



State of California—Health and Human Services Agency  
Department of Health Care Services



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GOVERNOR

SEP 10 2015

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**ACCEPTANCE OF THE "BRIDGE TO REFORM" DEMONSTRATION PROJECT  
(WAIVER NUMBER 11-W-00193/9) SPECIAL TERMS AND CONDITIONS AND  
EXPENDITURE AUTHORITY: DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM**

Dear Mr. Fishman, Ms. Hossain, and Ms. Sam-Louie,

On August 13, 2015, the State of California, Department of Health Care Services received an approval from the Centers for Medicare and Medicaid Services (CMS) of the state's request to amend the Special Terms and Conditions (STCs) for the "Bridge to Reform" Demonstration Project (Waiver Number 11-W-00193/9) authorized under section 1115 of the Social Security Act.

This letter serves as California's official acceptance of the STCs as set forth in CMS's approval letter regarding the state's authorization to deliver an organized delivery of health care services to Medi-Cal beneficiaries with a substance use disorder (SUD). The state will implement this pilot program and also adhere to CMS guidelines issued in the July 27, 2015 State Medicaid Directors letter on new service delivery opportunities for individuals with SUD. However, we propose the following technical corrections to the STCs for your consideration and approval:

## 167. DMC-ODS Benefit and Individual Treatment Plan (ITP) Table

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

### ***Explanation of Change***

Change from DMS to DMC for accuracy.

## 167. DMC-ODS Benefit and Individual Treatment Plan (ITP) (a)

**a- b.** The following services (Tables TWO and THREE) must be provided, as outlined in Table FOUR, to all eligible DMC-ODS beneficiaries for the identified level of care as follows. DMC-ODS benefits include a continuum of care that ensures that clients can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses.

### ***Explanation of Change***

Change a to b for proper continuity.

### **i. Early Intervention Services (ASAM Level 0.5)**

Screening, brief intervention and referral to treatment (SBIRT) services are provided by non-DMC providers to beneficiaries at risk of developing a substance use disorder. SBIRT services are not paid for under the DMC-ODS system. SBIRT services are paid for and provided by the managed care plans or by fee-for-service primary care providers. SBIRT attempts to intervene early with non-addicted people, and to identify those who do have a substance use disorder and need linking to formal treatment.

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

### ***Explanation of Change***

Change contracts to intergovernmental agreements to conform with CMS's request to amend this terminology.

### **The Components of Outpatient Services (c)**

C. Group Counseling: Face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 14 12 in the group, focusing on the needs of the individuals served.

#### ***Explanation of Change***

Change 14 to 12 as this was an error on California's end. California's statutory requirement for Drug Medi-Cal limits group size to 12 participants.

### **169. Responsibilities of Counties for DMC-ODS Benefits (iv)**

iv. Contract Denial: Counties shall serve providers that apply to be a contract provider but are not selected a written decision including the basis for the denial.

- County Protest: Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision.

- o Counties shall have a protest procedure for providers that are not awarded a contract.

- o The protest procedure shall include requirements outlined in the State/County ~~contract~~ intergovernmental agreement.

- o Providers that submit a bid to be a contract provider, but are not selected, must exhaust the county's protest procedure if a provider wishes to challenge the denial to the Department of Health Care Services (DHCS). If the county does not render a decision within 30 calendar days after the protest was filed with the county, the protest shall be deemed denied and the provider may appeal the failure to DHCS.

#### ***Explanation of Change***

Change contract to intergovernmental agreement to conform with CMS's request to amend this terminology.

### **169. Responsibilities of Counties for DMC-ODS Benefits (c)(e)**

c. County Implementation Plan: Counties must submit to the State a plan on their implementation of DMC-ODS. The State will provide the template for the implementation plan, which is included here as Attachment Z. Counties cannot commence services without an implementation plan approved by the state and CMS. Counties must also have an executed State/County intergovernmental agreement (managed care contract per federal definition) with the county Board of Supervisors and approved by CMS. County implementation plans must ensure that providers are appropriately certified for the services contracted,

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implementing at least two evidenced based practices, trained in ASAM Criteria, and participating in efforts to promote culturally competent service delivery. One ASAM level of Residential Treatment Services is required for approval of a county implementation plan in the first year. The county implementation plan must demonstrate ASAM levels of Residential Treatment Services (Levels 3.1-3.5) within three years of CMS approval of the county implementation plan and state-county intergovernmental agreement (managed care contract per federal definition). The county implementation plan must describe coordination for ASAM Levels 3.7 and 4.0.

Upon CMS approval of the implementation plan and an **executed contract executed intergovernmental agreement**, counties will be able to bill prospectively for services provided through this Pilot.

e. State-County Intergovernmental Agreement (Managed Care Contract per federal definition):

DHCS will require a State-County intergovernmental agreement (managed care contract per federal definition) to be signed between the state and the county in opt-in counties, subject to CMS approval. The **contract intergovernmental agreement** will provide further detailed requirements including but not limited to access, monitoring, appeals and other provisions. Access standards and timeliness requirements that are specified and described in the county implementation plans will be referenced in the state/county intergovernmental agreements (managed care contract per federal definition). CMS will review and approve the State-County intergovernmental agreement (managed care contract per federal definition).

i. Care Coordination: Counties' implementation plans and state/county **contracts intergovernmental agreements** (managed care contracts per federal definition) will describe their care coordination plan for achieving seamless transitions of care. Counties are responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the county will describe in the implementation plan and state/county intergovernmental agreement (managed care contracts per federal definition) how beneficiaries will access recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment. The county implementation plan and state/county intergovernmental agreement (managed care contract per federal definition) will indicate whether their care transitions approach will be achieved exclusively through case management services or through other methods. The county implementation plan and state/county intergovernmental agreement (managed care contract per federal

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definition) will indicate which beneficiaries receiving SUD services will receive care coordination.

***Explanation of Changes***

Change executed contract/contract to executed intergovernmental agreement/intergovernmental agreement to conform with CMS's request to amend this terminology.

**174. Federal 42 CFR 438 and other Managed Care Requirements (c)**

c. At least sixty (60) days prior to CMS ~~contract~~ intergovernmental agreement approval the state shall submit for each opt-in county the applicable network adequacy requirements as part of the county implementation plan. CMS concurrence with standards is required. At least sixty (60) days prior to CMS ~~contract~~ intergovernmental agreement approval the state shall provide all deliverables necessary to indicate compliance with network adequacy requirements.

***Explanation of Changes***

Change executed contract to executed intergovernmental agreement to conform with CMS's request to amend this terminology.

**Attachment Z Drug Medi-Cal Organized Delivery System (DMC-ODS) County Implementation Plan: Part I Plan Questions (4)**

4. Prior to any meetings to discuss development of this implementation plan, did representatives from Substance Use Disorders (SUD), Mental Health (MH) and Physical Health all meet together regularly on other topics, or has preparation for the Waiver been the catalyst for these new meetings?

SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.

There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.

There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.

There were no regular meetings previously, but they will occur during implementation.

There were no regular meetings previously, and none are anticipated.

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### ***Explanation of Change***

The extra boxes are unnecessary.

### **Attachment Z Drug Medi-Cal Organized Delivery System (DMC-ODS) County Implementation Plan: Part II Plan Description (Narrative) (6-21)**

~~6.~~ **5. Coordination with Mental Health. [...]**

~~7.~~ **6. Coordination with Physical Health. [...]**

~~8.~~ **7. Coordination Assistance. [...]**

~~9.~~ **8. Access. [...]**

~~10.~~ **9. Training Provided. [...]**

~~11.~~ **10. Technical Assistance. [...]**

~~12.~~ **11. Quality Assurance. [...]**

~~13.~~ **12. Evidence Based Practices. [...]**

~~14.~~ **13. Assessment. [...]**

~~15.~~ **14. Regional Model.** If the county is implementing a regional model, describe the components of the model. Include service modalities, participating counties, and identify any barriers and solutions for beneficiaries. How will the county ensure access to services in a regional model (refer to question ~~7~~ 6)?

~~16.~~ **15. Memorandum of Understanding. [...]**

~~17.~~ **16. Telehealth Services. [...]**

~~18.~~ **17. Contracting. [...]**

~~19.~~ **18. Additional Medication Assisted Treatment (MAT). [...]**

~~20.~~ **19. Residential Authorization. [...]**

~~21.~~ **20. One Year Provisional Period. [...]**

### ***Explanation of Change***

The numbering must change beginning in item 6 to ensure proper continuity.

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We look forward to your response. If you have any questions, please contact Angeli Lee at (916) 324-0184.

Sincerely,

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