Drug Medi-Cal
Organized Delivery System Waiver

Challenges and Opportunities

What this is about . . .

- Expanding availability of SUD treatment for low income residents of California.

- Creating a continuum of care.

- Better management of client movement towards recovery (and maintain the gains achieved in treatment).
What’s a Waiver?

Waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid. There are four primary types of waivers and demonstration projects:

- Section 1115 Research & Demonstration Projects: States can apply for program flexibility to test new or existing approaches to financing and delivering services.
- Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.
- Section 1915(c) Home and Community-Based Services Waivers: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.
- Concurrent Section 1915(b) and 1915(c) Waivers: States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met.

Key Waiver Elements

- Presently, key features will be:
  - Use of the ASAM Criteria for client placement and transition to the appropriate level of care.
  - Reimbursement for residential treatment.
  - Counties will have the authority to select providers.
  - DHCS retains provider certification authority but counties may also have a role.
Key Waiver Elements

• Key Elements Cont. -
  – MOUs with Health plans.
  – Establish a continuum of care.
  – Emphasis on medication assisted treatment.
  – Requirement for use of evidence-based practices.
  – Expansion of the role of Licensed Practitioners of the Healing Arts in assessment and other activities consistent with their scope of practice.

• More Key Elements -
  – Recovery residences.
  – Recovery management services.
  – Rehab model service delivery.
  – Case management reimbursed.
  – DHCS’s Organized Delivery system concept is broader than just DMC-financed services defined in the Waiver.
    • Includes DUI programs, Block Grant funding.
Key Waiver Elements

• Financial Provisions -
  – Per User Per Month reimbursement to counties.
  – County flexibility in provider rate setting.
    • More fee for service (volume-based financing)
    • Or case rates (value-based financing)?

DMC Organized Delivery System Waiver

Implementation Plan

• Sections in the Plan
  – Narrative
  – Assurances
  – Projected Beneficiaries
  – Projected Services
  – Proposed Rates
DMC Organized Delivery System Waiver

Implementation Plan

• Narrative
  – Service Delivery System
  – Assure Access
  – Quality Assurance Activities
  – Integration of Services

• Assurances

DMC Organized Delivery System Waiver

• Projected Beneficiaries
  – Projections for each service modality
  – Projections for each level of service

• Proposed Rates
  – Proposed rates for each service modality
  – Rates would correlate with utilization projections
  – Brief narrative would justify the rates
### DMC ODS Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Required</th>
<th>Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td>ODF &amp; IOT</td>
<td>Partial Hospitalization</td>
</tr>
<tr>
<td>Residential Services</td>
<td>At Least 1 Level of Service</td>
<td>Additional ASAM Levels</td>
</tr>
<tr>
<td>Withdrawal Management</td>
<td>At Least 1 Level of Service</td>
<td>Additional ASAM Levels</td>
</tr>
<tr>
<td>Medication Assisted Tx</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Recovery Services</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Physician Consultation</td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

### DMC ODS Benefits

**Outpatient Counseling**
- Basically the same as current benefits with some differences
  - < 9 hours per week for adults
  - < 6 hours per week for youth
- Family Therapy
- Patient Education
- Medication Services
DMC ODS Benefits

Intensive Outpatient
• 9 – 19 hours per week for adults
• 6 – 19 hours per week for youth
• Services are those defined for outpatient treatment.

DMC ODS Benefits

Residential Treatment –
• 90 day LOS for adults
• 30 day LOS for youth
• One 30 day extension
DMC ODS Benefits

• Withdrawal Management
• Includes
  – Intake
  – Observation
  – Medication Services
  – Discharge Services

DMC ODS Benefits

• Medication Assisted Treatment
  – In DMC
    • Methadone
    • Buprenorphine
    • Disulfiram
  – Pharmacy Benefit in Regular MC
    • Naltrexone Tablets
    • Naltrexone injection – Vivitrol
    • Acamprosate
    • Naloxone
DMC ODS Benefits

Recovery Services
• Recovery monitoring
• Substance abuse assistance
• Education & job skills
• Family support
• Support groups
• Ancillary Services

DMC ODS Benefits

Case Management
• Assistance in accessing medical, educational, vocational, social and other services.
• May include
  – Client service plan development
  – Client advocacy
  – Linkages to physical and MH care.
DMC ODS Benefits

Physician Consultation Services
- Consultation with ASAM or other addiction medicine specialists.
- Counties required to connect health providers with experts in SUD field.
- Services may include consultation on MAT, medication issues generally, and level of care recommendations.

County Responsibilities

Selective Contracting
- However, must maintain client access to services.
- Must provide a continuum of care with the required services.
- Must have policies & procedures for selection, retention, credentialing and re-credentialing.
**County Responsibilities**

- Authorization of Residential Services
- State-County contract with further detailed requirements for access, monitoring, appeals, etc.
- Beneficiary access number
- Coordination – MOU – with managed care plans.

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**County Responsibilities**

County Implementation Plan

- County implementation plans must ensure that providers are appropriately certified for the services contracted, implementing *at least two evidence based practices*, trained in ASAM Criteria, and participating in efforts to promote culturally competent service delivery.
County Responsibilities

Coordination with DMC-ODS Providers

• Culturally competent services
• Medication Assisted Treatment
• Evidence based practices
  – Evidence based programs – Matrix, Seeking Safety
  – Evidence based counseling methods and techniques – CBT, MI, etc.

What Does All This Mean?

• An expanded and more directive role for counties in provider oversight.
  – Medical, fiscal, utilization, QI

• An expanded and more directive role for counties in client access to and movement through the treatment system.
What Does All This Mean?

• More data to collect, report and analyze
  – For the evaluation
  – To monitor access
  – Assess the impact of cultural competence measures.
  – Support QI process
  – Monitor provider performance and client outcomes to support selective contracting process.

What Does All This Mean?

• More/different staff at county and provider levels
  – Physicians or other LPHAs
  – Licensed staff for youth treatment (e.g., MFT)
  – Clinical supervisors
  – Billing clerks
  – Data analysts
Evidence Based Practices

Some data on Motivational Interviewing

MI Training

- Ideally training shapes clinician responses, that should change practice behavior and improve client outcomes.
- Two early studies (2000) showed high trainee satisfaction and significant self-perceived gains after MI workshop.
  - Tape recorded sessions showed only modest changes in practice and no difference in client responses (change talk).
  - People need more than a one-time workshop.
  - progressive individual feedback on performance
  - personal follow-up coaching.

The MI Challenge

- A practical challenge in training clinicians in MI, then, is to help them persist in behavior change past an initial workshop exposure that may erroneously convince them that they have already learned the method, a motivational challenge not unlike that of helping clients change lifestyle behaviors. (Miller and Rose, 2004. KLD highlight)

- This is the challenge for EBP implementation in general.

MI Implementation Recommendations

- Two day introductory training
- Minimum six months coaching – can do webinar
- One Booster session
- MI for Supervisors
- Training for use of the Motivational Interviewing Treatment Integrity fidelity measurement scale (MITI 3.1)
Financing

- Do you know your true unit cost?
- How to move from volume based to value based reimbursement.
- How would this work in a multi-provider episode of care.

Volume Based Financing
Yet to be revealed . . .

- **PUPM algorithm**
  - “All models are wrong . . .”
  - Reflects the way the system is organized and operates now.

- **Local rate setting process**
  - Gift of public funds or higher value service?
  - Case rates or other value-based reimbursement?
Yet to be Revealed

• Specifics of youth treatment.

• Role of Block Grant
  – Recovery Residences.
  – Other uses that complement DMC funding
  – What about the Prevention Set-Aside?
  – Counties have broad discretion now.

In the Next 120 Days . . .

• Develop selective contracting standards.
• Recruit providers.
• Issue RFPs.
• Financial analysis – Where is the risk?
• Gap analyses
  – Data needs and associated technology.
  – Type and quality of contractor cost data.
In the Next 120 Days . . .

• Project the necessary regional service coverage that –
  – provides client choice,
  – is culturally competent, and
  – will meet county performance and quality standards.

• Develop key system baseline measures.

In the Next 120 Days . . .

• Develop Rehab model service provision rules.

• Forecast utilization and cost by modality.

• Gap analysis for network adequacy.

• Draw the network map.
Questions

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