



# **How Medi-Cal Expanded Substance Use Treatment and Access to Care:** A Close Look at Drug Medi-Cal Organized Delivery System Pilots

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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.

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*“This program has helped save my life. It has helped me find safe coping skills to better deal with my PTSD symptoms. The staff are caring, compassionate, and work hard to make a positive difference in as many lives as possible. I’m very thankful and grateful for this opportunity to live a better life.”*

— TPS client respondent

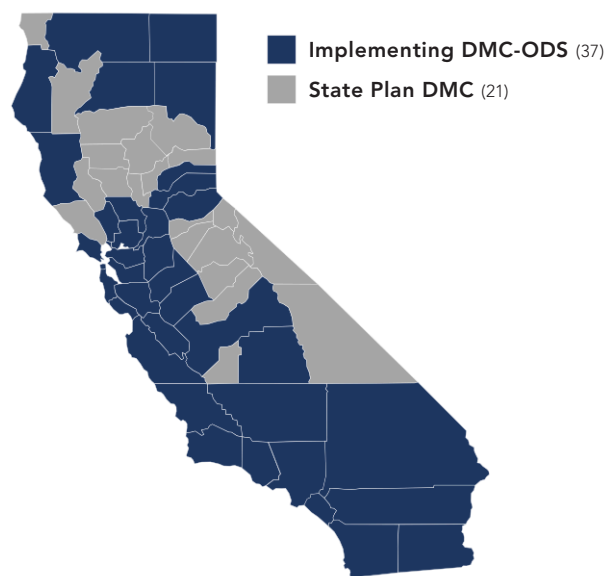
## Introduction

In 2015 California set out an ambitious, first-in-the-nation experiment to provide organized and comprehensive substance use disorder care for Medicaid enrollees — while reducing overall health care costs. California received the country’s first Medicaid Section 1115 waiver to expand access to substance use disorder services and launched the Drug Medi-Cal Organized Delivery System (DMC-ODS). While county participation in the program is voluntary, uptake has been strong. As of August 2020, 37 of California’s 58 counties are actively implementing DMC-ODS, representing 96% of the Medi-Cal population statewide (see Figure 1).<sup>1</sup>

The California Health Care Foundation’s 2018 paper *Medi-Cal Moves Addiction Treatment into the Mainstream* highlighted the initial experiences of four counties — Los Angeles, Marin, Riverside, and Santa Clara — that were early adopters of DMC-ODS. For this paper, the authors interviewed county substance use disorder (SUD) program administrators and behavioral health directors in the original four counties plus five additional counties representing various population sizes and geographic areas throughout the state: Nevada, San Francisco, San Luis Obispo, San Mateo, and Santa Cruz.

The authors also referenced the University of California, Los Angeles, annual evaluation of the program and the External Quality Review report. For more information on these reports, see the “Measuring the Impact of DMC-ODS” section.

Figure 1. Counties Implementing DMC-ODS



Source: “Counties Participating in DMC-ODS,” California Department of Health Care Services, accessed August 2020.

### Additional DMC-ODS Resources

Visit CHCF’s “Drug Medi-Cal Organized Delivery System” [project page](#) for more information and resources on the program. Key resources:

- ▶ *Medi-Cal Moves Addiction Treatment into the Mainstream* (August 2018): An initial look at the experience of some of the first counties to implement DMC-ODS.<sup>2</sup>
- ▶ *The Drug Medi-Cal Organized Delivery System* (August 2019): A brief overview of DMC-ODS.<sup>3</sup>
- ▶ *How Medi-Cal Is Improving Treatment for Substance Use Disorder in California* (December 2018): A summary of the key changes of the DMC-ODS program.<sup>4</sup>
- ▶ “Briefing — How Medi-Cal Is Modernizing Addiction Treatment:” A recording of the December 2018 briefing on DMC-ODS.<sup>5</sup>

# DMC-ODS Program Overview

The goal of the DMC-ODS pilot program is to increase the number of people receiving effective SUD treatment by expanding services and reorganizing Medi-Cal’s SUD delivery system. DMC-ODS is the nation’s first SUD demonstration project under a Medicaid Section 1115 waiver from the Centers for Medicare & Medicaid Services (CMS).<sup>6</sup> A Medicaid Section 1115 waiver gives states additional flexibility to design and improve their Medicaid programs in order to demonstrate and evaluate state-specific policy approaches intended to better serve Medicaid populations.<sup>7</sup> To date, 27 other states have followed California’s lead and received approval for similar SUD waivers.<sup>8</sup>

Counties participating in DMC-ODS are required to provide Medi-Cal enrollees with access to a full continuum of SUD services modeled after the American Society of Addiction Medicine (ASAM) criteria. These criteria, first developed in 1991, are the nation’s most widely used guidelines for creating comprehensive and individualized treatment plans for people with SUDs. Services provided under DMC-ODS are significantly more comprehensive than the limited set of services provided under the standard Drug Medi-Cal

program, which, like DMC-ODS, is administered at the county level by each behavioral health department (see Table 1).

Notably, for residential services, DMC-ODS includes an exemption from the federal Institution for Mental Disease (IMD) exclusion, which prohibits Medicaid programs from using federal funding for the treatment of SUD and mental health conditions for Medicaid enrollees age 21 to 64 *in any facility with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.*<sup>9</sup> The IMD exclusion, a part of the Medicaid program since it was established in 1965, has limited Medi-Cal enrollees’ access to residential treatment for SUD, since residential providers have found it financially prohibitive to operate facilities with so few beds. Historically, counties that provided residential treatment in facilities with more than 16 beds could not draw down federal Medicaid matching funds to pay for treatment, and had to find other sources of funding, such as grants and local resources. Under the expenditure authority for DMC-ODS, however, participating counties can claim federal Medicaid matching funds for covered residential SUD treatment regardless of the number of beds in the facility.

**Table 1. Services provided through Drug Medi-Cal and DMC-ODS**

DRUG MEDI-CAL	DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM
<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 no more than 16 beds)</li> <li>▶ Naltrexone treatment</li> <li>▶ Narcotic treatment programs (methadone only)</li> </ul>	<ul style="list-style-type: none"> <li>▶ All services provided under standard Drug Medi-Cal</li> <li>▶ Multiple levels of residential SUD treatment (not limited to perinatal women or to facilities with no more than 16 beds)</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>

## Eligibility for DMC-ODS

To be eligible for DMC-ODS services, people must:

- ▶ Be eligible for Medi-Cal
- ▶ Live in a county participating in DMC-ODS
- ▶ 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<sup>10</sup>

Note: Under the Early and Periodic Screening, Diagnostic, and Treatment benefit of the federal Medicaid program, for people under age 21, SUD treatment services are considered to be medically necessary if the individual is assessed to be at risk for developing an SUD.<sup>11</sup>

## Measuring the Impact of DMC-ODS

Several entities are monitoring the implementation of DMC-ODS to measure the successes and challenges in improving care quality as a result of the program.

- ▶ **University of California, Los Angeles, evaluation.** The UCLA Integrated Substance Abuse Programs conducts an annual evaluation of counties implementing DMC-ODS, measuring its impact on access to care, care quality, care coordination, and costs. As part of the annual evaluation, UCLA also conducts the Treatment Perceptions Survey (TPS), which asks clients for their perceptions related to their access to care, quality of care received, care coordination, outcomes, and general satisfaction with their care.<sup>12</sup> The most recent evaluation report for fiscal year (FY) 2019 was published in September 2019.<sup>13</sup>
- ▶ **External Quality Review.** As California's External Quality Review Organization (EQRO), Behavioral Health Concepts completes an annual review

of quality metrics in each county that has been implementing DMC-ODS for at least 12 months. The EQRO produces a county-level report and an annual summary of all county findings. The External Quality Review is a federal requirement of all Medicaid managed care programs.<sup>14</sup>

## Transforming Substance Use Disorder Care Through DMC-ODS

Across California, counties implementing DMC-ODS are transforming their SUD treatment delivery systems. They are working to improve access to SUD services, center care on the individual needs of patients, improve quality of SUD services, and expand access to medication-assisted treatment (MAT).<sup>15</sup> DMC-ODS also provides reimbursement for case management and recovery services benefits that were not available through Medi-Cal in the past. Interviews with the nine counties in this paper show that this transformation is well underway.

### Improved Access to SUD Services

The number of patients accessing services has risen in most DMC-ODS counties.<sup>16</sup> While an increase in the number of people seeking treatment was expected, in some cases the demand has greatly exceeded expectations. For example, Marin County's increase was double what the county behavioral health department expected. Despite this large increase, Marin County's system was able to accommodate the higher utilization without significant disruption.

According to the UCLA 2019 evaluation, the number of patients who received SUD services funded by DMC-ODS increased by 20% in the first five months after counties launched their DMC-ODS programs. However, some of this increase is due to patients who were receiving treatment through other funding sources and switched to DMC-ODS, so the actual change in new patients is likely lower. UCLA was unable to quantify this in 2019 due to data reporting issues.

More than 80% of county DMC-ODS administrators reported that the program has resulted in increased access to SUD services in their county. The FY 2019 UCLA evaluation also estimates that more than 60% of enrollees in DMC-ODS counties who thought they needed treatment accessed services through DMC-ODS. However, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), 95% of people with an SUD do not think they need treatment.<sup>17</sup>

**More than 60% of enrollees who thought they needed treatment accessed treatment through DMC-ODS.**



### Patient-Centered Care

Under DMC-ODS, providers use the comprehensive guidelines of the ASAM criteria to determine the appropriate level of care for each patient. The assessment is based on a multidimensional evaluation of each patient's individual risks, strengths, skills, and resources.<sup>18</sup> The result is an individualized, patient-centered treatment plan continuously adjusted throughout the course of treatment to best meet the patient's needs.

In addition to the patient-centered approach of the ASAM criteria, DMC-ODS also covers a wider set of benefits than the standard Drug Medi-Cal program (see Table 1 on page 4). These two factors allow counties to offer more services tailored to the needs of their patients and communities. Santa Cruz County described how their services have become significantly more consumer-centered, flexible, and focused on the needs of the individual in treatment rather than expecting the patient to fit into the limited menu of services available under the standard Drug Medi-Cal program. San Luis Obispo County noted increased success in being able to diagnose and place people

in the appropriate level of care. San Mateo County is working closely with one of its providers to create an ideal treatment environment and incorporate additional services to optimally treat patients with co-occurring severe mental illness.

*"We are building out levels of care that we never had and expanding choice for existing services."*

— Marin County

### Improved Quality and Increased Standardization of SUD Services

In addition to increasing the number and scope of services, DMC-ODS is also focused on improving service quality. DMC-ODS requires participating counties to operate as managed care plans, which requires them to develop quality-improvement plans. DMC-ODS counties are also required to increase coordination between physical and mental health delivery systems to aid in an individual's sustainable recovery. These requirements work together to ensure continuity of care and improved quality of services.

San Mateo County applies a continuous quality-improvement approach in its DMC-ODS program. The county and its providers view DMC-ODS as an opportunity to improve the services they provide and to shift toward consumer-centered care. Providers are actively working to build trust with patients who have experienced stigma and negative treatment experiences in the past.

DMC-ODS has also allowed counties to standardize available services for patients. Previously, services available at one provider or in one county differed based on the varying requirements of a patchwork of funding sources and arrangements with different community providers. Now, Medi-Cal enrollees have access to the same set of services throughout their county and, except for some minor variation related to optionally covered services, across all counties

participating in DMC-ODS. In Los Angeles County, the care system has transformed from isolated programs serving certain locations or populations to a network with bridges between levels of care and between the SUD, physical, and mental health systems.

While benefits for Medi-Cal enrollees have been standardized within DMC-ODS counties, challenges remain when serving enrollees from neighboring counties, particularly in areas with larger homeless populations. The “county of residency requirement” stipulates that people can only receive DMC-ODS services in the county of their residence, per their Medi-Cal eligibility file. If a person moves to a different county, it can take up to 90 days for their Medi-Cal enrollment to transfer to their new county of residence. During this 90-day period, they may face delays getting care, or providers and counties may carry the cost of delivering care before they can reconcile reimbursement responsibilities, which can be complex and administratively burdensome.

**In patient surveys, adult patients rated their satisfaction following SUD treatment an average of 4.3 out of 5.<sup>19</sup>**



Perhaps most importantly, patients are satisfied with the care they receive through DMC-ODS. According to the results of the Treatment Perception Survey, adult patients rated their satisfaction following SUD treatment an average of 4.3 out of 5. Patients provided the highest ratings on quality-of-care topics — 95% of survey participants judged that their treatment providers treated them with respect and communicated in a way they could understand. The lowest ratings were in the care coordination domain; however, 82% of patients still agreed that their SUD provider was working with their mental and/or physical health providers to promote their overall wellness.<sup>20</sup>

*“Being in the clinic has been a good experience. I’ve been able to get [sober], finish my master’s program, get a job, and care for my child. It saved my life.”*

— TPS client respondent

## Expanded Access to Medication-Assisted Treatment

Medication-assisted treatment (MAT) is the use of US Food and Drug Administration–approved medications, combined with counseling and behavioral therapies, to treat SUDs. It is an evidence-based treatment for patients with opioid use disorders and alcohol use disorders. MAT is offered in a variety of settings including narcotic treatment programs (NTPs), the only setting licensed to offer methadone to treat opioid use disorder. Through DMC-ODS, NTPs that contract with counties are required to provide more MAT medications, including methadone, buprenorphine, and disulfiram. They are also required to offer naloxone, a medication designed to rapidly reverse opioid overdose. According to the FY 2019 UCLA evaluation of DMC-ODS, access to MAT has increased in counties that were early implementers of DMC-ODS and remained relatively steady in counties that implemented more recently.<sup>21</sup>

In parallel with DMC-ODS implementation, other targeted efforts to address the opioid epidemic in California were implemented in recent years. Of particular note is the California MAT Expansion Project, which is funded by federal grants totaling \$265 million and aims to expand access to MAT, reduce unmet treatment need, and reduce opioid overdose deaths.<sup>22</sup> In addition to the California MAT Expansion Project, counties have formed unique partnerships in a variety of settings including residential treatment programs and outpatient programs, hospitals, primary care clinics, health plans, criminal justice system agencies, and opioid safety coalitions.<sup>23</sup> MAT provided through these partnerships often is not reimbursed through DMC-ODS. Instead, these services may be covered by other payers or, within Medi-Cal, as non-Drug

Medi-Cal services. As a result, it has been challenging to fully quantify the increase in access to MAT across the state, given the complexity of the delivery system and payer structure. For example, Santa Cruz County partnered with primary care clinics to expand access to MAT services, but the services are not captured in the county's DMC-ODS claims data.<sup>24</sup>

## The Added Value of Case Management Services

One new benefit under DMC-ODS is the coverage of case management services. While some counties may have offered limited case management services before DMC-ODS, these were not a Drug Medi-Cal benefit, and costs had to be covered with grants or other funding. Case management services assist patients in accessing complementary medical, mental health, educational, social, prevocational, vocational, rehabilitative, and other community services — services that can significantly impact a person's success with SUD treatment. According to the FY 2019 UCLA evaluation, more than 90% of county administrators reported that DMC-ODS had a positive impact on the delivery of case management services in their county.<sup>25</sup>

San Mateo County is using case management to better meet the needs of its patients with the most complex needs. Case managers are assigned to patients with complex needs who are involved with multiple systems. These case managers help connect these patients to an array of needed services and supports, including housing, and mental health and physical health services, and help them transition between levels of care — an important function to ensure treatment continuity and to promote better outcomes.

**28% of SUD treatment patients also received mental health services in the same year.<sup>26</sup>**

Although case management is a powerful tool, many counties and providers reported challenges with maximizing its potential. One barrier is the requirement that case management services under DMC-ODS be conducted by registered/certified counselors or licensed practitioners of the healing arts, which include physicians, registered nurses, and other licensed clinicians. According to San Luis Obispo County, this requirement prevents the county from being able to seek reimbursement for case management services delivered by trained peer support specialists, as most do not meet these requirements.

Another barrier counties frequently cited was a lack of clarity around the documentation required to be reimbursed for DMC-ODS case management services. Case management services provided without sufficient documentation — including duration of service and how it relates to the treatment plan — cannot be claimed for reimbursement. Santa Clara County reported that, since providers have operated for years *without* case management as a covered benefit, it has taken a lot of training to help them understand the importance of sufficiently documenting these services.

## Extending Treatment Through Recovery Services

Another DMC-ODS benefit not covered by the standard Drug Medi-Cal program is recovery services. Recovery services are intended to support a person's wellness and recovery after they complete a course of treatment. These services can be a valuable tool in preventing relapse and promoting continued recovery.

In Marin County, recovery coaches provide continued support to those who have completed treatment. Marin credits its recovery coaches for many of the county's successful patient outcomes in DMC-ODS. According to Marin County, recovery coaches bring a unique passion to the services they provide and are afforded a level of flexibility that enables them to truly "meet clients where they are at." In Santa Clara County, all outpatient discharge plans include a recovery services component. In developing the recovery



services benefit, Santa Clara County built in significant flexibility, encouraging providers to tailor recovery services to individuals and their unique recovery needs.

DMC-ODS allows counties to use peer providers — people in recovery from SUD — to provide recovery services. As part of Riverside County's Peer Support Specialist program, people with lived experience are present at almost every county-operated SUD treatment facility. The peer support specialists work with SUD counselors to help support those in recovery. Peer providers can only provide recovery services; they cannot be reimbursed for any other services under DMC-ODS.

*“Recovery services allow the county to continue treatment — a true continuum of care.”*

— Santa Clara County

While recovery services can be a valuable tool in preventing relapse and promoting continued recovery, according to DMC-ODS claims data, in 2018 less than 3% of those served received recovery services. County administrators noted that the low percentage in claims data reflects challenges interpreting the new recovery services benefit, particularly around the use of peer services, as well as a lack of clarity around billing and documentation requirements.<sup>27</sup>

Marin County acknowledged that outside of county-contracted recovery coaches, claims for recovery services through provider sites are low. This does not indicate that providers in Marin County are not offering recovery services, but that they are not documenting or billing for the services. San Luis Obispo County also indicated that while providers are providing recovery services, they struggle with Medi-Cal billing. As a result, recovery services provided are not reflected in the county's DMC-ODS claims, which means less federal matching funds in the program.

## Financial Implications for Counties

One key benefit of DMC-ODS is the availability of federal Medicaid funding for services not covered by the standard Drug Medi-Cal program. In addition to expanded MAT medications, case management, and recovery services, DMC-ODS counties receive federal matching funds for residential treatment (previously only available to perinatal women), new levels of withdrawal management, physician consultation, and partial hospitalization.

Historically, a significant portion of county SUD services — those not covered by the standard Drug Medi-Cal program — were paid for with grant funding, particularly the SAMHSA Substance Abuse Prevention and Treatment Block Grants (SABGs). Now that Medi-Cal covers expanded benefits in DMC-ODS counties, county SABG funds are freed up and can be used to further expand and support the community SUD treatment and prevention system.

In particular, many counties are now directing these freed-up SABG dollars to fund recovery housing. Since Medicaid funding cannot be used for “room and board,” it cannot fund housing support for people in SUD treatment — but there is no such restriction on SABG funds. In San Francisco County, an estimated 90% of all patients treated in a residential treatment setting were experiencing homelessness.<sup>28</sup> If a patient leaves residential treatment and returns to the streets, they will face significant challenges in achieving successful recovery. San Francisco uses SABG funds to pay for residential step-down beds, ensuring that patients can continue their outpatient treatment in a safe environment following a residential treatment stay. Santa Clara County is using increased federal funding and freed-up grant funds to develop additional outpatient services and to build up its provider network to meet community needs. As Los Angeles County noted, counties are more willing to challenge the status quo and try something new given the opportunity to do so through new and increased funding enabled by DMC-ODS.

*“DMC-ODS hasn’t solved complex problems, but the flexibility has allowed the county to be more creative in how we are able to meet these complex needs.”*

— Marin County

## Keys to Success in DMC-ODS

### Strong Leadership

Most counties voiced that strong leadership was essential to successful implementation of DMC-ODS. Whether educating the community about new services offered under DMC-ODS; engaging stakeholders, providers, or boards of supervisors; training staff on new billing and cost report systems as well as ASAM levels of care; or efforts to address stigma, strong leadership was seen as key to ensuring a smooth implementation of DMC-ODS. In Riverside County, “leadership was willing to take the risk and invest in the community.” With the support of county leadership, Riverside County increased its staff dedicated to SUD services to successfully expand services to county residents.<sup>29</sup>

### Working Hand-in-Hand with Providers

Strong partnerships between the county and its contracted providers are essential to DMC-ODS. In Riverside County, contracted providers helped develop the program during planning and implementation. Riverside County summed up its approach to provider partnerships with a quote from General George Patton: “Never tell people how to do things. Tell them what to do, and they will surprise you with their ingenuity.” This inclusive process fostered a team mindset among the providers and the county in which both parties felt invested in the program and its overall success.

In San Mateo County, the partnership between the county and providers evolved into improved relationships between the providers. San Mateo County held monthly calls with its providers during DMC-ODS implementation. Through this increased collaboration, providers created their own coalition to form their own partnerships. In addition, several smaller San Mateo County providers employ the same medical director, who serves as a common thread and contributes to the overall unity of the provider community.

Regularly checking in with providers has helped counties identify needs and then deliver technical assistance to help providers successfully implement the new requirements of DMC-ODS. San Francisco began its DMC-ODS implementation with an existing, robust continuum of providers. Although many of these providers had operated successfully for years, they are now doing so in a new environment, requiring them to change their processes to align with DMC-ODS requirements. For instance, providers formerly used their own processes to determine the proper level of care for a person seeking treatment. Under DMC-ODS, all providers must use the ASAM criteria to determine level of care placement. By regularly convening and encouraging discussion, counties can assess their providers’ needs and provide them with necessary technical assistance.

In addition, DMC-ODS encouraged counties to strengthen relationships with other players, such as local hospitals, community clinics and health centers, and health plans. Since the implementation of DMC-ODS, Marin County’s Substance Use Division has been able to forge more effective relationships with local hospitals and the county’s Medi-Cal health plan. As an example, the county recently entered into an expanded data-sharing arrangement with the local Medi-Cal health plan, allowing for expansion of quality management and collaboration opportunities. In Riverside County, mental health providers, hospitals, and community clinics have all reached out to the county to build partnerships. These relationships help to integrate services delivered in separate environments, and ultimately create a better, more seamless experience for those they serve.

## A Culture Shift

Attitudes about people who use drugs and SUD treatment are changing within the health care system as more providers recognize SUD as a disease. Perceptions of community SUD treatment are shifting, and SUD treatment is now more likely to be regarded as a component of the larger health care system. Nevada County recounts that SUD treatment feels less siloed under DMC-ODS, with greater coordination and integration with other health providers.

*“DMC-ODS brings addiction treatment into the family of medicine.”*

— San Francisco County

Although stigma surrounding SUD treatment still exists, counties reported that stigma is diminishing, particularly for MAT. Nevada County initially experienced a dramatic “not in my backyard” response to its efforts to establish medication unit services at a new site. The county responded to concerns by educating residents on the value of MAT, locating the building’s entrance in the back rather than directly on the street, and having staff stationed outside the entrance.<sup>30</sup> In San Mateo County, community partners such as emergency departments and mental health providers are increasingly supporting MAT, discovering that medications — paired with appropriate services and supports — can make a tremendous difference in patient outcomes.

## Remaining Challenges and Opportunities for Growth

**Residential treatment limitations.** Currently, adult residential SUD treatment services may be authorized for two noncontinuous stays within a 365-day period for up to 90 days for each stay, and a 30-day extension can be permitted for one of the stays. Similarly, adolescent residential treatment services may be authorized for two noncontinuous stays within a 365-day period of up to 30 days each, and an extension can be permitted for up to 30 days for one of the stays.<sup>31</sup> Several counties expressed challenges with the residential length-of-stay requirements. For example, Santa Cruz County expressed that sometimes someone may leave residential treatment after just a few days, return, and then leave again. Under the current structure of the program, this would count as two stays, even if each of the stays were only a few days, leaving the county responsible for additional residential treatment attempts.

The Department of Health Care Services (DHCS) has recognized the challenges counties face surrounding residential treatment lengths of stay and in a proposal to incorporate most DMC-ODS provisions into a new waiver has stated that “residential length-of-stay should be determined based on the individual’s condition, medical necessity, and treatment needs.” DHCS has proposed to remove the two-episode limit on residential treatment stays as DHCS has found this “inconsistent with the clinical understanding of relapse and recovery from SUDs.”<sup>32</sup>

**Inpatient withdrawal management.** All counties participating in DMC-ODS are required to offer at least one level of withdrawal management, a service that provides medical or psychological supervision in either an outpatient or inpatient setting while a patient reduces or stops substance use. Most counties have struggled to secure contracts with providers in their communities for inpatient levels of withdrawal management, a level of care provided in a hospital

setting, including chemical dependency recovery hospitals and freestanding acute psychiatric hospitals. Providers who have contracted with counties to provide inpatient withdrawal management services have encountered challenges with licensure, certification, staffing, and billing. Several counties are in the process of contracting with providers to offer inpatient withdrawal management services. Riverside County has a contract in place with an inpatient withdrawal management services provider, although no services have been delivered to date.

**Adapting to Medi-Cal documentation and billing requirements.** As discussed above, for many providers, DMC-ODS is their first experience as a Medi-Cal provider and they have had to learn the new documentation and billing requirements of the Medi-Cal program. Many counties described the lack of clarity around the DMC-ODS documentation requirements, particularly for case management and recovery services, as a challenge. Riverside and Santa Clara Counties both noted that adapting to new documentation requirements has been challenging for many of their residential providers. Additional guidance on billable activities and sufficient documentation for these services, as well as trainings for providers on the importance of sufficiently documenting these activities, are needed.<sup>33</sup>

### Training the Future SUD Workforce to Succeed in DMC-ODS

Los Angeles County is working with the certification bodies for SUD counselors to enhance counselor training for the DMC-ODS environment. The resulting SUD Workforce Enhancement for Longitudinal Learning (SWELL) Initiative curriculum focuses on the knowledge, competency, and skills required of an effective DMC-ODS workforce. Trainings are available for new counselors as part of their registration and certification process through the SUD counselor certifying bodies, and as continuing education for existing counselors seeking to renew their certifications.<sup>34</sup> To date, 145 counselors have been trained by SUD counselor certifying bodies following the principles outlined in the SWELL Initiative.<sup>35</sup>

**Confidentiality of SUD patient records (42 CFR Part 2).** Several counties said that 42 CFR Part 2 is a barrier to coordinating care in DMC-ODS. 42 CFR Part 2 is a federal law that requires providers to obtain patient consent before sharing their treatment or medical information, except in rare circumstances.<sup>36</sup> Providers noted 42 CFR Part 2 hinders their ability to coordinate care for the most complex patients as obtaining patient consent to release health information has been challenging, particularly in counties without countywide electronic health records.<sup>37</sup> Some counties have employed three-way calling to overcome this barrier, connecting the Access Call Center referrer, the provider, and the patient who can consent to information sharing in real time.<sup>38</sup>

**Resources in small counties.** To date, few small counties (those under 200,000 in population)<sup>39</sup> have implemented DMC-ODS, and those that have face unique challenges. Smaller counties are less likely than larger counties to have the resources needed to significantly expand their SUD systems of care — such as county staff and wide networks of community treatment providers — but they are still subject to the same DMC-ODS requirements. While most counties have added new positions to manage these requirements, rural Nevada County was only able to add half of a full-time employee position. To compensate, the county cross-trained existing staff and shifted them to DMC-ODS.

## Conclusion

Research for this report was conducted before the COVID-19 public health emergency was declared. Counties and providers have faced new challenges in providing services during the COVID-19 pandemic. To address these challenges, DHCS has implemented new flexibilities around telehealth, buprenorphine, take-home medications, and information sharing, among other things.<sup>40</sup>

The Medicaid Section 1115 waiver that established DMC-ODS expires December 31, 2020. In October 2019, California released the California Advancing and Innovating Medi-Cal (CalAIM) proposal, a multiyear initiative to implement overarching policy changes across all Medi-Cal delivery systems.<sup>41</sup> The CalAIM initiative proposes to incorporate most of the provisions in DMC-ODS into a Section 1915(b) waiver, except for the IMD expenditure authority, which will be pursued through another Section 1115 waiver. A Section 1915(b) waiver allows states to deliver Medicaid benefits through managed care systems and is typically considered a more “permanent” waiver than an 1115 waiver, which aims to demonstrate and test new programs. Moving DMC-ODS to a 1915(b) waiver sends a strong signal to the counties and providers that this program is here to stay. Furthermore, CalAIM proposes to seek federal authority for SUD (DMC-ODS), specialty mental health, and physical health programs all under the same 1915(b) waiver, which also sends a strong message about integration and the role of the SUD services within the broader health care system. While county participation in DMC-ODS would remain voluntary, the state encourages all counties to participate and will provide technical assistance to counties that have not yet implemented the program.

However, just as the state was preparing to initiate the formal waiver application process with CMS to move CalAIM forward, the nation was struck by the COVID-19 public health emergency, which has greatly impacted all aspects of California’s health care delivery system. As a result, key partners and stakeholders, including managed care plans, providers, and

counties, requested a delay in implementing CalAIM to focus on addressing the pandemic. While the goals and objectives of CalAIM continue to be a high priority for stakeholders and state officials alike, in May 2020, DHCS officially announced the delay of CalAIM. As a result, DHCS will submit a 12-month Section 1115 waiver extension request to CMS to ensure that programs authorized through Medi-Cal 2020 continue and are eventually transitioned under CalAIM. The proposed Medi-Cal 2020 12-month extension request is expected to be submitted this fall and, if approved, will provide continuing authority for DMC-ODS through the end of 2021.

As part of the extension request, California is also proposing to clarify and update certain provisions of DMC-ODS based on counties’ experiences implementing the program to date. Proposed technical changes include removing the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period, clarifying that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis is determined, clarifying the recovery services benefit, expanding access to MAT, and increasing access to SUD treatment for Native Americans.<sup>42,43</sup>

As California moves forward with the CalAIM initiative and works to address the COVID-19 public health emergency, DMC-ODS will continue to play a pivotal role in expanding access to SUD treatment and recovery services across the state of California. While challenges remain, Nevada County emphasized that by learning from each other, particularly drawing on lessons from counties that were early implementers, each county does not need to reinvent the wheel.

## Endnotes

1. "County Plans & Contracts," California Dept. of Health Care Services (DHCS), last modified January 23, 2020; and *Medi-Cal Certified Eligibles Data Table by County and Aid Code Group June 2020* (Dates Represented: March 2020), DHCS, June 2020. Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano Counties are part of a regional model implementing DMC-ODS in partnership with their local Medi-Cal managed care plan, Partnership HealthPlan of California.
2. *Medi-Cal Moves Addiction Treatment into the Mainstream: Early Lessons from the Drug Medi-Cal Organized Delivery System Pilots*, California Health Care Foundation (CHCF), August 2018.
3. Chelsea Kelleher, Allison Valentine, and Molly Brassil, *The Drug Medi-Cal Organized Delivery System* (PDF), CHCF, August 2019.
4. *How Medi-Cal Is Improving Treatment for Substance Use Disorder in California* (PDF), CHCF, December 2018.
5. "Briefing – How Medi-Cal is Modernizing Addiction Treatment," CHCF, December 6, 2018.
6. 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."
7. For additional information about Medicaid Section 1115 waivers, see "About Section 1115 Demonstrations."
8. "State Waivers List," CMS, accessed August 12, 2020. The other states are AK, DC, DE, ID, IL, IN, KS, KY, LA, MA, MD, MI, MN, NC, NE, NH, NJ, NM, OH, PA, RI, UT, VA, VT, WA, WI, and WV.
9. 42 U.S.C. § 1396d.
10. The CalAIM initiative is exploring opportunities to update and clarify the eligibility and medical necessity criteria for those seeking SUD treatment services. For additional information, see the [CalAIM web page](#).
11. *California Medi-Cal 2020 Demonstration* (PDF), Medicaid.gov, August 3, 2020: 96–128, 384–415.
12. For additional information, see [UCLA's TPS web page](#).
13. For additional information, see [UCLA's DMC-ODS Evaluation web page](#).
14. For additional information, see [Behavioral Health Concept's DMC-ODS EQRO web page](#).
15. Some providers use the term "medications for addiction treatment."
16. *Drug Medi-Cal Organized Delivery System: 2019 Evaluation Report* (PDF), UCLA Integrated Substance Abuse Programs, September 16, 2019.
17. *Drug Medi-Cal Organized Delivery System: 2019 Evaluation Report*.
18. For additional information about the ASAM criteria, see ASAM's "What is The ASASM Criteria?" web page.
19. *Drug Medi-Cal Organized Delivery System: 2019 Evaluation Report*.
20. *Drug Medi-Cal Organized Delivery System: 2019 Evaluation Report*.
21. *Drug Medi-Cal Organized Delivery System: 2019 Evaluation Report*.
22. For additional information, see the [California MAT Expansion Project website](#).
23. *Drug Medi-Cal Organized Delivery System External Quality Review Report: FY 2018–19* (PDF), Behavioral Health Concepts, October 20, 2019.
24. *2018–19 Drug Medi-Cal Organized Delivery System External Quality Review: Santa Cruz DMC-ODS Report* (PDF) (March 20–21, 2019), Behavioral Health Concepts, n.d.
25. *Drug Medi-Cal Organized Delivery System: 2019 Evaluation Report*.
26. *Drug Medi-Cal Organized Delivery System: 2019 Evaluation Report*.
27. *Drug Medi-Cal Organized Delivery System: 2019 Evaluation Report*.
28. Interview with San Francisco County, November 18, 2019.
29. *Drug Medi-Cal Organized Delivery System External Quality Review Report: FY 2018–19*.
30. *2018–19 Drug Medi-Cal Organized Delivery System External Quality Review: Nevada DMC-ODS Report* (PDF) (June 18, 2019), Behavioral Health Concepts, n.d.
31. "California Advancing and Innovating Medi-Cal Proposal," DHCS, accessed August 2020.
32. "California Advancing and Innovating Medi-Cal Proposal."
33. *Drug Medi-Cal Organized Delivery System: 2019 Evaluation Report*.
34. "SUD Workforce Enhancement for Longitudinal Learning (SWELL) Initiative," California Consortium of Addiction Programs and Professionals, accessed August 2020.
35. Email communication with Los Angeles County, May 5, 2020.
36. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) signed into law March 27, 2020 made changes to 42 CFR Part 2 easing patient consent requirements to align more closely with the Health Insurance Portability and Accountability Act (HIPAA).
37. *Drug Medi-Cal Organized Delivery System: 2019 Evaluation Report*.

38. *Drug Medi-Cal Organized Delivery System External Quality Review Report: FY 2018–19*.
39. Based upon county categorizations as determined by DHCS. See *Performance Outcomes System Reports* (PDF), report run on August 3, 2016.
40. “COVID-19 Information for Providers & Partners,” DHCS, accessed August 2020.
41. For additional information, see the [CalAIM web page](#).
42. For additional information, see the “[Medi-Cal 2020 12-Month Extension Request](#)” web page.
43. Medi-Cal uses the term *American Indians and Alaska Natives*.