



The DMC-ODS pilot program establishes that counties must:

- ▶ Use a benefit design modeled after the American Society for Addiction Medicine (ASAM) Criteria, covering a broad continuum of SUD treatment and support services
- ▶ Specify standards for quality and access
- ▶ Require providers to deliver evidence-based care, including medication management
- ▶ Coordinate with physical and mental health services
- ▶ Act as a managed care plan for SUD treatment services

As of July 2018, 19 counties were implementing plans and providing services under the pilot. These counties represented nearly 75% of the Medi-Cal population statewide. When the remaining 21 counties that have submitted implementation plans for approval by the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) begin services, over 97% of Medi-Cal enrollees will have access to DMC-ODS pilot programs.<sup>1</sup> The Tribal and Urban Indian Health Programs are scheduled to begin implementation in the summer of 2019.<sup>2</sup>

To provide interested counties and states with a view of the pilot counties' experiences and challenges, this paper highlights four early adopter counties: Los Angeles, Marin, Riverside, and Santa Clara. Its contents are based on interviews with county SUD program administrators and behavioral health directors which took place throughout February and

March of 2018. While acknowledging the considerable effort required by counties and providers to implement the DMC-ODS pilot program locally, the interviewees expressed strong support for and optimism about the program's potential to improve access to high-quality SUD treatment and services.

John Connolly, PhD, who is leading the implementation of the Los Angeles County DMC-ODS pilot program, believes the project represents a crucial change in addressing SUDs. "This is a generational opportunity to advance SUD treatment," he said. "Everyone — providers, patients, and plans — should realize how important this is. It's a watershed moment for Medi-Cal."

## Fundamental Reframing

Medi-Cal has long covered some SUD benefits through the "standard" Drug Medi-Cal program administered by counties, but services were limited and quality was variable.

### SUD treatment has historically been associated more with criminal justice than with health care.

SUD treatment has historically been associated more with criminal justice than with health care. Interviewed counties estimate that prior to the implementation of the DMC-ODS pilot program, at least one-third of SUD treatment services delivered by the county system were mandated by courts as part of sentences for drug-related offenses. More than one

county remarked that residential treatment was too often the court-ordered answer when intensive outpatient treatment would have been a cheaper and more effective option.

An observation made in all interviews was that under the DMC-ODS pilot program, SUD treatment has been "mainstreamed into the larger health care landscape," and that addiction is being reframed as a chronic disease. There is a fundamental shift underway in these counties in how people can access and receive services. By making a comprehensive set of services available through a formally organized structure with high expectations for quality and access, the DMC-ODS pilot program has substantially strengthened county delivery systems and is helping to promote long-term recovery among Medi-Cal enrollees.

## What Is California's Drug Medi-Cal Organized Delivery System?

In California, 8.5% of residents age 12 and older (2.7 million people) met the criteria for having had an SUD in the past year. Only about one in ten received treatment.<sup>3</sup> The goal of the DMC-ODS pilot program is to treat more people more effectively by reorganizing the delivery system for SUD treatment in Medi-Cal.

DMC-ODS is the nation's first SUD demonstration project under a Medicaid Section 1115 waiver from CMS.<sup>4</sup> To date, ten other states have received approval for similar SUD waivers.<sup>5,6</sup>

To be eligible for DMC-ODS pilot program services, beneficiaries must:

- ▶ Be eligible for Medi-Cal
- ▶ Reside in a county that is participating in the pilot program
- ▶ Have received at least one diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders* for substance-related and addictive disorders (except for tobacco-related disorders)
- ▶ Meet the ASAM Criteria definition of medical necessity for services

Individuals under age 21 are eligible to receive Medicaid services pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under this mandate, beneficiaries can receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under federal Medicaid authority.<sup>7</sup> Nothing in the DMC-ODS pilot program overrides any EPSDT requirements. Medical necessity for an adolescent (someone under age 21) is determined using the following criteria:

- ▶ Must be assessed to be at risk for developing an SUD
- ▶ Must meet the ASAM adolescent treatment criteria

Beneficiaries generally receive a referral to treatment from health care or mental health providers, law enforcement, schools, other county departments, or family members. Others self-refer. The Section 1115 waiver requires that participating counties have a

toll-free number available for beneficiaries to call 24 hours a day, seven days a week, to access DMC-ODS pilot program services. Oral language interpretation must be made available. Non-residential services do not require prior authorization.

The program uses a continuum of care modeled after the ASAM Criteria. These criteria, first developed in 1991, are the most widely used set of guidelines for assessing SUD patient needs and are used to create comprehensive, individualized patient treatment plans (see Appendices A and B). In the standard Drug Medi-Cal program, benefits include outpatient and intensive outpatient SUD services, perinatal residential SUD treatment (limited to facilities with 16 beds or fewer), and narcotic (opioid) treatment programs. DMC-ODS pilot program benefits include all the standard services plus case management, multiple levels of residential SUD treatment (not limited to perinatal or to facilities with 16 beds or fewer), withdrawal management, recovery services, physician consultation, and, if the county chooses, additional medication-assisted treatment (MAT) and partial hospitalization.

The waiver also includes an exemption from the Institution for Mental Disease (IMD) exclusion, which prohibits federal financial participation in the coverage of residential and inpatient SUD and mental health treatment for Medicaid enrollees age 21 to 64 in facilities with more than 16 beds. The IMD exclusion impacted most providers in the state who found it financially unviable to operate facilities with so few beds. Allowing for residential SUD treatment to be covered through the Medi-Cal program with no limitation on the number of beds in a facility means that counties can receive federal matching funds for

services that were previously paid for with grant dollars (to the extent they were available). This, in turn, frees up grant dollars to support other programs not covered by Medi-Cal.

Finally, the waiver allows for a workforce expansion. In the DMC-ODS pilot program, licensed practitioners of the healing arts (LPHAs) can determine medical necessity and direct client treatment plans, functions that could previously only be carried out by a physician. LPHAs include:

- ▶ Physician, licensed/waivered psychologist
- ▶ Licensed/waivered/registered social worker
- ▶ Licensed/waivered/registered marriage and family therapist
- ▶ Licensed/waivered/registered professional clinical counselor
- ▶ Registered nurse
- ▶ Nurse practitioner

## The Standard Drug Medi-Cal System

Prior to the implementation of the DMC-ODS pilot program (and still in counties not participating in it), Medi-Cal enrollees with SUD were served through the standard Drug Medi-Cal program. It covered a limited set of services reimbursed at insufficient state plan rates and was largely disconnected from the physical and mental health systems serving the same enrollees. Covered services were those specified in the state's Medicaid plan; these primarily included outpatient counseling and methadone maintenance.

**Table 1. Drug Medi-Cal Program vs. the Drug Medi-Cal Organized Delivery System Pilot Program**

DRUG MEDI-CAL (STANDARD PROGRAM)	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (PILOT PROGRAM)
<b>Providers contract with:</b> Counties or state	<b>Providers contract with:</b> Counties
<p><b>Services:</b></p> <ul style="list-style-type: none"> <li>▶ Outpatient drug-free treatment</li> <li>▶ Intensive outpatient treatment</li> <li>▶ Residential SUD services for perinatal women only (limited to facilities with 16 beds or fewer)</li> <li>▶ Naltrexone treatment</li> <li>▶ Narcotic treatment programs (methadone only)</li> <li>▶ Detoxification in a hospital</li> </ul>	<p><b>Services:</b></p> <p>All services provided in the standard Drug Medi-Cal program, plus:</p> <ul style="list-style-type: none"> <li>▶ Multiple levels of residential SUD treatment (not limited to perinatal women or to facilities with 16 beds or fewer)</li> <li>▶ Case management</li> <li>▶ Narcotic treatment programs expanded to include buprenorphine, disulfiram, and naloxone</li> <li>▶ Withdrawal management (at least one ASAM level)</li> <li>▶ Recovery services</li> <li>▶ Case management</li> <li>▶ Physician consultation</li> <li>▶ Partial hospitalization (optional)</li> <li>▶ Additional medication-assisted treatment (optional)</li> </ul>

**Drug Medi-Cal covered a limited set of services by “any willing provider” and was largely disconnected from the physical and mental health systems serving the same enrollees.**

Table 1 compares standard Drug Medi-Cal services with DMC-ODS pilot program services. For example, treatment in Drug Medi-Cal had to be directed by a physician and delivered within the four walls of a state-certified treatment provider. As the program was a fee-for-service program, federal managed care standards related to quality and access did not apply.

DHCS contracted with counties to administer and pay for the program. But under the “any willing

provider” provision, providers still had the option to contract directly with DHCS, which made it difficult for counties to build networks based on local needs. Effectively monitoring the program was challenging for both the state and for counties because of a lack of clearly defined roles related to program integrity and quality assurance. This problem was cited as a major contributing factor to widespread fraud and abuse in the program that was documented in a statewide audit published in 2014.<sup>8</sup>

## New Roles for Counties in the Pilot Program

Perhaps the biggest change associated with the DMC-ODS pilot program is the role of counties.

County participation in DMC-ODS is voluntary. Counties participating in the program serve as managed care plans (technically, “prepaid inpatient health plans”) responsible for ensuring that all Medi-Cal beneficiaries living in their county have access to the SUD treatment services they need when they need them, and that the providers are qualified and trained to deliver evidence-based care, including medication management and care coordination.

Counties have the authority and responsibility to contract directly with qualified service providers to deliver care under county direction, which has meant that counties can better assure the quality of providers in their network. Under the DMC-ODS pilot program, counties also can offer providers “other than state plan rates,” which typically means higher rates.

**Counties now serve as managed care plans, responsible for assuring timely access to quality SUD treatment services for their Medi-Cal enrollees.**

However, serving as a managed care entity means that DMC-ODS pilot program counties have taken on the full array of managed care responsibilities described in the 2016 Medicaid Managed Care Final Rule (“Final Rule”).<sup>9</sup> Among these are network adequacy, quality assurance and performance improvement, beneficiary rights and protections, and program integrity.

**Beneficiary relations.** Interviewed counties said that meeting the Final Rule requirements has necessitated the creation of a formal infrastructure for beneficiary relations — something that did not exist in most counties prior to the DMC-ODS pilot program. For example, counties were required to develop and maintain a beneficiary handbook that describes available benefits and how to access them, as well as an up-to-date provider directory. DMC-ODS pilot program counties must also maintain a system for grievances and appeals that is accessible to beneficiaries and meets the many federal requirements related to notifications and timeframes.

**Technology to improve beneficiary access.** To help beneficiaries locate and link to services, Los Angeles County adapted an online locator tool used to help beneficiaries find and contact mental health services to be able to serve the needs of those with SUDs. The locator offers a filterable list based on language, operation, number of residential beds available, and other characteristics of contracted providers in the DMC-ODS pilot program network. Using this technology, patients can reach out directly to providers for information.

While most counties have successfully leveraged existing processes within the county mental health system to develop this infrastructure, counties like Los Angeles — where SUD and mental health services are administered through separate departments — have had to build entirely new systems to meet the many requirements related to protecting and informing beneficiaries.

**Contracting processes.** Another hurdle is county contracting, specifically the competitive procurement processes required by the board of supervisors in most counties. These lengthy processes are often in conflict with the need to quickly build and modify provider networks.

Some counties, such as Marin, have turned to master contracts which define the terms and conditions for all providers in the county and allow SUD program administrators and directors to move funds between provider types (and between individual providers) to better meet the demand for specific services. A similar arrangement in Riverside County has allowed the Riverside University Health System, which houses the county’s SUD treatment program, to authorize a change in service type and location without approval from the board of supervisors. Such approval requirements are typical of county procurement protocols. This flexibility allows the department to make changes quickly to address gaps in access. For example, when Riverside University Health System administrators learned that adolescents in a day treatment program were being transported 30 miles each way for services, they were quickly able to amend the relevant agreements to allow the provider to use an alternative location.

Playing this expanded role in managing the delivery system has resulted in an increased workload for county SUD administrators and program directors. Interviewed counties described the efforts to take on this new role and meet the rigorous waiver requirements as a “tremendous lift.” The interviewees cited strong local leadership and positive relationships with providers and other county partners as crucial for success.

Counties voiced resounding optimism about the managed care structure, particularly related to selective provider contracting, quality assurance, and alignment with how county mental health plans operate.

## Funding Increases and Freed-Up Dollars

One of the key benefits of the DMC-ODS pilot program is the new federal Medicaid funding that has been infused into California’s public SUD treatment system. These funds are associated with services not otherwise matchable outside of the waiver program, such as non-perinatal residential treatment, case management, new levels of withdrawal management, physician consultation, expanded MAT, and recovery services. In addition, the ability to offer services in the field (not just within clinic walls, as is required in standard Drug Medi-Cal) and to use a broader range of licensed providers to direct treatment means that counties and providers can claim — and seek federal financial participation for — more Medi-Cal SUD treatment services than ever before.



There are several other positive financial factors associated with the DMC-ODS pilot program for counties, including:

**Rate-setting and matching funds.** Along with allowing new matchable services, the Section 1115 waiver changes the methodology for claiming federal matching funds. Counties' ability to set "other than state plan" rates for interim reimbursement means that matching federal funding (when combined with local matching funds) more closely reflects the actual costs, both direct and indirect, of delivering services. This is a shift from a statewide rate methodology that does not reflect the economic and geographic diversity of a state like California, where the cost of doing business varies widely across the state between extremely high-cost, high-density urban areas and rural and frontier communities with different costs and needs. Furthermore, the approved certified public expenditure protocol allows counties to establish interim rates, enabling them to offer more competitive payment to providers if the providers can demonstrate through cost reports that they have the costs to support the contracted rate. This encourages providers to increase capacity by hiring quality providers, retaining staff through competitive wages and benefits, and requiring training.

**Eligibility expansion.** California's implementation of the optional Medicaid expansion under the Affordable Care Act (ACA) grew the Medi-Cal program from 7.6 million people to more than 12 million — an increase of 4.5 million — between December 2012 and December 2014. As of February 2018, there were nearly 13.3 million people certified as being eligible for the Medi-Cal program, and just

over 3.8 million of them were considered part of the new "expansion" eligibility category that is associated with a substantially higher federal matching assistance percentage than other eligibility groups, such as families or individuals with disabilities (94% matching funds in calendar year 2018).<sup>10</sup> This means that counties are able to receive more federal matching funds for covered services delivered to individuals eligible under this new "expansion" category. More people covered, a higher match rate for these people, and additional federally-reimbursable services means a substantial increase in federal dollars into waiver counties — covering more than 75% of the eligible costs associated with the expansion of services in the first year of implementation.<sup>11</sup>

**Benefit expansion.** In addition to the most notable new benefit — residential treatment services for non-perinatal beneficiaries — Riverside County cites the ability for providers to bill and be reimbursed for SUD case management services as a game-changer. Case management services assist a person in accessing needed medical, mental health, educational, social, prevocational, vocational, rehabilitative, and other community services. In the past, case management was offered in the county by community providers to the extent that local resources were available, but it was not reimbursable under the standard Drug Medi-Cal program. Covering case management services through the DMC-ODS pilot program has improved clinical quality and the ability to evaluate care delivery (when case management services are billable, they must be documented in a medical chart). In addition, new billable services have freed up dollars in the county's Substance Abuse and Mental Health Services Agency (SAMHSA) Substance Abuse

Prevention and Treatment Block Grants (SABGs) — the primary source of funding for services not covered by the Drug Medi-Cal program prior to the waiver. As a result, Riverside County has been able to aim its SABG funds toward recovery housing, a service not covered under the DMC-ODS pilot program but which is much-needed in the community. Los Angeles is also focused on creating recovery housing as an option for post-residential treatment for people who are newly sober and learning to sustain long-term recovery.

**Staffing expansion.** Some counties have added positions that assist in program administration both to fulfill managed care requirements and to provide direct services. For example, Marin County now has a county-employed clinician who participates in quality assurance and improvement activities. Marin has also hired four recovery coaches who are helping to fill gaps in care. The coaches provide roving direct recovery support services for anyone along the treatment continuum, including patients who are involved in the justice system. These positions were once funded with local probation dollars, but now that they are a part of the DMC-ODS pilot program, they are available to serve all Medi-Cal beneficiaries in the county and are no longer limited to justice-involved people.

## Improving Access and Quality

Under the DMC-ODS pilot program, counties are required to adopt the ASAM Criteria definition of medical necessity. The ASAM Criteria provide a matrix for matching severity and level of function with type and intensity of treatment needs.<sup>12</sup> They are intended to help the field move from a program-driven system to an assessment-driven methodology in the treatment and placement of patients. The availability of intensive and long-term community-based services, such as intensive outpatient services, case management, and recovery support services, has allowed individuals to receive more appropriate and effective care. Also, the continuum of SUD care in California now includes an expansion of access to MAT, an effective treatment for people with opioid use disorder and alcohol use disorder.

### The continuum of SUD care in California now includes an expansion of access to MAT.

DMC-ODS pilot program counties must require that their network providers implement at least two evidence-based treatment practices per service modality. Examples of required evidence-based practices include motivational interviewing, cognitive behavioral therapy, relapse prevention, trauma-informed treatment, and psycho-educational groups. Counties must ensure that providers have effectively implemented the required practices, and the state will monitor the implementation during reviews.

Under federal managed care requirements, DMC-ODS pilot program counties must implement an ongoing comprehensive quality assessment and performance improvement program. DMC-ODS pilot program counties must have a quality improvement plan that monitors the accessibility of services covered through the DMC-ODS pilot program, and they are required to maintain a minimum of two active performance improvement projects that meet criteria established in federal managed care regulations. Counties must also establish a quality improvement committee to review the quality of SUD treatment services provided to beneficiaries. In several counties, such as Santa Clara, leadership has sought to implement this requirement through an integrated SUD and mental health quality program, establishing a single, integrated committee. As is the case for all managed care plans, DMC-ODS pilot program counties are subject to annual review by the state's external quality review organization (EQRO).

Counties participating in the DMC-ODS pilot program must also have a utilization management program that ensures that beneficiaries have appropriate access to SUD services, medical necessity has been established, the beneficiary is at the appropriate ASAM Criteria level of care, and that the interventions fit the diagnosis and level of care. The county must 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 pilot program service at an appropriate level of care following initial request or referral.

All counties interviewed expressed the need for additional staffing resources to meet the new demands related to quality and access.

## Keys to Success

All the counties cited a few key strategies to which they attribute their start-up successes. Here are the ones most consistently described:

**Provider engagement.** The early adopter counties pointed to engaging providers early and often in the process of implementation. Los Angeles County, for example, underwent a two-year planning process that prepared everyone involved for their July 1, 2017 “go-live” date, as opposed to implementing the changes on a rolling basis. The county provided policy guidance and held regular public meetings on provider requirements, training, and billing and claims processes so that everyone in the DMC-ODS community was prepared for the new delivery system.

**Ongoing communications plan.** The counties stressed the necessity of having a broad, ongoing communications plan about DMC-ODS. They encourage talking about the comprehensive services and the new delivery system with sister county agencies, criminal justice partners, providers, health plans, and advocates to foster awareness and support. Santa Clara County used stakeholder meetings to prepare for waiver implementation and has continued using them to reinforce waiver requirements, policies, and procedures.

**Creative partnerships.** Riverside County collaborated with other entities as part of the DMC-ODS pilot program. It partnered with a hospital's neonatal unit to connect new mothers whose babies had fetal exposure to substances to appropriate treatment services through DMC-ODS. Riverside County also built on its existing partnership with the school system to ensure that students receive an appropriate level of intervention for substance use. The county has ramped up prevention efforts by increasing access to school programs focused on it, such as the Friday Night Live youth development and substance use education program.

All counties noted that they benefited from the technical assistance and guidance provided by DHCS — including assistance from Harbage Consulting supported by the California Health Care Foundation — and the California Institute for Behavioral Health Solutions. The state's website contains fact sheets, FAQs, webinars, and other resources that the counties have encouraged employees, providers, and community partners to review.<sup>13</sup>

## Remaining Challenges

The interviewed counties discussed some persistent challenges they face as they work within the DMC-ODS program:

**Stigma.** One of the greatest remaining issues is the stigma and persistent misconceptions around SUD and its treatment. Some people continue to believe that addiction is a personal or moral failing, and that SUD is not a medical condition. Los Angeles County

used a cancer analogy — for example, one would not tell someone with cancer that they are not trying hard enough to get better and therefore cannot get any further treatment. Public attitudes toward SUD as a medical condition continue to evolve, but there is still work to do. The expansion of MAT in California has been met with some misunderstanding and resistance, in part due to the historic reliance by consumers, providers, and counties on a “social model,” rather than a medical model, of treatment.

**Mentoring and training for prescribers.** Marin County hired an addiction medicine specialist to help encourage physicians, nurse practitioners, and physician assistants to complete the short training required to receive an “X-waiver” from the Drug Enforcement Administration to prescribe buprenorphine to treat opioid use disorders. The addiction medicine specialist can move easily throughout the system and provide training in a variety of settings, from primary care to hospitals. To further promote access to MAT, the specialist physician works with primary care providers who can prescribe MAT for their own patients in the primary care setting. This specialist also provides MAT training to criminal justice employees, judges, and providers, teaching them about medical necessity and the benefits of MAT. Having a physician champion was critical in bringing other providers on board.

**Criminal justice interactions.** The DMC-ODS pilot program has disrupted patterns embedded in county criminal justice systems. For example, some judges send individuals with drug-related offenses to residential treatment rather than to jail. Mandating a

specific level of care in this manner, while enabling the individual to avoid immediate incarceration, does not consider their unique treatment needs. For example, one county reinforced this by pointing out that “a judge would not be determining how much chemotherapy someone got because she stole a car.” Because the DMC-ODS pilot program structure requires placement according to the ASAM Criteria, court-ordered treatment assignments may not meet medical necessity criteria and therefore would not be eligible for reimbursement as DMC-ODS pilot program services. According to some interviewees, not only is an unnecessary residential stay a misuse of resources, it could result in a more difficult transition for individuals when they return to the community.

*“A judge would not be determining how much chemotherapy someone got because she stole a car.”*

**Administrative infrastructure.** All the counties that were interviewed pointed to the need for increased provider administrative infrastructure under the DMC-ODS pilot program as a significant challenge. With more documentation requirements, ongoing staff trainings, and new care coordination functions, provider productivity has declined in some instances; as a result, providers are having to reexamine their business models. Santa Clara County, despite having already integrated elements of the ASAM Criteria into its SUD treatment program prior to DMC-ODS, found that substantial training and support for providers was still a critical need. Providers have also had to front the start-up and infrastructure costs



necessary to deliver care under the pilot program, including expenses for new staff, technology, facility improvements, and training.

**Provider supply.** While network adequacy requirements provide a structure for planning delivery systems based on beneficiary need and provider capacity, identifying sufficient qualified providers is an ongoing challenge for all counties. The higher demand for services has left some counties and providers scrambling to fill positions or contract with specific types of providers. Finding providers — especially residential providers — equipped to effectively serve youth has been particularly challenging for counties, especially in rural areas. Adaptations of adult SUD treatment models geared at addressing youth often fall short, as youth treatment should be appropriate to a person’s age, stage of development, culture, and gender.

**Drug Medi-Cal certification for community partners.** To meet the demand for services, Los Angeles County partnered with hospitals and community health centers that provide primary care services to participate in the county’s DMC-ODS pilot program network. Community health centers are becoming Drug Medi-Cal-certified, allowing primary care providers to offer SUD treatment onsite. The county also helped mental health community providers become Drug Medi-Cal-certified so that beneficiaries can access DMC-ODS pilot program services in an environment where they would also be able to address their mental health needs.

**Fiscal forecasting.** The interviewed counties noted that increased demand for services has created a need for fiscal forecasting that was not commonly part of their budgetary exercises in the past. To create a balanced budget, counties now need to estimate how many people will be served in each eligibility group, what the direct and indirect costs will be, and how much the county can expect in terms of realigned state tax revenues, state general funds, and federal matching funds. For example, this is a new responsibility in Riverside County, where SUD services have been grant-funded with a fair amount of predictability for many years.

## Conclusion

The DMC-ODS pilot program is a demonstration project, meaning that if a strategy is not found to work, it will only strengthen and inform future planning. A formal evaluation by the University of California, Los Angeles (UCLA) is underway to examine progress toward the ultimate goals of the demonstration using a variety of quantitative and qualitative measures. These goals include enhanced access the treatment, quality of services, and coordination of care.

In the meantime, 21 additional counties throughout California have submitted their plans for implementation, and the 19 live DMC-ODS pilot program counties are in the process of rolling out their quality improvement work, a required element of participation. This quality improvement effort involves site visits from the EQRO and the creation of performance improvement plans. All counties emphasized the need for an extension of the pilot program’s timeline, since a change of this magnitude requires

long-term commitment. Counties and DHCS are currently planning for the Section 1115 waiver renewal and determining the next steps in expanding and improving SUD treatment in Medi-Cal.

### About the Authors

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### About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit [www.chcf.org](http://www.chcf.org).

## Appendix A. ASAM Criteria Dimensions

DIMENSION	DESCRIPTION
1 Acute intoxication and/or withdrawal potential	Exploring an individual's past and current experiences of substance use and withdrawal.
2 Biomedical conditions and complications	Exploring an individual's health history and current physical condition.
3 Emotional, behavioral, or cognitive conditions and complications	Exploring an individual's thoughts, emotions, and mental health issues.
4 Readiness to change	Exploring an individual's readiness to and interest in changing.
5 Relapse, continued use, or continued problem potential	Exploring an individual's unique relationship with relapse, continued use, or problems.
6 Recovery/living environment	Exploring an individual's recovery or living situation, and the surrounding people, places, and things.

Source: "The ASAM Criteria: Resources, American Society of Addiction Medicine," [www.asam.org](http://www.asam.org).

## Appendix B. ASAM Criteria Levels of Care

LEVEL OF CARE	DESCRIPTION
<b>0.5</b> Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT)
<b>1</b> Outpatient Services	Fewer than nine hours of service per week (adults); fewer than six hours per week (adolescents) for recovery or motivational enhancement therapies/strategies
<b>2.1</b> Intensive Outpatient Services	Nine or more hours of service per week (adults); six or more hours per week (adolescents) to treat multidimensional instability
<b>2.5</b> Partial Hospitalization Services	Twenty or more hours of service per week for multidimensional instability not requiring 24-hour care
<b>3.1</b> Clinically Managed Low-Intensity Residential Services	Twenty-four-hour structure with available trained personnel; at least five hours of clinical service per week, and preparation for outpatient treatment
<b>3.3</b> Clinically Managed Population-Specific High-Intensity Residential Services	Twenty-four-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense environment and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community. Preparation for outpatient treatment.
<b>3.5</b> Clinically Managed High-Intensity Residential Services	Twenty-four-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.
<b>3.7</b> Medically Monitored Intensive Inpatient Services	Twenty-four-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. Sixteen hours per day counselor availability.
<b>4</b> Medically Managed Intensive Inpatient Services	Twenty-four-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.
<b>OTP</b> 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.
<b>1-WM</b> Ambulatory withdrawal management without extended on-site monitoring	Mild withdrawal with daily or less than daily outpatient supervision.
<b>2-WM</b> Ambulatory withdrawal management with extended on-site monitoring	Moderate withdrawal with all-day withdrawal management, support, and supervision; has supportive family or living situation at night.
<b>3.2-WM</b> Clinically managed residential withdrawal management	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.
<b>3.7-WM</b> Medically monitored inpatient withdrawal management	Severe withdrawal needing 24-hour nursing care and physician visits; unlikely to complete withdrawal management without medical monitoring.
<b>4.0-WM</b> Medically managed intensive inpatient withdrawal management	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

Source: "The ASAM Criteria: Resources, American Society of Addiction Medicine," [www.asam.org](http://www.asam.org).

## Endnotes

1. "Medi-Cal Certified Eligibles — Recent Trends," Department of Health Care Services, accessed March 15, 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov). Estimates were based on October 2017 eligibility data, which were the most recent data available at the time of publication.
2. "Indian Health Program Organized Delivery System," Department of Health Care Services, November 2, 2017, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
3. "Table 20. Selected Drug Use, Past Year Alcohol Use Disorder, and Past Year Mental Health Measures in California, by Age Group: Percentages, Annual Averages Based on 2015–2016 National Survey on Drug Use and Health," in National Survey on Drug Use and Health, California, accessed April 12, 2018, [www.samhsa.gov](http://www.samhsa.gov).
4. The DMC-ODS pilot program was approved by the Centers for Medicare & Medicaid Services (CMS) as an amendment to California's 1115 "Bridge to Reform" waiver in August 2015. The program was then reauthorized in January 2016 as part of California's waiver renewal — now called "Medi-Cal 2020."
5. "State Waivers List," Centers for Medicare & Medicaid Services, [www.medicaid.gov](http://www.medicaid.gov).
6. The other states are Illinois, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, New Jersey, Utah, Virginia, and West Virginia.
7. Social Security Act § 1905(r)(5).
8. "California Department of Health Care Services: Its Failure to Properly Administer the Drug Medi-Cal Program Created Opportunities for Fraud," California State Auditor, August 2014, [www.auditor.ca.gov](http://www.auditor.ca.gov) (PDF).
9. "Medicaid and Chip Managed Care Final Rule," [www.medicaid.gov](http://www.medicaid.gov).
10. "County Certified Eligibles as of February 2018," Department of Health Care Services, [www.dhcs.ca.gov](http://www.dhcs.ca.gov).
11. Based on approved claims data provided by the California Department of Health Care Services for the period of February 1, 2017 to June 14, 2018.
12. David Mee-Lee, ed., *The ASAM Criteria: Treatment for Addictive, Substance-Related, and Co-Occurring Conditions*, 3rd ed. (Rockville, MD: American Society of Addiction Medicine, 2013).
13. "Drug Medi-Cal Organized Delivery System," Department of Health Care Services, [www.dhcs.ca.gov](http://www.dhcs.ca.gov).