



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



EDMUND G. BROWN JR.  
GOVERNOR

November 21, 2014

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**RE: California Bridge to Reform Demonstration (No. 11-W-00193/9) Amendment  
for Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver**

Dear Ms. Hossain, Ms. Garner, and Ms. Lee:

The California Department of Health Care Services (State) proposes to amend the Special Terms and Conditions (STCs) of Waiver 11-W-00193/9, California Section 1115 "Bridge to Reform" Demonstration (Demonstration Waiver).

California's Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 demonstration waiver provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services. The waiver amendment will make improvements to the Drug Medi-Cal (DMC) service delivery system, more local control and accountability in selection of high quality providers, improved local coordination of case management services, implementation of evidenced based practices in substance abuse treatment, and coordination with other systems of care including physical health. The DMC-ODS will demonstrate how organized substance use disorder (SUD) care increases the success of DMC beneficiaries while decreasing other system health care costs. Participation for providing services under this waiver is voluntary; eight to twelve counties are expected to initially opt-in to waiver participation.

This waiver amendment would allow the State to extend the DMC Residential Treatment Service, as an integral aspect of the continuum of care, to additional beneficiaries. Historically, the Residential Treatment service was only available to pregnant/postpartum beneficiaries in facilities with a capacity of 16 or less beds. This waiver will create a Residential Treatment service operable in facilities with no bed capacity limit.

The State is requesting that this Demonstration Waiver amendment request be approved as soon as possible and no later than April 1, 2015, to ensure that necessary preparations are completed. State staff will collaborate in the coming months with the Centers for Medicare and Medicaid Services (CMS) to secure prompt approval of this amendment.

## **BACKGROUND**

California Assembly Bill (AB) 1, First Extraordinary Session, Statutes of 2013 authorized the expansion of Medi-Cal eligibility to childless adults with annual incomes up to 133 percent of the Federal Poverty Level, effective January 1, 2014.

## **IMPACT TO SERVICES**

Upon approval of the waiver, the State will make the Residential Treatment Service available to beneficiaries other than pregnant/postpartum, and make it operable in facilities with no bed capacity limit. It will establish a residential treatment limit of a 90-day maximum for adults and 30-day maximum for adolescents, unless Medi-Cal necessity authorizes a one-time extension of up to 30 days. Additional details on waiver provisions are contained in the Special Terms and Conditions (Exhibit 1).

The waiver will also make the following improvements to DMC services:

- Continuum of Care: Putting together into a continuum of care those services available to address substance use, including: physician consultation,

- outpatient treatment, case management, medication assisted treatment, recovery services, recovery residence, withdrawal management, and residential treatment.
- **Assessment Tool:** Establishing the ASAM assessment tool to determine the most appropriate level of care so that clients can enter the system at the appropriate level and step up or step down in intensive services, based on their response to treatment.
  - **Case Management and Residency:** Providing case management services to ensure that the client is moving through the continuum of care, and providing that counties coordinate care for those residing within the county.
  - **Selective Provider Contracting:** Giving counties more authority to select quality providers. Safeguards include providing that counties cannot discriminate against providers, that beneficiaries will have choice within a service area, and that a county cannot limit access.
  - **Provider Appeals Process:** Creating a provider contract appeal process where providers can appeal to the county and then the state. State appeals will focus solely on ensuring network adequacy.
  - **Clear State and County Roles:** Counties will be responsible for oversight and monitoring of providers as specified in their county contract.
  - **Coordination:** Supporting coordination and integration across systems, such as with the provision that counties enter into Memoranda of Understanding (MOUs) with managed care health plans for referrals and coordination, providing that county substance use programs collaborate with criminal justice partners.
  - **Authorization and Utilization Management:** Providing that counties authorize services, with residential treatment required and others as counties determine, and ensuring Utilization Management.
  - **Workforce:** Expanding service providers to include Licensed Practitioners of the Healing Arts for the assessment of beneficiaries, and other functions within their scope of practice.
  - **Program Improvement:** Promoting a consumer-focus, using evidence-based practices including medication assisted treatment services and increasing system capacity for youth services.

#### **WAIVER AUTHORITY**

The State believes the existing waivers of freedom of choice, statewide, and comparability encompasses this proposed Demonstration Waiver amendment. To the

extent necessary, the State requests its authority to operate under these waivers extends to the amendments contained in this request.

The State has ensured its compliance with the Medicaid CFR 438 requirements and will seek amendments to waive some of these requirements as the State did with the implementation of the Low Income Health Program.

### **EXPENDITURE AUTHORITY**

This proposed Demonstration Waiver amendment will not impact the existing Waiver Expenditure Authority. Expenditures not otherwise eligible for Federal Financial Participation may be claimed for covered services furnished to DMC-ODS beneficiaries who are residents in facilities that meet the definition of an Institution for Mental Disease. These facilities include, but are not limited to, free standing psychiatric hospitals, chemical dependency recovery hospitals, and state licensed residential facilities for residential treatment, and withdrawal management services.

### **PUBLIC NOTICE AND TRIBAL NOTICE**

The State has provided, and will continue to provide, Public Notice on the DMC-ODS through various means including but not limited to:

- January-March 2014 Stakeholder Conference Calls
- January 28 Narcotic Treatment Program Advisory Group
- April 2, 2014 Waiver Advisory Group
- April 15, 2014 Waiver Advisory Group
- April 30, 2014 Waiver Advisory Group
- July 29, 2014 Narcotic Treatment Program Advisory Group
- July 30, 2014 Waiver Advisory Group
- August 12, 2014 DHCS SUD Conference
- October 2, 2014 Behavioral Health Forum
- October 16, 2014 California Mental Health Planning Council
- October 21, 2014 Senate Legislative Hearing
- November 3, 2014 Waiver Advisory Group
- November 4, 2014 Narcotic Treatment Program Advisory Group

On August 28, 2014, the State issued the Tribal Notice regarding the State's intention to request the Waiver amendment for the DMC-ODS. On October 17, 2014, questions and comments from the Tribal Notice were posted to the DHCS website [http://www.dhcs.ca.gov/services/rural/Pages/Tribal\\_Notifications.aspx](http://www.dhcs.ca.gov/services/rural/Pages/Tribal_Notifications.aspx) .

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## **BUDGET NEUTRALITY**

A revised budget neutrality calculation for the complete Waiver is enclosed (Enclosure 2). As noted in the budget neutrality file, the estimates were based on an assumption of eight specific counties opting in for participation. The eight counties used in the computation were used exclusively for budget neutrality purposes and is not intended to imply which counties will opt-in or out of the waiver. The budget neutrality will be updated to reflect estimates of actual opt-in counties as each county enters the program.

## **EVALUATION**

Through an existing contract, the University of California, Los Angeles, Integrated Substance Abuse Programs will conduct an evaluation to measure and monitor the outcomes from the waiver. The design of the evaluation will focus on the four key areas of access, quality, cost, and integration and coordination of care. California will utilize the SUD data system currently in place known as the California Outcomes Measurement System (CalOMS). CalOMS captures data from all SUD treatment providers which receive any form of government funding. The CalOMS data set, along with additional waiver specific data, will enable the State to evaluate the effectiveness of the DMC-ODS. The State will submit the complete design of the evaluation within 60 days of the approval of the amendment.

Thank you for your assistance and continued support of California's commitment to improving health care delivery and innovation. The State is happy to assist you and your staff in any way as you review the proposed Demonstration Waiver amendment. If you have any questions, please contact Karen Baylor, Ph.D., LMFT, Deputy Director Mental Health and Substance Use Disorder Services at (916) 440-7566.

Sincerely,

*ORIGINAL SIGNED BY TOBY DOUGLAS*

Toby Douglas  
Director

### Enclosures

- Enclosure 1-Special Terms and Conditions
- Enclosure 2-Budget Neutrality

cc: Please see next page.

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**CA Bridge to Health Reform  
Drug Medi-Cal Organized Delivery System Waiver  
Standard Terms and Conditions (STCs)  
(November 2014)**

**Drug Medi-Cal Organized Delivery System**

**1. Drug Medi-Cal Eligibility and Delivery System.** The “Drug Medi-Cal Organized Delivery System (DMC-ODS)” provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs.

a. DMC Beneficiaries

i. DMC-ODS beneficiaries:

- Have no age restrictions to receive DMC-ODS services;
- Are self-referred or receive referral by another person or organization, including but not limited to, physical health providers, law enforcement, family members, mental health care providers, schools, and county departments;
- Derive their Medicaid eligibility from the State Plan and meet the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and meet medical necessity criteria for services received as determined by the ASAM Criteria;
- Fit into the DMC continuum of care of services based on the ASAM Criteria; and,
- Reside in a county that opts into the Demonstration Waiver.

ii. Intersection with the Criminal Justice System: Beneficiaries involved in the criminal justice system often are harder to treat for SUD. While research has shown that the criminal justice population can respond effectively to treatment services, the beneficiary may require more intensive services. Additional services for this population may include:

- Eligibility: Counties recognize and educate staff and collaborative partners that Parole and Probation status is not a barrier to expanded Medi-Cal substance use disorder treatment services if the parolees and probationers are eligible.

- Lengths of Stay: Additional lengths of stay for withdrawal and residential services for criminal justice offenders if assessed for need (e.g. up to 6 months residential; 3 months FFP with a one-time 30-day extension if found to be medically necessary and if longer lengths are needed, other county identified funds can be used).
- Promising Practices: Counties utilize promising practices such as Drug Court services.

b. Delivery System

DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into the Waiver. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the waiver. Upon approval of an implementation plan, the State will contract with the county to provide DMC-ODS services. The county will subcontract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the State may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

c. DMC-ODS Program Eligibility Criteria

The DMC-ODS benefit shall be available to all beneficiaries who meet the requirements of Standard Terms and Conditions (STCs) 1(a) and for whom DMC-ODS is available based on STC 1(b) and who qualify based on the medical criteria outlined below. In order for Drug Medi-Cal reimbursement, the beneficiary must meet the following medical necessity criteria:

- i. Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders;
- ii. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Medical necessity encompasses all six dimensions so that a more holistic concept would be clinical necessity, necessity of care or clinical appropriateness. Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It must not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality).

d. DMC-ODS Eligibility Determination

Eligibility determination for the DMC-ODS benefit will be performed as follows:



- i. The eligibility determination will be conducted by the county or county contracted provider. When the county contracted provider conducts the initial eligibility, it will be reviewed and approved by the county prior to payment for services.
- ii. The initial eligibility determination for the DMC-ODS benefit will be performed through a face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA), which includes the following: physician, licensed/waivered psychologist, licensed/waivered/registered social worker, licensed/waivered/registered marriage and family therapist, licensed/waivered/registered Licensed Professional Clinical Counselor or registered nurse and nurse practitioners. After establishing a diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services.
- iii. Eligibility for ongoing receipt of DMC-ODS is determined at least every six months through the reauthorization process for individuals determined by the Medical Director, licensed physician or LPHA to be clinically appropriate.

e. Grievances and Appeals

- i. Each County shall have an internal grievance process that allows a beneficiary, or provider on behalf of the beneficiary, to challenge a denial of coverage of services or denial of payment for services by a participating County.
- ii. The Department of Health Care Services will provide beneficiaries access to a state fair hearing process.

**2. DMC-ODS Benefit and Individual Treatment Plan (ITP)**

Standard DMC services approved through the State Plan Benefit will be available to all beneficiaries in all counties. Beneficiaries that reside in a Waiver County will receive Waiver benefits. County eligibility will be based on the MEDs file. Counties that do not opt into the Waiver are only allowed to access federal funding to perform services outlined in the approved state plan amendment for DMC services. Beneficiaries receiving services in counties which do not opt into the Waiver will not have access to the services outlined in the DMC-ODS.

DMC Services	State Benefit Plan (Non-Waiver)	Opt-In Waiver
Outpatient/Intensive Outpatient	X	X
NTP	X	X
Residential	Perinatal Only	X (one level)
Withdrawal Management		X (one level)
Additional MAT		X
Recovery Services		X
Case Management		X
Physician Consultation		X

The following services shall be provided 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.

ASAM Criteria Continuum of Care Services and the DMC-ODS System

ASAM Level of Care	Title	Description	Provider
1	Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies	DHCS Certified Outpatient Facilities
2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	DHCS Certified Intensive Outpatient Facilities
2.5	Partial Hospitalization Services	20 or more hours of service/week for multidimensional instability not requiring 24-hour care	DHCS Certified Intensive Outpatient Facilities
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 20 hours of clinical service/week and prepare for outpatient treatment.	DHCS Licensed Residential Providers
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	DHCS Licensed Residential Providers
3.5	Clinically Managed High-Intensity Residential Services	24-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	DHCS Licensed Residential Providers
3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor availability	Chemical Dependency Recovery Hospitals; Free Standing Psychiatric hospitals
4	Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage patient in treatment	Chemical Dependency Recovery Hospitals, Hospital; Free Standing Psychiatric hospitals
OTP	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	DHCS Licensed OTP Maintenance Providers, licensed prescriber

ASAM Criteria Withdrawal Services (Detoxification/Withdrawal Management)  
and the DMC-ODS System

Level of Withdrawal Management	Level	Description	Provider
Ambulatory withdrawal management without extended on-site monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	DHCS Certified Outpatient Facility with Detox Certification; Physician, licensed prescriber; or OTP for opioids.
Ambulatory withdrawal management with extended on-site monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.	DHCS Certified Outpatient Facility with Detox Certification; licensed prescriber; or OTP.
Clinically managed residential withdrawal management	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	DHCS Licensed Residential Facility with Detox Certification; Physician, licensed prescriber; ability to promptly receive step-downs from acute level 4.
Medically monitored inpatient withdrawal management	3.7-WM	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.	Chemical Dependency Recovery Hospitals; Free Standing Psychiatric hospitals; ability to promptly receive step-downs from acute level 4
Medically managed intensive inpatient withdrawal management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Hospital, sometimes ICU, Chemical Dependency Recovery Hospitals; Free Standing Psychiatric hospitals

Counties are required to provide the following services outlined in the chart below. Upon State approval, counties may implement a regional model with other counties or contract with providers in other counties in order to provide the required services.

Service	Required	Optional
Outpatient Services	<ul style="list-style-type: none"> <li>• Outpatient</li> <li>• Intensive Outpatient</li> </ul>	<ul style="list-style-type: none"> <li>• Partial Hospitalization</li> </ul>
Residential	<ul style="list-style-type: none"> <li>• At least one level of service</li> </ul>	<ul style="list-style-type: none"> <li>• Additional levels</li> </ul>
Withdrawal Management	<ul style="list-style-type: none"> <li>• At least one level of service</li> </ul>	<ul style="list-style-type: none"> <li>• Additional levels</li> </ul>
Medication Assisted Tx	<ul style="list-style-type: none"> <li>• Required</li> </ul>	
Recovery Services	<ul style="list-style-type: none"> <li>• Required</li> </ul>	
Case Management	<ul style="list-style-type: none"> <li>• Required</li> </ul>	
Physician Consultation		<ul style="list-style-type: none"> <li>• Optional</li> </ul>

- i. Outpatient Services (ASAM Level 1) counseling services are provided to beneficiaries up to 9 hours a week for adults and less than 6 hours a week for adolescents when determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

The Components of Outpatient are:

- Intake: The process of determining that a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
- Individual Counseling: Contacts between a beneficiary and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service.
- 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 12 in the group, focusing on the needs of the individuals served.
- Family Therapy: The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery as well as their own recovery can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.
- Patient Education: Provide research based education on addiction, treatment, recovery and associated health risks.
- Medication Services: The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.
- Collateral Services: Face-to-face sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

- Crisis Intervention Services: Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation.
  - Treatment Planning: The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed upon intake and then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan. The treatment plan shall include: a statement of problems to be addressed, goals to be reached which address each problem, action steps which will be taken by the provider and/or beneficiary to accomplish identified goals, target dates for accomplishment of action steps and goals, and a description of services including the type of counseling to be provided and the frequency thereof. Treatment plans have specific quantifiable goal/treatment objectives related the beneficiary's substance use disorder diagnosis and multidimensional assessment. The treatment plan will identify the proposed type(s) of interventions/modality that includes a proposed frequency and duration. The treatment plan will be consistent with the qualifying diagnosis and will be signed by the beneficiary and the Medical Director or LPHA.
  - Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.
- ii. Intensive Outpatient Treatment (ASAM Level 2.1) structured programming services are provided to beneficiaries a minimum of nine hours with a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for adolescents when prescribed by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary. Services consist primarily of counseling and education about addiction-related problems. Services can be provided by a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

The Components of Intensive Outpatient are (see Outpatient Services for definitions):

- Intake
- Individual and/or Group Counseling
- Patient Education
- Family Therapy

- Medication Services
  - Collateral Services
  - Crisis Intervention Services
  - Treatment Planning
  - Discharge Services
- iii. Residential Treatment (ASAM Level 3) is a non-institutional, 24-hour non-medical, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when prescribed by a Licensed Practitioner of the Healing Arts. Residential services are provided to non-perinatal and perinatal beneficiaries. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. In the residential treatment environment, an individual's functional cognitive deficits may require treatment that is primarily slower paced, more concrete and repetitive in nature. The daily regimen and structured patterns of activities are intended to restore cognitive functioning and build behavioral patterns within a community. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain and apply interpersonal and independent living skills and access community support systems. Providers and residents work collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.

Residential services are provided in DHCS licensed residential facilities that also have DMC certification. Residential services can be provided in facilities with no bed capacity limit. The length of residential services range from 1 to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents; unless medical necessity authorizes a one-time extension of up to 30 days. Peri-natal clients may receive a longer length of stay based on medical necessity. Adolescents require shorter lengths of stay and should be stabilized and then moved down to a less intensive level of treatment.

The components of Residential Treatment Services are (see Outpatient Services for definitions):

- Intake
- Individual and Group Counseling
- Patient Education
- Family Therapy
- Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.
- Collateral Services
- Crisis Intervention Services

- Treatment Planning
  - Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment.
  - Discharge Services
- iv. Withdrawal Management (Levels 1, 2, 3.2, 3.7 and 4 in ASAM) services are provided in a continuum of WM services as per the five levels of WM in the ASAM Criteria when authorized by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, and approved and authorized according to the state of California requirements.

The components of withdrawal management services are:

- Intake: The process of admitting a beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
  - Observation: The process of monitoring the beneficiary's course of withdrawal. To be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary's health status.
  - Medication Services: The prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license.
  - Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.
- v. Medication Assisted Treatment (ASAM OTP Level 1) includes the ordering, prescribing, administering, and monitoring of all medications for substance use disorders. Opioid and alcohol dependence, in particular, have well established medication options. The current reimbursement mechanisms for medication assisted treatment (MAT) will remain the same except for adding buprenorphine and disulfiram to the DMC waiver benefit package for opt-in counties. The goal of the Waiver for MAT is to open up

options for patients to receive MAT by requiring MAT services in all counties, educate counties on the various options pertaining to MAT and provide counties with technical assistance to implement any new services. These medications are available both inside and outside of Drug Medi-Cal programs as detailed in the following table:

Medication	TAR* Required	Availability
Methadone	No	Only in NTP/OTP
Buprenorphine	Yes, unless provided in an NTP/OTP	Pharmacy Benefit, NTP/OTP
Naltrexone tablets	No	Pharmacy Benefit, Medical Benefit, DMC Benefit
Naltrexone long-acting injection	Yes	Pharmacy Benefit, Medical Benefit
Disulfiram	No	Pharmacy Benefit, NTP/OTP
Acamprosate	Yes	Pharmacy Benefit
Naloxone	No	Pharmacy Benefit

\*TAR (Treatment Authorization Request)

A patient must receive at minimum of fifty minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.

The Components of Medication Assisted Treatment are (see Outpatient Treatment Services for definitions):

- Intake
- Individual and Group Counseling
- Patient Education
- Medication Services
- Collateral Services
- Crisis Intervention Services
- Treatment Planning
- Medical Psychotherapy: Type of counseling services consisting of a face-to-face discussion conducted by the Medical Director of the NTP on a one-on-one basis with the patient.
- Discharge Services

- vi. Recovery Services: Recovery services are important to the beneficiary's recovery and wellness. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, beneficiaries will be linked to applicable recovery services. The treatment community becomes a therapeutic agent through which patients are empowered and prepared to manage their health



and health care. Therefore, treatment must emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients. Services are provided as medically necessary.

The components of Recovery Services are:

- Recovery Monitoring: Recovery coaching, monitoring via telephone and internet
- Substance Abuse Assistance: Outreach, peer-to-peer services, relapse prevention, and substance abuse education
- Education and Job Skills: Linkages to life skills, employment services, job training, and education services
- Family Support: Linkages to childcare, parent education, child development support services, family/marriage education
- Support Groups: Linkages to self-help and support, spiritual and faith-based support
- Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination

- vii. Case Management: Counties will coordinate case management services. Case management services can be provided at DMC provider sites, county locations, regional centers or as outlined by the county in the implementation plan; however, the county will be responsible for determining which entity monitors the case management activities. Services may be provided by a Licensed Practitioner of the Healing Arts or certified or certified eligible counselor.

Counties will be responsible for coordinating case management services for the SUD client. Counties will also coordinate a system of case management services with physical and/or mental health in order to ensure appropriate level of care.

Case management services are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed. Case management services may be provided face-to-face, by telephone, or by telemedicine with the beneficiary and may be provided anywhere in the community.

Case management services include:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services;

- Transition to a higher or lower level SUD of care;
- Development and periodic revision of a client plan that includes service activities;
- Communication, coordination, referral and related activities;
- Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
- Monitoring the beneficiary's progress; and,
- Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services.

iv. Physician Consultation Services include physician consultation services with preferably American Board of Addiction Medicine Specialists or other addiction specialist physicians and clinical pharmacists. Counties are required to provide technical assistance opportunities within their Implementation Plan to connect SUD and physical health providers with experts in the SUD field. Physicians may consult, in person or via telemedicine, with trained and certified physicians in the field of addiction medicine or addiction psychiatry. Counties may contract with one or more addiction medicine or psychiatry specialist in order to provide the Medical Director or Licensed Practitioner of the Healing Arts with consultation services including but not limited to information pertaining to the effectiveness of medication assisted treatment, prescribing medication to treat substance use disorders, dosage recommendations, management of unusual or difficult cases, and level of care recommendations.

### 3. **DMC-ODS Provider Specifications**

DMC-ODS staff shall include:

- a. Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioner of the Healing Arts includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.
- b. Non-professional staff shall receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff will be supervised by professional and/or administrative staff.
- c. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring.
- d. Registered and certified alcohol and other drug counselors must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

#### 4. Responsibilities of Counties for DMC-ODS Benefits

The responsibilities of counties for the DMC-ODS benefit shall be consistent with each counties contract with DHCS and shall include that counties do the following.

- a. Selective Provider Contracting Requirements for Counties: Counties may choose the DMC providers to participate in the DMC-ODS. DMC certified providers that do not receive a county contract cannot receive a direct contract with the State in counties which opt into the waiver.
  - i. Beneficiary Selection: Beneficiaries will be given a choice of providers in their service area.
  - ii. Access: Each county must ensure that all required services covered under the DMC-ODS program are available and accessible to enrollees of the DMC-ODS waiver program.

The DMC-ODS waiver program is administered locally by each demonstration county and each county provides for, or arranges for, substance use disorder treatment for Medi-Cal beneficiaries. Access cannot be limited in any way when counties select providers. Access to State Plan services must remain at the current level or expand upon implementation of the waiver. The county shall maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this Waiver. In establishing and monitoring the network the county must consider the following:

- The anticipated number of Medi-Cal eligible clients.
  - The expected utilization of services, taking into account the characteristics and substance use disorder needs of beneficiaries.
  - The expected number and types of providers in terms of training and experience needed to meet expected utilization.
  - The number of network providers who are not accepting new beneficiaries.
  - The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disable beneficiaries.
  - Require its providers to meet Department standards for timely access to care and services.
- iii. Medication Assisted Treatment Services: Counties must describe in their implementation plan how they will guarantee access to medication assisted treatment services. Counties currently with inadequate access to medication assisted treatment services must describe in their implementation plan how they will provide the service modality.

Counties are encouraged to increase medication assisted treatment services by exploring the use of the following interventions:

- Establish programs for buprenorphine in primary care.
  - Provide buprenorphine onsite in OTP's for patients requiring a higher level of care.
  - Extend OTP programs to remote locations using mobile units and contracted pharmacies which may have onsite counseling and urinalysis.
  - Implement medication management protocols for alcohol dependence including naltrexone, disulfiram, and acamprosate. Alcohol maintenance medications may be dispensed onsite in OTPs or prescribed by providers in outpatient programs.
  - Provide ambulatory alcohol detoxification services in settings such as outpatient programs, OTPs, and contracted pharmacies.
  - Design and implement a naloxone distribution program for DMC-ODS beneficiaries.
- iv. Selection Criteria: In selecting providers, counties:
- Must have written policies and procedures for selection, retention, credentialing and re-credentialing of providers.
  - Must not discriminate against persons who require high-risk or specialized services.
  - Must not discriminate against for-profit organizations.
  - Must not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of their certification.
  - Must include the following provider requirements in the contract:
    - Provide the six quality aims for health care services outlined by the Institute of Medicine. According to IOM, high quality care is safe, effective, patient-centered, timely, efficient and equitable;
    - Possess the necessary license and/or certification;
    - Maintain a safe facility;
    - Maintain client records in a manner that meets state and federal standards;
    - Be trained in the ASAM Criteria prior to providing services;
    - Meet quality assurance standards and any additional standards established by the county as part of credentialing or other evaluation process;
    - Provide for the appropriate supervision of staff;
- v. 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.
- i. County Protest: Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision.
- Counties shall have a protest procedure for providers that are not awarded a contract.

- The protest procedure shall include requirements outlined in the State/County contract.
  - 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).
- ii. DHCS Appeal Process:
1. A provider may appeal to DHCS, following an unsuccessful contract protest, if the contract was denied because the county has an adequate network of providers to meet beneficiary need.
  2. A provider may not appeal to DHCS a county's decision not to contract for any other reason including allegations of violations of Federal or State equal employment opportunity laws.
  3. A provider shall have 10 calendar days from the conclusion of the county protest period to submit an appeal to the DHCS. Untimely appeals will not be considered. The provider shall serve a copy of its appeal documentation on the county. The appeal documentation, together with a proof of service, may be served by certified mail, facsimile, or personal delivery.
  4. The provider shall include the following documentation to DHCS for consideration of an appeal:
    - a. Response to the county's solicitation document;
    - b. County's written decision not to contract
    - c. Documentation submitted for purposes of the county protest;
    - d. Decision from county protest; and
    - e. Evidence supporting the basis of appeal.
  5. The county shall have 10 calendar days from the date set forth on the provider's proof of service to submit its written response with supporting documentation to DHCS. The county shall serve a copy of its response, together with a proof of service, to the provider by certified mail, facsimile, or personal delivery.
  6. Within 10 calendar days of receiving the county's written response to the provider's appeal, DHCS will set a date for the parties to discuss the respective positions set forth in the appeal documentation. A representative from DHCS will be present to facilitate the discussion.
  7. If following the facilitated discussion, DHCS determines the county does not have adequate access for the modality at issue, the county must submit a Corrective Action Plan (CAP) to DHCS. The CAP must detail how the county will remedy the access issue. DHCS may remove the county from participating in the Waiver if the CAP is not implemented.

8. If DHCS determines that the county has adequate access for the modality at issue, no further action will be required of the county.
9. The decision issued by DHCS shall be final.

b. Authorization: Counties must authorize residential services within 5 business days of the service being provided to the beneficiary. Counties will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service. Counties shall have written policies and procedures for processing requests for initial and continuing authorization of services. Counties are to have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. Counties are to meet the established timelines for decisions for service authorization.

c. County Implementation Plan: Counties must submit to the State a plan on their implementation of DMC-ODS. The State will provide the format for the implementation plan. Counties cannot commence services without an approved implementation plan. County implementation plans must ensure that providers are appropriately certified for the services contracted, implementing at least two evidenced based practices, trained in ASAM Criteria, and participating in efforts to promote culturally competent service delivery. Counties will also describe how they will phase in the additional services within the Waiver which the county does not currently have established.

Counties will be provided a transition period of one year after approval of the implementation plan in order to build system capacity, provide training, implement the required services as outlined in the STCs and create the necessary county systems as described in the Waiver. Counties will describe in the implementation plan how over the course of the Waiver time period, the county will provide or establish services to achieve the ultimate goal that all beneficiaries shall receive the least intensive clinically appropriate level of care identified on the ASAM Criteria. Upon State approval of the implementation plan, counties will be able to bill back to the date the implementation plan was submitted to the State.

d. State-County Contract: DHCS will require a State-County contract with opt-in Waiver counties. The contract will provide further detailed requirements including but not limited to access, monitoring, appeals and other provisions. CMS will review and approve the State-County contract.

e. Coordination with DMC-ODS Providers: Counties will include the following provider requirements within their contracts with the providers.

- **Culturally Competent Services**: Providers are responsible to provide culturally competent services. Providers must ensure that their policies, procedures, and practices are consistent with the principles outlined and

are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation services must be available for beneficiaries, as needed.

- Medication Assisted Treatment: Providers will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. Provider staff will regularly communicate with physicians of clients who are prescribed these medications assuming the client has signed a 42 CFR part 2 compliant release of information for this purpose.
- Evidenced Based Practices: Providers will implement at least two of the following evidenced based treatment practices (EBPs) based on the timeline established in the county implementation plan. Counties will ensure the providers have implemented EBPs. The State will monitor the implementation of EBP's during reviews. The required EBP include:
  - *Motivational Interviewing*: A client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes.
  - *Cognitive-Behavioral Therapy*: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
  - *Relapse Prevention*: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
  - *Trauma-Informed Treatment*: Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.
  - *Psycho-Education*: Psycho-educational groups are designed to educate clients about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to clients' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

f. Beneficiary Access Number: All counties shall have a toll free number for prospective beneficiaries to call to access DMC-ODS services. Oral interpretation services must be made available for beneficiaries, as needed.

g. Coordination with Managed Care Plans:

The following elements should be implemented at the point of care to ensure clinical integration:

- Comprehensive substance use, physical, and mental health screening;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Collaborative treatment planning with managed care;
- Care coordination and effective communication among providers;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals between systems.

The participating county shall enter into a memorandum of understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement can be met through an amendment to the Mental Health Plan-Managed Care Plan MOU. MOU's should at a minimum include bidirectional referral protocols between plans, the availability of clinical consultation, including consultation on medications, the management of a beneficiary's care, including procedures for the exchanges of medical information and a process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved.

#### **5. DMC-ODS State Oversight, Monitoring, and Reporting.**

- a. Monitoring Plan: The State shall maintain a plan for oversight and monitoring of DMC-ODS providers and counties to ensure compliance and corrective action with standards, access, and delivery of quality care and services.

*Timely Access.* The state must ensure that demonstration counties comply with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to Medi-Cal population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed.

*Program Integrity.* The State has taken action to ensure the integrity of oversight processes and will continue to closely monitor for any wrongdoing that impacts the DMC-ODS. The State will continue to direct investigative staff, including trained auditors, nurse evaluators and peace officers to continue to discover and eliminate complex scams aimed at profiting from Medi-Cal. Efforts include extensive mining and analyzing of data to identify suspicious Drug Medi-Cal providers; designating DMC providers as "high risk" which requires additional onsite visits, fingerprinting and background checks; and regulations that strengthen DMC program integrity by clarifying the requirements and responsibilities of DMC providers, DMC Medical Directors, and other provider personnel. The State shall require DMC providers that are actively billing to submit to a recertification process every five years. In addition, providers that have not billed DMC in the last 12 months have been and will continue to be decertified.



The State will ensure that the counties are providing the required services in the DMC-ODS, including but not limited to the proper application of the ASAM Criteria, through the initial approval in the county implementation plan and the through ongoing county monitoring.

b. Reporting of Activity: The State will report activity consistent with the Quarterly and Annual Progress Reports as set forth in this Waiver, Section IV, General Reporting Requirements. Such oversight, monitoring and reporting shall include all of the following:

- i. Enrollment information to include the number of DMC-ODS beneficiaries served in the DMC-ODS program.
- ii. Summary of operational, policy development, issues, complaints, grievances and appeals. The State will also include any trends discovered, the resolution of complaints and any actions taken or to be taken to prevent such issues, as appropriate.

c. Triennial Reviews: During the triennial reviews, the State will review the status of the Quality Improvement Plan and the county monitoring activities. This review will include the counties service delivery system, beneficiary protections, access to services, authorization for services, compliance with regulatory and contractual requirements of the waiver, and a beneficiary records review. This triennial review will provide the State with information as to whether the counties are complying with their responsibility to monitor their service delivery capacity. The counties will receive a final report summarizing the findings of the triennial review and if out of compliance, the county must submit a plan of correction (POC) within 60 days of receipt of the final report.

#### **6. DMC-ODS County Oversight, Monitoring and Reporting.**

The contract with the state and counties that opt into the waiver, require counties to have a Quality Improvement Plan that includes the counties plan to monitor the service delivery, capacity as evidenced by a description of the current number, types and geographic distribution of substance use disorder services. For counties that have an integrated mental health and substance use disorders department, this Quality Improvement Plan may be combined with the MHP Quality Improvement Plan.

- a. The county shall have a Quality Improvement committee to review the quality of substance use disorders services provided to the beneficiary. For counties with an integrated mental health and substance use disorders department, the county may use the same committee as required in the MHP contract.
- b. The QI committee shall recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions, ensure follow-up of QI process and document QI committee minutes regarding decisions and actions taken. The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:
  - i. Timeliness of first face to face appointment
  - ii. Timeliness of services for urgent conditions

- iii. Access to after-hours care
  - iv. Responsiveness of the beneficiary access line
  - v. Strategies to reduce avoidable hospitalizations
  - vi. Coordination of physical and mental health services with waiver services at the provider level
  - vii. Assessment of the beneficiaries' experiences
- c. Counties will have a Utilization Management (UM) Program assuring that beneficiaries have appropriate access to substance use disorder services; medical necessity has been established and the beneficiary is at the appropriate ASAM level of care and that the interventions are appropriate for the diagnosis and level of care.
- d. Counties will provide the necessary data and information required in order to comply with the evaluation required by the Waiver.

## **7. Financing**

Counties will propose county-specific rates and the State will approve the rates. If during the rate setting process, the State denies the proposed rates, the county will be provided the opportunity to adjust the rates and resubmit to the State. The State will retain all approval of the rates in order to assess that the rates are sufficient to ensure access to available DMC-ODS waiver services. Rates will be set in the State and County contract. For county-operated services, the county will follow all CPE principles.

## **8. Evaluation**

Through an existing contract with DHCS, University of California, Los Angeles, (UCLA) Integrated Substance Abuse Programs will conduct an evaluation to measure and monitor the outcomes from the DMC ODS Waiver. The design of the DMC-ODS evaluation will focus on the four key areas of access, quality, cost, and integration and coordination of care. California will utilize the SUD data system currently in place known as the California Outcomes Measurement System (CalOMS). CalOMS captures data from all SUD treatment providers which receive any form of government funding. The CalOMS data set, along with additional waiver specific data, will enable the State to evaluate the effectiveness of the DMC-ODS. The state will submit the complete design of the evaluation within 60 days of the approval of the amendment.

## Attachment A: Operational Protocol

### ASAM Criteria

A primary goal underlying the ASAM Criteria is for the patient to be placed in the most appropriate level of care. For both clinical and financial reasons, the preferable level of care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient. The ASAM Criteria is a single, common standard for assessing patient needs, optimizing placement, determining medical necessity, and documenting the appropriateness of reimbursement. ASAM Criteria uses six unique dimensions, which represent different life areas that together impact any and all assessment, service planning, and level of care placement decisions. The ASAM Criteria structures multidimensional assessment around six dimensions to provide a common language of holistic, biopsychosocial assessment and treatment across addiction treatment, physical health and mental health services.

The ASAM Criteria provides a consensus based model of placement criteria and matches a patient's severity of SUD illness with treatment levels that run a continuum marked by five basic levels of care, numbered Level 0.5 (early intervention) through Level 4 (medically managed intensive inpatient services).

There are several ASAM training opportunities available for providers and counties. The ASAM eTraining series educates clinicians, counselors and other professionals involved in standardizing assessment, treatment and continued care. One-on-one consultation is also available to review individual or group cases with the Chief Editor of the ASAM Criteria. Additionally, there is a two-day training which provides participants with opportunities for skill practice at every stage of the treatment process: assessment, engagement, treatment planning, continuing care and discharge or transfer. There are also a variety of webinars available.

At a minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care. A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver. With assistance from the State, counties will facilitate ASAM provider trainings.

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
EXPENDITURE AUTHORITY**

**NUMBER:** 11-W-00193/9

**TITLE:** California Bridge to Reform Demonstration

**AWARDEE:** California Health and Human Services Agency

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by California for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration, be regarded as expenditures under the State's title XIX plan. The expenditure authority period of this demonstration is from the effective date identified in the demonstration approval letter through October 31, 2015, except that the expenditure authority for the SNCP Uncompensated Care, Delivery System Reform Incentive Pool (Item I.c below.) and Designated State Health Care Programs (Item I.b below) extends through October 31, 2015, and the expenditure authority for the SNCP Uncompensated Care for certain services for Indian Health Service (IHS) and tribal facilities (Item I.f.2 below) extends through December 31, 2014.

The following expenditure authorities shall enable California to implement the California Bridge to Reform Demonstration. There are additional individual limitations on expenditure authorities as outlined below.

**I. SAFETY NET CARE POOL PROGRAM**

Subject to an overall cap on the Safety Net Care Pool (SNCP), the following expenditure authorities are granted for the period of the Demonstration:

**Provider and Program Support:** Authority for (a) (b), and (c) shall apply from the effective date identified in the demonstration approval letter through October 31, 2015.

- a. Uncompensated Care.** Expenditures for care and services that meet the definition of 'medical assistance' contained in section 1905(a) of the Act that are incurred by hospitals, providers and clinics for uncompensated medical care costs of medical services provided to Medicaid eligible or uninsured individuals, and to the extent that those costs exceed the amounts paid to the hospital pursuant to section 1923 of the Act.
- b. Designated State Health Care Programs (DSHP).** Expenditures for DSHP, which are otherwise state-funded programs that provide services as specified in the funding and reimbursement protocol for the SNCP.

- 1. Expenditures for medical care under:
  - i. Breast and Cervical Cancer Treatment Program (BCCTP);
  - ii. Medically Indigent Adults/Long Term Care (MIA/LTC) Program;

- iii. California Children’s Services (CCS) Program, individuals in the Medicaid State plan are excluded;
  - iv. Genetically Handicapped Persons Program (GHPP);
  - v. Expanded Access to Primary Care (EAPC); and
  - vi. AIDS Drug Assistance Program (ADAP).
  - vii. Departmental of Developmental Services (DDS)
  - viii. County Mental Health Services
2. Expenditures for workforce development programs related to medically disadvantaged service areas:
- i. Office of Statewide Health Planning & Development
    - a. Song Brown HealthCare Workforce Training
    - b. Health Professions Education Foundation Loan Repayment
    - c. Mental Health Loan Assumption.
    - d. Training program for medical professionals at CA Community Colleges, CA State Universities, and the University of California.
- c. Delivery System Reform Incentive Pool.** Expenditures for incentive payments from a Delivery System Reform Incentive Pool and from July 1, 2012, through December 31, 2013, expenditures for incentive payments for the HIV Transition Projects defined in STC 39.c.v. of the Delivery System Reform Incentive Pool.
- d. New Health Care Coverage Initiative (HCCI) Recipient:** From July 1, 2011 through December 31, 2013, expenditures for New HCCI Recipients defined in Paragraphs 39 and 52 of the STCs who have family incomes above 133 through 200 percent of the FPL based on available funding as described in the Safety Net Care Pool STCs.
- e. Existing Health Care Coverage Initiative (HCCI) Recipient:** From the effective date identified in the demonstration approval letter through December 31, 2013, expenditures for Existing HCCI Recipients defined in Paragraphs 39 and 52 of the STCs whose family income is above 133 through 200 percent of the FPL, based on available funding as described in the Safety Net Care Pool STCs.
- f. Uncompensated care for Indian Health Service (IHS) and tribal facilities:**  
Expenditures for supplemental payments to participating IHS and tribal facilities to take into account the burden of:
- 1) uncompensated primary care services furnished to uninsured individuals with incomes up to 133 percent of the Federal Poverty Line (FPL) who are not enrolled in a Low-Income Health Program (LIHP);and
  - 2) uncompensated services for which Medi-Cal coverage was eliminated by SPA 09-001, furnished to such uninsured individuals and to individuals enrolled in the Medi-Cal program.

Computation of such payments shall be based on the applicable published IHS encounter rate.

## II. DEMONSTRATION POPULATION

A. **New and Existing Medicaid Coverage Expansion (MCE) Recipient:** From the effective date identified in the demonstration approval letter through December 31, 2013, expenditures for medical assistance furnished to individuals who meet county residency requirements of a participating county, U.S. citizenship or qualified alien requirements, are not eligible for Medicaid or CHIP, are not pregnant, are between 19 and 64 years of age, have family incomes at or below a county-established standard that shall not exceed 133 percent of the FPL.

B. **Healthy Family Program (HFP) Transition Children and New Enrollees:** Effective January 1, 2013 through no later than December 31, 2013, expenditures for medical assistance furnished to uninsured children with family income up to 250 percent of the FPL not otherwise eligible under the state plan who are either: a) transition children previously enrolled in the state's separate CHIP who meet the conditions for phased-in enrollment in the demonstration population described in Section XVIII.E of the STCs; or b) new enrollees who would otherwise meet the eligibility criteria for enrollment in the state's approved separate CHIP.

## III. Expenditures Related to Delivery Systems for the Low Income Health Populations.

A. Expenditures under contracts with county-based delivery systems that do not meet the requirements in section 1903(m)(2)(A) of the Act regarding managed care organizations (MCOs), specified below. The county-based delivery systems providing services under this demonstration shall meet all requirements of section 1903(m)(2)(A) except the following:

1. Section 1903(m)(2)(A)(vi) insofar as it requires compliance with section 1932(a)(4) of the Act regarding the ability of enrollees to disenroll from a managed care entity. Enrollees' right to disenroll from a county-based delivery system will be restricted to the conditions detailed within STC paragraph 66 entitled "Disenrollment of Recipients."
2. Section 1903(m)(2)(A)(xii) but only insofar as it requires compliance with section 1932(a)(3)(A) in counties without health-insuring organizations by offering a choice of at least two managed care organizations to enrollees. Enrollees shall have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in Federal regulations at 42 CFR 438.56(c).
3. Section 1903(m)(2)(A)(xii) but only insofar as it requires compliance with section 1932(b)(2) regarding payment of emergency services furnished by non-contracted providers. Payments made by county-based delivery systems for out-of-network emergency services may differ from the requirements in statute.
4. Section 1903(m)(2)(A)(xii) but only insofar as it requires compliance with section 1932(b)(5) regarding network adequacy. The State will be required to ensure that county-based delivery systems comply with the network adequacy requirements set forth in the STCs.
5. Section 1903(m)(2)(A)(xii) but only insofar as it requires compliance with section



program.

**3. Cost Sharing Requirements**

**Section 1902(a)(14) insofar  
as it incorporates Section 1916**

To enable California to impose premiums, enrollment fees, deductions, cost sharing, and similar charges that exceed the statutory limitations to individuals enrolled in the Low Income Health program.

**4. Retroactive Eligibility**

**Section 1902(a)(34)**

To enable California to waive or modify the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made for the Low Income Health program.

**5. Early Periodic Screening Diagnosis and Treatment (EPSDT) Section 1902(a)(43)**

To the extent necessary to enable the State to not provide coverage of early and periodic screening, diagnostic and treatment services to 19- and 20-year-old individuals in the Low Income Health program.

**6. Comparability**

**Section 1902(a)(17)**

To permit the state to apply differences in eligibility standards among counties for the Low Income Health program.

**7. Single State Agency**

**Section 1902(a)(5)**

To the extent necessary to enable the California to allow county health department employees to determine eligibility for the Low Income Health program.

**8. Periodic Redeterminations of Medicaid Eligibility**

**Section 1902(a)(17)**

To the extent necessary to enable the counties to not to perform redeterminations for Low Income Health program beneficiaries between October 1, 2013 and December 31, 2013.