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| **Department of Health Care Services****Drug Medi-Cal Organized Delivery System Waiver** **County Implementation Plan**  |

This document will be used by the Department of Health Care Services (DHCS) to help assess the county’s readiness to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver and for the counties to determine capacity, access and network adequacy. The tool draws upon the Special Terms and Conditions and the appropriate CFR 438 requirements. DHCS will review and render an approval or denial of the county’s participation in the Waiver.

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**Part I Plan Questions**

This part is a series of questions regarding the county’s DMC-ODS program.

**Part II Plan Description: Narrative Description of the County’s Plan**

In this part, the county describes its DMC-ODS program based on guidelines provided by the Department of Health Care Services.

**Part III Projected Expenditures, Capacity Projections, and Client Projections**

Under this section, the county enters data showing projected expenditures, capacity, and client counts. There are three sections:

* + - **Modality Plan (Expenditures by Modality)**
		- **Capacity Projections**
		- **Client Projections**

**Part IV Proposed Rates**

In this section, the county submits documentation showing proposed rates for each modality.

 (Revised 2/3/15)

Part I

Plan Questions

This part is a series of questions that summarize the county’s DMC-ODS plan.

1. Identify the county agencies and other entities involved in developing the county plan. (Check all that apply) Input from stakeholders in the development of the county implementation plan is required; however, all stakeholders listed are not required to participate.

⬜ County Behavioral Health Agency

⬜ County Substance Use Disorder Agency

⬜ Providers of drug/alcohol treatment services in the community

⬜ Representatives of drug/alcohol treatment associations in the community

⬜ Physical Health Care Providers

⬜ Medi-Cal Managed Care Plans

⬜ Federally Qualified Health Centers (FQHCs)

⬜ Clients/Client Advocate Groups

⬜ County Executive Office

⬜ County Public Health

⬜ County Social Services

⬜ Foster Care Agencies

⬜ Law Enforcement

⬜ Court

⬜ Probation Department

⬜ Education

⬜ Recovery support service providers (including recovery residences)

⬜ Health Information technology stakeholders

⬜ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How was community input collected?

* Community meetings
* County advisory groups
* Focus groups
* Other method(s) (explain briefly) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Specify how often entities and impacted community parties will meet during the implementation of this plan to continue ongoing coordination of services and activities.

* Monthly
* Bi-monthly
* Quarterly
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review Note: One box must be checked.

 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.

 5. What services will be available to DMC-ODS clients under this county plan?

 **REQUIRED**

 ⬜ Withdrawal Management (minimum one level)

 ⬜ Residential Services (minimum one level)

 ⬜ Intensive Outpatient

* Outpatient
* Opioid (Narcotic) Treatment Programs
* Recovery Services
* Case Management
* Physician Consultation

 How will these required services be provided?

 ⬜ All county operated

 ⬜ Some county and some contracted

 ⬜ All contracted.

 **OPTIONAL**

* Additional Medication Assisted Treatment
* Recovery Residences
* Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Has the county established a toll free number for prospective clients to call to

 access DMC-ODS services?

* Yes (required)
* No. Plan to establish by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Review Note: If the county is establishing a number, please note the date it will be established and operational.

7. The county will participate in providing data and information to the University of

 California, Los Angeles (UCLA) Integrated Substance Abuse Programs for the

DMC-ODS evaluation.

* Yes (required)
* No

PART II

PLAN DESCRIPTION (Narrative)

In this part of the plan, the county must describe certain DMC-ODS implementation policies, procedures, and activities.

General Review Notes:

* Number responses to each item to correspond with the outline.
* Keep an electronic copy of your implementation plan description. After DHCS reviews your plan description, you may need to make revisions.
* Counties must submit a revised plan to DHCS whenever the county requests to add a new level of service.

**Narrative Description**

**1. Collaborative Process.** Describe the collaborative process used to plan DMC-ODS services. Describe how county entities, community parties, and others participated in the development of this plan and how ongoing involvement and effective communication will occur.

Review Note: Stakeholder engagement is required in development of the implementation plan.

**2. Client Flow.**Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, transitions to another level of care). Describe what entity or entities will conduct ASAM criteria interviews, how admissions to the recommended level of care will take place, how often clients will be re-assessed, and how they will be transitioned to another level of care accordingly.

Review Note: A flow chart may be included.

**3.** **Beneficiary Access Line**. For the beneficiary toll free access number, what data will be collected (i.e,, measure the number of calls, waiting times, and call abandonment)?

**4. Treatment Services.** Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences) to be provided. What barriers, if any, does the county have with the required service levels? Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county.

Review Note: Include in each description the corresponding American Society of Addiction Medicine (ASAM) level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date.

**5. Expansion of Services.** Describe how the county plans to expand the required levels of services outlined in the standard terms and conditions (STCs). In the description, include the timeline for expansion.

Review Note: Include services identified in the implementation plan and also the projected timeline for the county to add additional level of services.

**6. Coordination with Mental Health.** How will the county coordinate mental health services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

**7. Coordination with Physical Health**. Describe how the counties will coordinate physical health services within the waiver. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

**8.** **Coordination Assistance.** The following coordination elements are listed in the STCs. Based on discussions with your health plan and providers, do you anticipate substantial challenges and/or need for technical assistance with any of the following? If so, please indicate which and briefly explain the nature of the challenges you are facing.

* 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.

**9**. **Access.** Describe how the county will ensure access to all service modalities. Describe the county’s efforts to ensure network adequacy. Describe how the county will establish and maintain the network by addressing the following:

* The anticipated number of Medi-Cal clients.
* The expected utilization of services.
* The numbers and types of providers required to furnish the contracted

 Medi-Cal services

* Hours of operation of providers.
* Language capability for the county threshold languages
* Timeliness of first face-to-face visit, timeliness of services for urgent conditions

 and access afterhours care.

* The geographic location of providers and Medi-Cal beneficiaries, considering

 distance, travel time, transportation, and access for beneficiaries with

 disabilities.

**10. Training Provided.** What training will be offered to providers chosen to participate in the waiver? How often will training be provided? Are there training topics that the county wants to provide but needs assistance?

Review Note: Include the frequency of training and whether it is required or optional.

**11. Technical Assistance.** What technical assistance will the county need from DHCS?

**12. Quality Assurance.**  Describe the quality assurance activities the county will conduct. Include the county monitoring process (frequency and scope), Quality Improvement plan, Quality Improvement committee activities and how counties will comply with CFR 438.200, 438.202, 438.204 and with 438 Subpart E (External Quality Review Organizations). Please also list out the members of the Quality Improvement committee.

**13. Evidence Based Practices.** How will the counties ensure that providers are implementing at least two of the identified evidence based practices? What action will the county take if the provider is found to be in non-compliance?

**14. Assessment**. Describe how and where counties will assess beneficiaries for medical necessity and ASAM Criteria placement. How will counties ensure beneficiaries receive the correct level of placement?

**15. 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)?

**16. Memorandum of Understanding.** Submit a draft copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery. Signed MOU’s must be submitted to DHCS within three months of the waiver implementation date.

**17. Telehealth Services.** If a county chooses to utilize telehealth services, how will telehealth services be structured for providers and how will the county ensure confidentiality? (Please note: group counseling services cannot be conducted through telehealth).

**18. Contracting.** Describe the county’s selective provider contracting process. What length of time is the contract term? Describe the local appeal process for providers that do not receive a contract. If current DMC providers do not receive a DMC-ODS contract, how will the county ensure beneficiaries will continue receiving treatment services?

Review Note: A list of all contracted providers (modality, provider, address) must be submitted to DHCS within 30 days of the waiver implementation date and as new providers are awarded contracts. DHCS will provide the format for the listing of providers.

**19. Additional Medication Assisted Treatment (MAT).** If the county chooses to implement additional MAT beyond the requirement for NTP services, describe the MAT and delivery system.

**20. Residential Authorization.** Describe the county’s authorization process for residential services. Prior authorization is not required; however, the county needs to provide a standard timeline for completion of the authorization.

DMC-ODS Projected Expenditure Modality Plan

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Implementation Date: \_\_\_\_\_\_\_\_\_

Include two years of projected expenditures and projected clients. Base years on proposed implementation date.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Services Provided By Modality (funded by DMC) | FY \_\_\_\_\_\_\_Projected Expenditures\* | FY \_\_\_\_\_\_\_Projected Expenditures\* | FY \_\_\_\_\_\_\_\_Projected Clients | FY \_\_\_\_\_\_\_Projected Clients |
| Withdrawal Management |  |  |  |  |
|  Level 1-WM |  |  |  |  |
|  Level 2-WM |  |  |  |  |
|  Level 3-WM |  |  |  |  |
|  Level 4-WM |  |  |  |  |
| Residential |  |  |  |  |
|  Level 3.1 |  |  |  |  |
|  Level 3.3 |  |  |  |  |
|  Level 3.5 |  |  |  |  |
|  Level 3.7 |  |  |  |  |
|  Level 4 |  |  |  |  |
| Intensive Outpatient |  |  |  |  |
| Outpatient |  |  |  |  |
| Opioid (Narcotic) Treatment Programs |  |  |  |  |
| Recovery Services |  |  |  |  |
| Case Management |  |  |  |  |
| Physician Consultation  |  |  |  |  |
| Total |  |  |  |  |

\*Includes the FMAP, State and County Costs.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Services Provided by Modality  | FY \_\_\_\_\_\_\_\_\_Projected Expenditures | FY \_\_\_\_\_\_\_\_Projected Expenditures | FY \_\_\_\_\_\_\_\_ Projected Clients | FY \_\_\_\_\_\_\_ Projected Clients |
| Recovery Residences |  |  |  |  |
| Additional MAT |  |  |  |  |
| Total |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Services Provided By Modality (funded by DMC) | Proposed Rate Range | Service Length/Unit of Service (day, hour) |
| Withdrawal Management (WM) |  |  |
|  Level 1-WM |  |  |
|  Level 2-WM |  |  |
|  Level 3-WM |  |  |
|  Level 4-WM |  |  |
| Residential |  |  |
|  Level 3.1 |  |  |
|  Level 3.3 |  |  |
|  Level 3.5 |  |  |
|  Level 3.7 |  |  |
|  Level 4 |  |  |
| Intensive Outpatient |  |  |
| Outpatient |  |  |
| Opioid (Narcotic) Treatment Programs |  |  |
| Recovery Services |  |  |
| Case Management |  |  |
| Physician Consultation |  |  |

Proposed Rates

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counties must provide proposed rates for each modality identified in the DMC-ODS. Please note the following when proposing rates:

* Counties are required to provide a rate range or a standard rate for all modalities.
* If a county is not providing a level of service for Withdrawal Management or Residential, please mark the rate as n/a.
* For residential services, rates cannot include room and board expenditures.
* Level 4-Withdrawal Management is paid for through the fee for service system.

Rates Narrative

1. Describe the process used to develop the proposed rates above. Include data utilized and brief justifications for each proposed rate.
2. If rates for Intensive Outpatient, Outpatient or Opioid (Narcotic) Treatment Programs fall below the current state plan rate, please explain why the rate is lower.
3. If a rate range is utilized for a modality(ies), how will the county determine which providers will receive the lower or higher rate identified in a range?

County Authorization

The County Behavioral Health Director (for Los Angeles and Napa AOD Program Director) must review and approve the Implementation Plan. The signature below verifies this approval.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

County Behavioral Health Director\* County Date

(\*for Los Angeles and Napa AOD Program Director)

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 Print Name Title Phone Number

*Please mail the completed Implementation Plan to:*

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SUD Compliance Division

Attn: Marlies Perez

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