - – External Quality Review

42 CFR Part 438 (cont.)

- Further Provisions –
  - –Grievance System
  - –Certifications and Program Integrity
  - –Sanctions
  - –Conditions for Federal Financial Participation.

Implementation Timeline

- Phase I will include Bay Area Counties
  - –21% of state population
  - – Planned start was April – July 2015
- Phase II will include LA, Orange, Riverside, and San Bernardino Counties
  - – 61% of state population
  - – Planned Start TBD

Public Health

Discussion and Questions

Facilitator: Victor Kogler

Participants: Wayne Sugita, System of Care Branch/Deputy Director
Gary Tsai, Clinical Services Branch
Raymond Low, Administrative Services Branch

Public Health

Next Steps and Participation in the Regional Stakeholder Meetings

Michelle Gibson, M.P.H.
Strategic Planning Director
Substance Abuse Prevention and Control

Public Health

The Regional Stakeholder Process

The purpose of the upcoming regional meetings is to obtain feedback on LAC's DMC-ODS Implementation Plan/Application.

SAPC's *Vision Description: Transforming the Los Angeles County Substance Use Disorder System of Care* and CMS' July 27, 2015 letter to State Medicaid Directors (SMD #15-003) titled *New Service Delivery Opportunities for Individuals with a Substance Use Disorder* provide additional background on the future direction of SUD services.

Public Health

Regional Stakeholder Meeting Schedule

August 19, 2015, 2:00 P.M. – 4:00 P.M.
MLK Community Engagement Center
11833 South Wilmington Avenue
Los Angeles, CA 90059

August 20, 2015, 10:00 A.M. – 12:00 P.M.
Department of Health Services, Auditorium
5555 Ferguson Drive
Commerce, CA 90022

August 24, 2015, 10:00 A.M. – 12:00 P.M.
High Desert Medical Center, Conference Room 11 B/C
335 East Avenue I
Lancaster, CA 93535

August 27, 2015, 10:00 A.M. – 12:00 P.M.
Behavioral Health Services
15519 South Crenshaw Boulevard
Gardena, CA 90249

August 31, 2015, 10:00 A.M. – 12:00 P.M.
Phoenix Houses of Los Angeles, Day Room
11600 Eldridge Avenue
Lake View Terrace, CA 91346

September 1, 2015, 2:00 P.M. – 4:00 P.M.
Arcadia Park, Community Room
405 South Santa Anita Avenue
Arcadia, CA 91006

September 3, 2015, 10:00 A.M. – 12:00 P.M.
Burton W. Chace Park, Community Room
13650 Mindanao Way
Marina del Rey, CA 90292

September 8, 2015, 10:00 A.M. – 12:00 P.M.
Eagle Rock Library
5027 Caspar Avenue
Los Angeles, CA 90041

September 9, 2015, 2:00 P.M. – 4:00 P.M.
MLK Community Engagement Center
11833 South Wilmington Avenue
Los Angeles, CA 90059

Public Health

Recommendations on the Implementation Plan/Application

To provide written feedback on LAC's DMC-ODS Implementation Plan, please go to the *DMC-ODS Application Online Feedback Questionnaire* tab at the following link (to be posted soon):

http://publichealth.lacounty.gov/sapc/HeathCare/HealthCareReform.htm

Remember, while some of the DMC-ODS terms and conditions are non-negotiable, please still include recommendations on how requirements can best be implemented, or to better understand local or provider level challenges. Your feedback will greatly contribute to LAC's success in expanding and improving SUD services.

If you are unable to attend any of the stakeholder meetings, or do not have internet access, please contact Julia Sandoval at (626) 299-3540 for further assistance on how to participate in this feedback process.

Public Health

DMC Certification Information

Visit DHCS' website for more information on how to become a DMC certified provider. Please note, however, because the Waiver has not received final approval from the federal Centers for Medicare and Medicaid (CMS), new levels of care are not listed at this time.

http://www.dhcs.ca.gov/services/adp/Pages/Drug_MediCal.aspx

Public Health

AdditionalResources

- **SAPC Website: Provider Information, HCR/DMC-ODS**
  http://publichealth.lacounty.gov/sapc/HeathCare/HealthCareReform.htm
- **UCLA-SAPC Lecture Series**
  http://publichealth.lacounty.gov/sapc/media/lectureseries.htm
- **ASAM Criteria**
  http://www.asam.org /publications/the-asam-criteria

Public Health

Thank you for attending the Kick-Off Meeting. We look forward to your participation at the Regional Stakeholder Meetings and your feedback on how to make this a successful SUD system transformation!

Please also invite current or former clients, and other stakeholders to the regional meetings as appropriate.