

A photograph of a city skyline, likely Sacramento, California, featuring various skyscrapers and buildings. The image is partially obscured by a green diagonal overlay in the top left and a dark blue diagonal overlay in the bottom right.

# Practice Guidelines Provider Procedure Manual

January 2019

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# **SUBSTANCE USE DISORDER TREATMENT PROVIDER MANUAL**

## **INTRODUCTION**

The Sacramento County Substance Use Disorder (SUD) Treatment Practice Guidelines and Provider Manual offers user friendly guidance to all Sacramento County SUD contractors, including Drug Medi-Cal (DMC) certified providers, in complying with State, Federal, and Sacramento County SUD treatment requirements and standards. The Practice Guidelines/Provider Manual reflects the best possible quality client care standards and seeks to prevent program deficiencies that can lead to the assessment of recoupment of funding. It has been developed in partnership with SUD treatment providers in the spirit of collaboration and transparency.

The Sacramento County Substance Use Disorder (SUD) Treatment Practice Guidelines and Provider Manual is available to providers on the Sacramento County Behavioral Health Services website and will be managed to provide required and necessary updates. This manual is specifically designed to be used by all administrative and direct service staff to ensure understanding of core values and requirements for the SUD system of care and adherence to the clinical and business expectations within Sacramento County.

## **ALCOHOL AND DRUG SERVICES MISSION STATEMENT**

To promote a healthy community and reduce the harmful effects associated with alcohol and drug use, while remaining responsive to and reflective of the diversity among individuals, families and communities

## **BEHAVIORAL HEALTH SERVICES MISSION**

To provide a culturally competent system of care that promotes holistic recovery, optimum health and resiliency.

## **BEHAVIORAL HEALTH SERVICES VISION STATEMENT**

We envision a community where persons from diverse backgrounds across the life continuum have the opportunity to experience optimum wellness.

## **BEHAVIORAL HEALTH SERVICES CULTURAL COMPETENCY STATEMENT**

Sacramento County Behavioral Health/Alcohol and Drug Services is proud of its commitment to cultural competency and the acceptance of people from all ethnic and religious backgrounds, regardless of their age, gender, sexual orientation, or disability.

## **DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER SACRAMENTO COUNTY SUD REQUIREMENTS**

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a State Pilot to test a new paradigm for the organized delivery of health care services for Medicaid (Medi-Cal) eligible individuals with substance use disorders. The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC clients while decreasing other system health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for substance use disorder treatment services, increased local control and accountability, greater administrative oversight, new utilization controls to improve care and efficient use of resources, evidence-based practices in substance abuse treatment, and increased coordination with other systems of care. The DMC-ODS Pilot approach is expected to provide Medi-Cal clients with improved access to care and to support the level of system interaction needed to achieve sustainable recovery.

Not only do DMC treatment standards and requirements reflect good clinical practice, but they offer Sacramento County the opportunity to improve access to high quality care under the DMC-ODS Pilot program. Sacramento County's specific Implementation Plan can be found on the Sacramento County and DHCS websites.

### **SUBSTANCE USE DISORDER TREATMENT SERVICES PROGRAM OVERSIGHT**

The Department of Health Care Services (DHCS) is responsible for administering SUD treatment in California (DHCS Substance Use Disorder Services). The Sacramento County Department of Health Services, contracts with DHCS to fund local SUD treatment services. As part of the contract with DHCS, Sacramento County Alcohol and Drug Services ensures that state SUD treatment requirements and standards are met by maintaining fiscal management systems, monitoring provider billing, conducting compliance site visits, processing claims for reimbursement, and offering training and technical assistance to SUD treatment providers.

Sacramento County Provider SUD treatment programs shall be licensed, registered, AOD licensed and DMC certified and approved in accordance with applicable laws and regulations.



## **DHCS ALCOHOL AND DRUG (AOD) AND DRUG MEDI-CAL (DMC) CERTIFICATION REQUIREMENTS**

The Department of Health Care Services offers voluntary facility certification to programs providing outpatient, intensive outpatient, residential treatment and nonresidential detoxification. This voluntary certification is granted to programs that exceed minimum levels of service quality and are in substantial compliance with State program standards, specifically the Alcohol and/or Other Drug Certification Standards.

In addition, DHCS provides Drug Medi-Cal Certification to SUD treatment providers that meet requirements found under Title 22 of the California Code of Regulations (CCR): 1) Section 51431.1 – Program Administration; 2) Section 51490.1 – Claim Submissions Requirements; and 3) Section 51561.1 – Reimbursement Rates and Requirements. Title 22 refers and ties to Title 9 of the CCR which governs requirements for Narcotic Treatment Programs. Providers are encouraged to learn more about state licensing and certification requirements by visiting the DHCS website.

## **THE DISEASE CONCEPT OF SUBSTANCE USE DISORDER**

Substance use disorders are often chronic, relapsing conditions of the brain that affect behavior by reinforcing compulsive alcohol and drug seeking and use, despite catastrophic consequences to individuals, their families, and others around them. Although most diseases cannot be cured, they can be monitored and managed over time. Examples of manageable chronic diseases include diabetes, HIV infection, asthma, and heart disease. While there is no cure for these diseases, when managed and monitored properly, individuals with such diseases are able to live a fairly normal life. While some individuals may develop a substance use disorder and achieve recovery after minimal intervention over a brief time, others will succumb to an intensified and relapsing course.

Approaching substance use disorders as a disease, assists with framing interventions aimed at managing the condition through a model of care that provides a continuum of services tailored to an individual's needs. As individuals progress through their recovery journey, the type and intensity of treatment services they receive should change and reflect the severity and nature of the person's substance use disorder. This approach also highlights the need for person centric care coordination to ensure that service delivery matches client need. Effective and efficient care for chronic conditions requires productive interactions between clients, their families, and allied health.

## **SPECIAL POPULATION GUIDELINES**

Sacramento County Alcohol and Drug Services and its providers/contractors shall comply with state and federal mandates to provide SUD treatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and post-partum women, and (2) adolescents under age 21 who are eligible under the EPSDT program.

SUD services are provided to pregnant and post-partum women. Coverage for post-partum women begins the day after termination of pregnancy, plus sixty (60) days, then until the end of the month if the 60th day falls mid-month. Providers who offer perinatal DMC services are required to be properly certified to provide these services and shall comply with the Perinatal Services Guidelines.

Individuals under age 21 are eligible to receive Medi-Cal services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, clients under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. No provisions in the DMC-ODS will override any EPSDT requirement. Medical necessity for an adolescent individual (an individual under the age of 21) is determined using the following criteria: The adolescent shall be assessed to be at risk for developing a SUD.

The adolescent shall meet the American Society of Addiction Medicine (ASAM) adolescent treatment criteria. Contracting providers shall follow the Youth Treatment Guidelines in developing and implementing adolescent treatment programs funded through the DMC-ODS Waiver.

## **NEW TITLE 22: DRUG MEDI-CAL PROGRAM INTEGRITY REGULATIONS**

As a result of the findings of targeted field reviews of DMC providers suspected of committing fraud and abuse within the State, the DHCS has promulgated new regulations under CCR, Title 22, Section 51341.1 in the form of a California State Plan Amendment. The DHCS DMC Program Integrity regulations address abusive and fraudulent practices, promote treatment practices that are based sound medical practice, and provide DHCS with increased regulatory authority to ensure both program integrity and that providers meet performance expectations. The Provider Manual incorporates the DHCS DMC Program Integrity Regulations which have been approved by the federal government and became effective July 1, 2015.

## **CLIENT CENTERED CARE AND COORDINATION OF CARE**

To better serve the comprehensive needs of its client population, a key goal of the specialty SUD system is to better integrate SUD care into healthcare and social service systems, and vice versa. In addition, there is also need for the specialty SUD system to be better organized and coordinated so that clients are effectively accessing the full continuum of SUD services and levels of care available to them.

**Integrated care** is the routine and systematic coordination of health services so that the varied needs of clients are addressed both comprehensively and cohesively. An example of care integration is an SUD program that has primary care and mental health providers stationed in the SUD program so that clients with multiple healthcare needs can have them addressed in one location. Integrating social services such as housing assistance is also important. Broadly speaking, integrated care should make it easier for clients to receive the care they need by positioning health services in ways that make them more accessible.

**Care coordination** is the deliberate organization of client care activities and sharing of information among care providers to ensure that the needs of clients are addressed comprehensively and across all their areas of need. Care coordination needs to be client-centered and driven by a combination of client need and preference. It should also be based on clinical judgment, so that the information being shared, and the care being coordinated is in the best interests of the client. The primary goal of care coordination is to ensure that while there may be multiple health and social service providers involved in an individual's care, the services being provided are all organized and coordinated to collectively provide comprehensive, appropriate, and effective care to the client.

Retention in treatment is one of the most important factors that lead to successful outcomes of SUD care. In order to engage and retain clients in treatment, it is paramount that care be delivered in a client-centered manner. In client centered care, respect for the client is the guiding principle that ensures care is responsive to the client's individual needs, preferences, and values. Client preferences and values are considered and used as a guide in any decision making process.

Clients accessing services through County programs and providers are entitled to receive services that meet industry standards and are of the highest quality.

Additionally, Sacramento County Alcohol and Drug Services strives to provide integrated care and care coordination. Efforts are made to ensure that primary care and mental health services are easily accessible and that connections or referrals to social services are available. Case management of clients is also of great importance. Our programs, clinics and providers will organize client care activities and coordinate the sharing of information to ensure that the needs of the clients are addressed.

Providers shall allow each client to choose his or her network provider to the extent possible and appropriate.

## **CHARITABLE CHOICE AND FUNDING RESTRICTIONS**

For a counseling or referral service that the provider does not cover because of moral or religious objections, the provider shall provide information to the client about where and how to obtain the service. No State or Federal funds shall be used by the Provider for sectarian worship, instruction, and/or proselytization. No State funds shall be used by the provider to provide direct, immediate, or substantial support to any religious activity.

## **EVIDENCE BASED PRACTICES (EBPs)**

Evidence-based practices (EBPs) are interventions that have been shown to be effective and are supported by evidence. In Sacramento County, although other psychosocial approaches may be used (e.g., relapse prevention, trauma informed treatment, and psychoeducation), SUD treatment agencies must at a minimum implement Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT).

Providers are also expected to support the use of medications for addiction treatments as an evidence-based intervention, when clinically appropriate.

Sacramento County Alcohol and Drug Services and contracted providers make available and offer services that are based on Evidence Based Practices (EBP) that have undergone stringent evaluation and meet clinical standards. Such practices include, but are not limited to, Motivational Interviewing (MI), Cognitive Behavior Therapy (CBT) and curriculum based concepts such as Matrix Model and Living in Balance.

Sacramento County SUD providers will implement at least two of the following EBPs. The two EBPs are per provider per service modality. Providers will monitor the implementation and regular annual training of EBPs to staff. The required EBPs 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. According to the National Institute of Drug Abuse's *Principles of Drug Addiction Treatment: A Research-Based Guide*, "Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it. A central element of CBT is anticipating likely problems and enhancing clients' self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use and developing strategies for coping with cravings and avoiding those high-risk situations." The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.

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. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide clients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client's overall coping capacity.

Trauma-Informed Treatment: According to SAMHSA's concept of a trauma-informed approach, "a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization." Seeking Safety is an example of an evidence-based trauma-informed practice. Services shall 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 client lives, to instill self-awareness, suggest options for growth through 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.

## **MEDICAL NECESSITY**

Medical necessity refers to the applicable evidence based standards applied to justify the level of services provided to a client so the services can be deemed reasonable, necessary and/or appropriate. It is imperative that medical necessity standards be consistently and universally applied to all clients.

All Sacramento County SUD treatment providers must ensure that treatment services are medically necessary. Medical necessity for services must be determined as part of the intake assessment process and will be performed by a Licensed Practitioner of the Healing Arts (LPHA) directly or with an SUD registered/certified counselor and validated by a face to face review by an LPHA or the Medical Director.

For all DMC certified providers, medical necessity must be established by the Medical Director or an LPHA. Throughout the treatment process, client records must document and demonstrate that a physician or LPHA directed the provider of treatment including the establishment of medical necessity at admission and for continuing services, the development and review of client treatment plans, and medical consultation and evaluation.

Physician (or LPHA) shall:

- Review personal, medical, and substance use history.
- Evaluate each client and diagnose using DSM-5.
- Document basis for diagnosis within seven (7) days of admission via face-to face session with the client.
- Exceptions: Withdrawal Management and OTP/NTP must be documented on day 1.

The Medical Director or LPHA shall evaluate each client's assessment and intake information if completed by a counselor through a **face-to-face** with the client to establish whether the client meets medical necessity criteria or not.

For outpatient services: the Medical Director or LPHA shall document, in narrative format, separately from the treatment plan, the basis for the diagnosis in the client's record within 30 calendar days of each client's admission to treatment date. No sooner than 5 months and no later than 6 months after a client's admission to treatment, or the completion of the most recent justification for services. For NTP: annual re-assessment.

The Medical Director or LPHA shall type or legibly print their name, sign and date the diagnosis documentation. After establishing a diagnosis and documenting the basis for diagnosis, the ASAM criteria shall be applied by the diagnosing LPHA to determine or confirm placement into the appropriate modality or level of assessed services.

The Diagnostic and Statistical Manual of Mental Disorders, Version 5 (DSM-5) will be utilized by providers for all clients accessing SUD services. DSM-5 diagnosis. Youth (ages 12 – 17) and Young Adults (ages 18 – 20) either meet criteria for the DSM-5 specification for adults. OR be determined to be at-risk for developing a SUD.

Adults (ages 21+) must meet criteria for at least one diagnosis from the current DSM-5 for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.

Medical necessity encompasses all six (6) ASAM dimensions and takes into consideration the extent and biopsychosocial severity of the various dimensions within the full ASAM assessment. Medical necessity must not be restricted to acute care and narrow medical concerns. The six dimensions are:

- Acute Intoxication and/or Withdrawal Potential,
- Biomedical Conditions and Complications,
- Emotional, Behavioral, or Cognitive Conditions and Complications,
- Readiness to Change,
- Relapse, Continued Use, or Continued Problem Potential, and
- Recovery/Living Environment.

Youth (ages 12 – 17) and Young Adults (ages 18 – 20) are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Eligibility for EPSDT broadens the definition of medical necessity for youth to include individuals who are deemed “at-risk” for SUDs, and also makes the full SUD benefit package available to all individuals up to age 21 without any caps or limitations, assuming medical necessity is established. *Importantly, these federal EPSDT requirements supersede state Medi-Cal requirements, and the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver does not override EPSDT.*

**DHCS Title 22 Diagnosis Medical Necessity FAQ**  
**SUP07-2016 Bulletin Medical Necessity Statement**  
**DHCS DSM-5 Information Notice 16-051**

## **ELIGIBILITY DETERMINATION**

### **COVERED BENEFICIARIES AND ELIGIBLE PARTICIPANTS**

Sacramento County SUD system is available to individuals who are:

- Residents of Sacramento County
- Medi-Cal eligible, including those served by local Medi-Cal managed care plans and their plan partners
- Other low-income individuals who are concurrently participating in other County funded programs/projects such as California Work Opportunity and Responsibility to Kids (CalWORKs), SAPT

Given that SUD services are carved out from Medi-Cal managed care plans, the specialty SUD system is responsible for the spectrum (mild to severe) of SUD treatment services, excluding:

- Early intervention (ASAM level 0.5), which is the responsibility of the managed care health plans
- Services provided in general acute hospitals, which are the responsibility of fee-for-service (FFS) Medi-Cal.

### **COUNTY OF RESPONSIBILITY**

In accordance with State policy, the Sacramento County SUD benefit package follows a County of residence model of service delivery. As such, the County of responsibility for SUD services is the County of residence of the individual being served. Sacramento SUD benefit package is only available to Sacramento County residents. Sacramento County providers that render services to individuals whose County of Residence is not Sacramento will not be reimbursed by Sacramento for those services. Only services rendered to individuals who have Sacramento County as their County of Residence and are treated at a contracted site will be reimbursed.

Effective July 1, 2019, if a new referral or current continuing client does not reside in Sacramento County and does not intend to move, they need to be referred to a provider in their county of residence or the provider enters into contract with the outside County..

### **OPIOID TREATMENT PROGRAMS (OTP) COURTESY DOSING**

Sacramento County will reimburse courtesy dosing of methadone and buprenorphine for up to 30 days for OTP clients who are Medi-Cal beneficiaries and have traveled to Sacramento County for business or leisure, and who do not qualify for, or are unable to bring enough take-home doses for the trip duration. The contracted provider must receive a courtesy dosing order from the home clinic that is signed by the medical director or program physician. The order form must outline dose, duration, and any other special instructions, such as take-home doses. Compliance with relevant Title 9 regulations is required.



## **INTER-COUNTY TRANSFERS**

In situations where the individual resides in Sacramento County, but Medi-Cal benefits are assigned to another County, network providers conduct the screening/assessment and admit the client for medically necessary services while Medi-Cal benefits are being transferred. Clients cannot be delayed or denied admission for eligible (i.e. Medi-Cal) SUD treatment services due to incomplete or pending application and/or if Medi-Cal benefits are assigned to another County.

To initiate the transfer of benefits between counties, clients need to contact the public social services agency in the originating county. Clients will need to provide new physical and mailing addresses, and the primary contact number. Ideally, this process will occur on the same day as Assessment/Intake, so services can be reimbursed under DMC. If clients are assisted by providers, services are reimbursable under Case Management (see the Case Management section for more information).

Visit <http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx> to find contact information for public social services agencies outside of Sacramento County.

## **FINANCIAL ELIGIBILITY**

It is the responsibility of each SUD provider to conduct a verification/determination of financial eligibility (each client's Medi-Cal eligibility) and county of residence as part of program acceptance. Providers will have Avatar accessThe program must inform and include in all client service contracts that client may request the program to conduct a financial assessment in accordance with these standards to determine his/her ability to pay program fees. Programs may not deny services to client if, based on the results of financial assessment, the program determines that the client is unable to pay the program fee. In no case is a qualified Medi-Cal client who is pregnant or less than 60 days postpartum to be charged for any residential treatment. A sliding fee scale shall be utilized for non-Medi-Cal clients. Providers must assess the client program fee and set the payment schedule based on the client's documentation of income. Providers must maintain in the client records a copy of all financial assessments and documentation of income provided by the client.

If a client loses Medi-Cal eligibility while in treatment, and the treatment duration extends beyond the end of the month in which the termination occurred (as services would continue to be reimbursable by DMC during this period) the following should occur:

1. Determine if the client is eligible for other funding sources (e.g., CalWORKs, Realignment, SAPT):
  - a. If yes – the client's treatment would move to the secondary funding source; this would apply to any level of care listed in the Rates and Standards Matrix.
  - b. If no – continued payment will depend on the level of care:
    - i. Residential (ASAM 3.1, 3.3, 3.5) –would pay for services for the remainder of service authorization period with other funds. If the agency elects to continue providing services to the client beyond the service authorization period, it must be on a sliding scale basis with no financial participation.

- ii. Outpatient (ASAM 1.0-AR, 1.0, 2.1) – In instances where the agency elects to continue providing services to the client, it must be on a sliding scale basis.
  - iii. Withdrawal management (ASAM 1-WM, 3.2-WM, 3.7-WM, 4-WM) – This situation is likely very rare since the maximum duration is 14-days. However, if this occurs, contact Alcohol and Drug Services.
2. If the agency did not identify an alternate funding source in Avatar (EHR), but the client is actually eligible, providers will need to make that modification, so funding can be appropriately allocated.

### **ESTABLISHING BENEFITS AND DELIVERING CONCURRENT SERVICES**

When an individual makes the decision to seek SUD treatment services, it is critical to provide services as soon as possible and to avoid any unnecessary barriers to care. In addition, it is likely that many individuals seeking care may be “eligible” for Medi-Cal but whose benefits are not active at the time of assessment and intake.

For these reasons, **eligible individuals may NOT be denied services pending establishment of Medi-Cal. Medi-Cal eligible beneficiaries/participants may NOT be charged sliding scale fees or flat fees.**

Therefore, providers need to use the Case Management benefit to:

- Assist individuals obtain Medi-Cal if qualified but whose benefits are not active at the time of first contact. Providers should initiate the process on or before the date of first Treatment Service to better ensure reimbursement for delivered services.
- Assist Sacramento County residents transfer Medi-Cal benefits to Sacramento County if assigned to another County on or before the date of first Treatment Service. Reimbursement shall be denied for non-County residents.

For these individuals, Network Providers must also meet access to care requirements which necessitates that the date of first service or intake appointment occurs no later than 10 calendar days from the date of referral or screening.

## **MEDI-CAL ELIGIBLE BUT BENEFITS NOT ACTIVE**

To facilitate access to care, Network Providers will be **reimbursed** for delivered treatment services **for up to 60 days** after admission, assessment and completion of CalOMS for:

- Clients who are likely eligible for Medi-Cal and whose complete Medi-Cal application is submitted with a Client Identification Number (CIN) number assigned but whose application was not processed by the 60th day or it was ultimately denied by the State; and
- Clients who need current Medi-Cal benefits re-assigned to Sacramento County due to a permanent move and who submitted a transfer request to the County of residence but whose transfer was not processed by the 60th day.

If Medi-Cal benefits are ultimately established, SUD treatment services are reimbursable to the date of application. Therefore, it is essential to initiate this process as close to the date of first service as possible. It is also critical that:

- Individuals step-up or step-down to another level of care whenever clinically appropriate (e.g., from withdrawal management to outpatient) both to support improved and sustained recovery outcomes and to increase the time needed for clients to obtain health benefits; and
- The initial case manager communicates with the new case manager regarding the status of the client's benefits application. The initial provider will rely on the subsequent provider to support the client in completing the paperwork, so all are reimbursed once the application is approved.

## **MEDI-CAL MANAGED CARE**

Medi-Cal managed care plans in Sacramento County include Aetna, Kaiser Foundation Health Plan, Anthem Blue Cross, Health Net, and Molina Healthcare. If the individual is a Medi-Cal beneficiary and has a member card from one of these health plans, they are entitled to the full SUD benefit package and thus should to be referred to an appropriate Network Provider. It is then the treating provider's responsibility to coordinate care as appropriate with the Health Plan and/or their primary care physician.

## **MEDI-CAL AND MEDICARE: "MEDI-MEDI"**

Dually eligible individuals, or those with Medi-Cal and Medicare, are entitled to the full DMC benefit package, including any County-specific supplemental services such as Recovery Bridge Housing. Medicare does not cover SUD services, and thus does not need to be billed first. Any Medicare associated share-of-cost cannot be collected before delivery of services.

## **MEDI-CAL AND PRIVATE INSURANCE**

If the individual has private insurance (e.g., employer-sponsored, small group, or individual commercial insurance) and has Medi-Cal, the private insurance coverage must be fully utilized before Medi-Cal coverage can be accessed.

## MEDI-CAL AND SHARE-OF-COST

Some Medi-Cal beneficiaries are required to share in the cost of their treatment services. These individuals must pay out of pocket until the share-of-cost (deductible) is met. This “spend down” is a clearance of the client’s share-of-cost liability. The client must pay an amount towards medical expenses prior to receiving Medi-Cal benefits for that month.

	Eligibility Requirement	Source of Verification
<b>Step 1</b>	Resident of Sacramento County and if Medi-Cal beneficiary, benefits are assigned to Sacramento County.	Proof of residence (e.g., identification card, utility bill, etc.)
<b>Step 2</b>	<ul style="list-style-type: none"> <li>• Medi-Cal Eligible or Enrolled</li> </ul> <u>OR</u> <ul style="list-style-type: none"> <li>• Participant in other qualified County funded programs/projects (e.g., CalWORKs, SAPT)</li> </ul>	<ul style="list-style-type: none"> <li>• Medi-Cal application submitted or Medi-Cal verification via MEDS file</li> <li>• Proof of participation in other qualified County funded programs/projects</li> </ul>
<b>Step 3</b>	Meets medical necessity criteria for specialty SUD services (see Determining Medical Necessity section of Provider Manual for additional information)	<p>Completed ASAM assessment</p> <p>Adults (ages 21+)</p> <ul style="list-style-type: none"> <li>• Must meet criteria for at least one diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders.</li> </ul> <p>Youth (ages 12 – 17) and Young Adults (ages 18 – 20)</p> <ul style="list-style-type: none"> <li>• Either meet criteria for the DSM criteria specified for adults;</li> </ul> <p><u>OR</u></p> <ul style="list-style-type: none"> <li>• Be determined to be “at-risk” for developing a SUD (see Definition of At-Risk for Individuals up to Age 21 section for additional details).</li> </ul>

## ACCESS TO CARE

Access to care refers to the psychosocial and physical access to the location where treatment services are rendered. Physical barriers may include the architecture of the site, such as treatment providers with steps but no ramp entrance for disabled individuals. There may also be geographical or environmental barriers such as program locations that are inaccessible by public transportation, far from areas where clients live, or where clients do not feel safe. Lack of soundproofing in counseling offices and lack of privacy in assessment rooms are also potential barriers. Psychosocial barriers may include lack of communication capabilities for those who are non-English monolingual or limited English proficiency and hearing- or visually-impaired individuals, attitudes expressed by counselors or other staff that denote biases or communicate stigma to the clients, lack of a diverse workforce, operational hours that restrict access to services, or a lack of opportunity for client input into his or her Treatment Plan or program operations.

While there is no “wrong door” to enter the specialty SUD system, there are three (3) main portals of entry:

- Toll-free 24 hour phone line 1-888-881-4881
- Sacramento County System of Care
- Direct-to-provider self-referrals

In all instances, maximizing access and minimizing the time and barriers to care are fundamental priorities for the specialty SUD system. Every effort must be made to minimize the elapsed time between the initial verification of eligibility, clinical need determination, referral, and the first clinical encounter.

Provider will have hours of operation during which services are provided to Medi-Cal clients that are no less than the hours of operation during which the provider offers services to Non Medi-Cal clients.

Provider shall post and record the **24-hour phone line 1-888-881-4881 and 916-875-1055** during hours of non-operation.

All clients requesting SUD screening services shall be screened for need and level of care the same day, or given an appointment for screening the next business day. The client shall complete the screening/LOC determination during the initial phone call, initial face-to-face interaction, or during the scheduled appointment. Clients shall receive an intake assessment within seven (7) calendar days after the initial screening or request for services.

Once the predetermination level of care is made through the screening tool, the client shall be scheduled for an appointment with Sacramento County System of Care or Provider for a complete intake and assessment to determine diagnosis and medical necessity.

If the provider determines the client requires residential or withdrawal management services, they will contact the County to coordinate the clients appointment with a contracted residential provider. The County will authorize residential treatment services.

Client preferences shall be considered such as cultural, geographical, gender, language and personal schedule. These preferences and special circumstances shall be documented in the Provider client chart if applicable. CFR\_42\_431201.

Urgent conditions shall be addressed by the counselor while in contact with the client. Counselor staff shall reach out to police, a 24-hour crisis behavioral health team, or emergency personnel as the need arises. Additionally, Sacramento County Alcohol and Drug Services will be informed of the emergency and details about how the client accessed any services.

### **TIMELINESS AND ACCESS STANDARDS**

Ensuring timely access to services is essential to accomplish the aim of improving outcomes of the specialty SUD system, as is engaging clients when they are ready to initiate treatment.

In addition to time, distance is another component of treatment access that has been linked to client outcomes. Generally, the shorter the distance between a client and his/her treatment site, the better the client outcome. Unless otherwise requested by the client, every effort must be made to refer the client to a treatment program that is within 30 minutes of travel time by personal or public transportation or fifteen (15) miles from the clients' location of choice (see Table). If this is not feasible, every effort should be made to decrease the likelihood that the commute or transportation issues serve as a barrier to accessing treatment. If clients prefer to have some aspect of treatment delivered in a different region than where they reside or work, this preference must be considered and noted in their clinical record.

<b>SERVICE</b>	<b>DUE DATE</b>
Distance Standards for Referrals	Every effort must be made to refer patients to a treatment program within (1) 30 minutes of travel time by personal or public transportation or (2) 15 miles from the patients' location of choice
Screening for Provisional LOC* *If the agency does not offer the provisional LOC or a Slot/Bed will not be available within 10 days, referrals must be provided (no waitlists allowed)	Date of first contact (walk-ins only)  Provide two alternate referral agencies and connect the patient within 48 hours to the preferred provider
Assessment Appointment - Scheduled	Immediately but no longer than 3 calendar days of screening/referral
Assessment Appointment - Conducted	Within 10 business days of screening/referral
County Residency Eligibility Verification	Date of first service/intake appointment*
Medi-Cal Eligibility Verification	
Patient Handbook Provided	
Notice of Policy Practice Provided	

SERVICE Cont.	DUE DATE Cont.
Notice of Privacy Practices	Within 5 calendar days of first service or first intake appointment
ASAM Assessment	Within 7 calendar days of first service or first intake appointment* for adults (18+)
Medical Necessity Determination	<u>OR</u> Within 14 calendars days of first service or first intake appointment* for youth (ages 12-17)
Data Submission (e.g., CalOMS)	If every attempt has been made to complete and finalize the ASAM within the 7 or 14 calendar day timeframe, but circumstances do not allow for full completion, then the provider must include a Miscellaneous Note detailing the reason for the inability to meet the established standard.
Treatment Plan (Initial Only)	<p>Within 7 calendar days of first service or first intake appointment* for adults (18+), including signatures by both patient and LPHA</p> <p><u>OR</u></p> <p>Within 14 calendars days of first service or first intake appointment* for youth (ages 12-17) including signatures by both patient and LPHA</p> <p>If every attempt has been made to complete and obtain signatures within the 7 or 14 calendar day timeframe, but circumstances do not allow for full completion, then the provider must:</p> <ul style="list-style-type: none"> <li>• Include a Miscellaneous Note with justification detailing what prevented completion within the timeframe;</li> <li>• Complete an initial Treatment Plan based on the information (and signatures) available at the 7 or 14 calendar day deadline; and</li> <li>• Within 30 days (28 for OTP) of first service or first intake appointment, * complete a Treatment Plan based on the assessment, that includes all elements and is signed by the patient and LPHA. The LPHA or Medical Director must then sign the Treatment Plan within 15 days of the patient signing.</li> </ul>

To optimize access to SUD services, SUD treatment agencies must implement an ongoing, systematic evaluation process for identifying physical and/or psychosocial access issues that may impede SUD treatment seeking behavior. The evaluation process should identify counselor/staff attitudes around substance use, client transportation, or any other accessibility issues. Providers must also consider client and stakeholder feedback during this process. Once barriers are identified, SUD treatment agencies should develop a plan detailing how they plan to address the identified barriers. The plan may be a Quality Improvement Project that specifies the barrier(s) and action(s) that will be taken to eliminate or reduce the impact of the barrier, and when these specific actions will be completed.

## **SUD TREATMENT PROCESS OVERVIEW**

The SUD treatment process reflects a logical approach that can be applied to solving challenges in any area. Solving a challenge begins with the preliminary identification of the general nature of the challenge, followed by a more detailed determination of the specifics of the challenge. For substance use disorder treatment providers, this preliminary step is the intake process of admission (identifying the challenges faced by a client and establishing how a provider can help) and assessment (determining the various issues that make up the challenge).

As a next step in the process, a treatment plan is developed in partnership with clients to address issues identified during the assessment process, followed by the implementation of the treatment plan (clients receiving treatment and referrals). The treatment plan is continually updated and changed to reflect any changes in problems or a new treatment focus. When SUD treatment services are completed and a program determines the client has made sufficient progress to be discharged, providers discharge a client, prepare a discharge plan, and close the client record.

If any of the SUD treatment process steps are not completed, the chances for positive client and program compliance outcomes are greatly reduced.

## **CLIENT ENGAGEMENT**

All SUD providers must have a treatment planning process that meaningfully engages clients in the development of initial treatment plans and any updates to the treatment plan. Each client must review, approve, type or legibly print their name, sign and date his or her treatment plans and indicate whether he or she was involved in the plan's development. If a client refuses to sign his or her treatment plan, providers must indicate the reason for refusal and document strategies that will be taken to engage the client in treatment.



## **INTAKE, SCREENING, ASSESSMENT AND ADMISSION REQUIREMENTS**

### **SCREENING**

Providers shall only admit Sacramento County residents directly to County funded programs and work cooperatively with Sacramento County Alcohol and Drug Services System of Care and the Alcohol and Drug Administrator (or designee) to form an integrated network of care for individuals experiencing substance use/abuse problems. The Provider shall maintain close communication with Sacramento County Alcohol and Drug Services System of Care in the coordination of client admission and transition so that contracted treatment services can be accessed in a timely manner.

Provider shall use the County initial screening/assessment tool consistent with the American Society of Addiction Medicine (ASAM) client placement criteria.

The process for walk-in screenings and call-in screenings shall be identical. When a client calls by telephone, they will receive a complete County approved SUD screening. Once the predetermination of the ASAM level of care is made, the client shall be scheduled with a Provider for a complete assessment to determine diagnosis and medical necessity. The SUD screening and predetermination level of care will be entered into the Provider's Electronic Health Record (EHR) at that time and the client shall be linked to an appointment before the call is terminated.

The Provider must verify Medi-Cal eligibility of the individual. When the Provider conducts the initial eligibility verification, that verification shall be reviewed and approved by the County prior to payment for services.

A registered/certified substance abuse counselor, or licensed clinician shall be available to screen clients, enter client information into the Provider's EHR system and place the client in an appropriate ASAM level of care, including education classes and individual prevention services.

For withdrawal management/detox and residential treatment: upon determination of level of care, the Provider will FAX to Sacramento County Alcohol and Drug Services System of Care information for Authorization of Services.

Providers shall admit on a priority basis, pregnant women who are using or abusing substances, women who are using or abusing substances and who have dependent children, injecting drug users, and substance abusers. Priority admissions shall be given in the following order:

- Pregnant women who are using or abusing substances.
- Women who are using or abusing substances who have dependent children.
- Injecting drug users.
- Substance users.

## **42 CFR 431.201**

### **County of Residence Guideline**

#### **Adolescent SUD Assessment/LOC determination**

#### **Adolescent Level of Care Guidelines**

#### **Adult SUD Assessment/LOC determination**

#### **Adult Level of Care Guidelines**

The first step in the treatment process is client intake and assessment. Drug Medi-Cal requires all providers to have written documentation on procedures for client admission to SUD treatment. Sacramento County Alcohol and Drug Services is adopting this standard for all SUD treatment providers regardless of their DMC certification status. A client admission to treatment date is the date on which any face-to-face treatment service is provided to a client. Once an individual has completed the intake and assessment process, the individual becomes a client of the program.

All SUD treatment providers, regardless of DMC certification status, must complete a personal, medical and substance use history for each client upon admission to treatment to support the treatment plan for each client. In addition, all providers must complete a DHCS Health Questionnaire for each client and enter the required information into Avatar, the Sacramento County electronic behavioral health record system. For DMC certified programs, the Medical Director or LPHA must review each client's history within *30 calendar days* of the client's admission to treatment date.

## **ASSESSMENT**

Assessments are the evaluation, measurement and documentation of clients to determine diagnoses and service needs. In the treatment of persons with SUDs, assessments are an ongoing process and are essential to identify client needs and help the provider focus their services to best meet those needs. Assessments are also important opportunities for client engagement and Treatment Planning. Assessments are generally performed in the initial phases of treatment, though not necessarily during the initial visit.

Comprehensive, validated, and standardized assessments tools, and their corresponding documentation, form the foundation of high quality SUD services. Assessments based on the ASAM Criteria ensure that there is a standardized structure by which to collect necessary clinical information to make appropriate SUD level of care determinations. Assessments need to be appropriately documented, reviewed, and updated on a regular basis, including at every care transition, to promote engagement and meet the client's needs and preferences.

Full ASAM assessments include a comprehensive evaluation of the six (6) dimensions of the ASAM Criteria, in addition to other important clinical elements captured during the assessment interview. Medical necessity must be determined by a full ASAM Continuum and not solely by a screening. Full ASAM assessments include a determination if an individual meets the diagnostic criteria for a SUD from the DSM-5.

If while assessing the client the provider determines that adequate progress toward treatment goals has been made, plans to build upon these achievements need to be made, which may include transitions to other services and recovery-focused strategies. Similarly, reassessments of the diagnosis, treatment modalities/intensity/goals need to be performed if progress toward agreed upon goals is not being made within a reasonable time.

Providers shall assure a Registered/Certified Counselor or LPHA completes a personal, medical and substance use history for each client upon admission to treatment. The Medical Director or LPHA will review each client's personal, medical and substance use history if completed by a Registered/Certified Counselor. At the minimum, the assessment shall include:

- Drug/Alcohol use history,
- Medical history,
- Family history,
- Psychiatric/psychological history,
- Social/recreational history,
- Financial status history,
- Educational history,
- Employment history,
- Criminal history and legal status, and
- Previous SUD treatment history.

Please note that not all of the data points listed above are obtained through the ASAM. Therefore, providers need to make certain to gather the required information via other documentation.

Clients who choose to directly contact a DMC-ODS service provider will be screened and assessed, if indicated, and offered admission to the appropriate ASAM level of care. If a beneficiary goes to a DMC-ODS service provider without an appointment and there is qualified staff to perform an assessment, then the beneficiary will be seen the same day. If there is no qualified staff available to perform an assessment on the same day, then they will be given an appointment to return for a face-to-face assessment within **3 days**. If after assessing the beneficiary they are determined to be more appropriate for an ASAM level of care not offered by the provider, then the provider will immediately refer the beneficiary to another DMC-ODS service provider that provides the indicated ASAM level of care, to the BHS Access Line, or the System of Care and will document the referral.

DMC-ODS providers will aim to admit eligible beneficiaries **within five (5) business days—but will be no later than 10 business days**—from the assessment. In the unlikely event that admission to treatment will be greater than 10 business days.

## **RE-ASSESSMENT (CONTINUING SERVICES)**

Continuing services shall be justified for case management, outpatient services, intensive outpatient, and medication assisted treatment.

Providers are required to demonstrate that clients continue to meet current LOC criteria or determine that an alternative is most appropriate. All clients will be reassessed any time there is a significant change in their status, diagnosis, a revision to the client's individual treatment plan, and as requested by the client.

For outpatient services, each client, no sooner than five (5) months and no later than six (6) months after the client's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the client progress and eligibility to continue to receive treatment services, and recommend whether the client should or should not continue to receive treatment services at the same level of care. For NTP/MAT services, reassessment is completed annually.

Changes that could warrant a re-assessment and possibly a transfer to a higher or lower level of care include, but are not limited to:

- Achieving treatment plan goals.
- Inability to achieve treatment plan goals despite amendments to the treatment plan.
- Identification of intensified or new problems that cannot adequately be addressed in the current level of care or change in diagnosis or status.
- At the request of the client.

For each client, no sooner than five months and no later than six months after the client's admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the client. The determination of medical necessity shall be documented by the Medical Director or LPHA in the client's individual client record and shall include documentation that all of the following have been considered:

- The client's personal, medical, and substance use history.
- Documentation of the client's most recent physical examination.
- The client's progress notes and treatment plan goals.
- The LPHA's or counselor's recommendation pursuant to the client's progress or lack of progress.
- The MD or LPHA shall type or legibly print their name, and sign and date the documentation.

If the MD or LPHA determines that continuing treatment services for the client is not medically necessary, the provider shall discharge the client from treatment and arrange for the client to proceed to an appropriate level of treatment services.

## LEVELS OF CARE

Addiction treatment is delivered across a continuum of services that reflect illness severity and the intensity of services required. One of the key goals of the County is to facilitate SUD service delivery that is the right service, at the right time, for the right duration, in the right setting. The levels of care need to be viewed as points along a continuum of treatment services, each of which may be provided in a variety of settings.

Referral to a specific level of care must be based on a comprehensive and individualized assessment of the client, with the primary goal of placing the client at the most appropriate level of care. Initial referrals may be accomplished through a brief screening tool with a more comprehensive assessment completed at the treatment program to confirm placement. In Sacramento County, level of care determinations are based on the ASAM Criteria to organize the assessment and clinical formulation to provide more consistency in level of care determinations. In general, the preferable and most appropriate level of care is one that is the least intensive while still safely meeting the unique treatment objectives of the client and treatment team.

Level of care determinations begin with the full ASAM multidimensional assessment, which explores client risks, needs, strengths, skills, and resources. Dimension-specific risk ratings are generated from the assessment process and are used to help inform providers as to dimensional priorities, which are subsequently used for service planning and placement. When physical or mental health conditions are apparent, the need for immediate stabilization should be prioritized and the highest severity problem should determine the client's entry point into the treatment continuum, whether it is within the SUD system of care (including Opioid Treatment Programs), or in the physical or mental health systems. Treatment is best conceptualized as a flexible continuum, marked by different ASAM levels of care, with gradations of service intensities for residential and withdrawal management services.

<b>SUD CONTINUUM AND LEVELS OF CARE</b>		
<b>Benefits</b>	<b>ASAM Level of Care</b>	<b>Description</b>
Outpatient	1.0	Appropriate for patients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.
Intensive Outpatient	2.1	Appropriate for patients with minimal risk for acute intoxication/withdrawal potential, medical, and mental health conditions, but need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting.
Low Intensity Residential (Clinically Managed)	3.1	Appropriate for individuals who need time and structure to practice and integrate their recovery and coping skills in a residential environment.
High Intensity Residential, Population Specific (Clinically Managed)	3.3	Appropriate for patients with functional limitations that are primarily cognitive, who require a slower pace to treatment, and are unable to fully participate in the social and therapeutic environment

**SUD CONTINUUM AND LEVELS OF CARE – Cont.**

<b>Benefits</b>	<b>ASAM Level of Care</b>	<b>Description</b>
High Intensity Residential, Non-Population-Specific (Clinically Managed)	3.5	Appropriate for patients who have specific functional limitations and need a safe and stable living environment to develop and/or demonstrate sufficient recovery skills to avoid immediate relapse or continued use of substances
Opioid Treatment Program	1-OTP	Appropriate for patients with an opioid use disorder that require methadone or other medication-assisted treatment.
Recovery Support Services	N/A	Appropriate for any patient who has completed SUD treatment.
Ambulatory (Outpatient) Withdrawal Management	1-WM	Appropriate for patient with mild withdrawal who require either daily or less than daily supervision in an outpatient setting.
Clinically Managed Residential Withdrawal Management	3.2-WM	Appropriate for patient with moderate withdrawal who need 24-hour support to complete withdrawal management and increase the likelihood of continuing treatment or recovery.
Medically Monitored Inpatient Withdrawal Management	3.7-WM	Appropriate for patients with severe withdrawal that requires 24-hour inpatient care and medical monitoring with nursing care and physician visits.
Medically Managed Inpatient Withdrawal Management	4-WM	Appropriate for patients with severe withdrawal that requires 24-hour nursing care and physician visits to modify withdrawal management regimen and manage medical instability.

Source: American Society of Addiction Medicine

**Note:** Currently the ADS provider network does not provide level 3.3 Residential, or levels 3.7-4 of Medically Managed Inpatient Withdrawal Management. If the patient screens for level 3.3 or 3.7-4 WM, then the provider may consider the following options as clinically appropriate:

- Refer patient to 3.5 High Intensity Residential as clinically necessary.
- Refer patient to 3.2-WM as clinically necessary.
- Refer patient to a general acute hospital for medical treatment or an inpatient psychiatric hospital if the patient requires psychiatric treatment.

Services provided at the various levels of care should reflect the client’s clinical condition, including consideration for severity level and functional impairment. Interventions may include, but are not limited to: individual counseling, group counseling, family therapy, client education, psychosocial interventions, medication-assisted treatments, collateral services, case management, crisis intervention, Treatment Planning, recovery support services, and discharge services.

As client’s transition between levels of service, progress in all six (6) dimensions should be formally assessed at regular intervals, in accordance with the client’s severity level and functional impairment, as clinically indicated. These assessments help to ensure that clients are placed in the appropriate level of care based on medical necessity, as reviewed and verified by a LPHA. Level of care transitions need to be based on clinical need, as opposed to funding source or provider preferences.

Continuity of care and longitudinal follow up are critical for SUD clients. Referrals and linkages to different service and levels of care within the SUD, physical, and mental health systems help to ensure that client needs are appropriately addressed. High quality care is characterized by the seamless linking of different levels of care, both within the SUD system of care and between other systems of health care. This streamlined system of care can be achieved by case management, role induction (preparing individuals for treatment by sharing the rationale of treatment, treatment process, and their role in that process), warm hand-offs, and assertive outreach.

Providers must also familiarize themselves with other requirements that govern SUD treatment. These include the California Code of Regulations Title 22, Title 9, Alcohol and/or Other Drug Program Certification Standards, and the provisions Drug Medi-Cal Organized Delivery System including County and DHCS Bulletins/information notices, and the contract's specific services to be provided and definitions of services.

## **PHYSICAL HEALTH**

Substance use can complicate and lead to serious health conditions making it important to assess medical illnesses that clients may face. If left untreated, significant medical illnesses may lead to poor treatment outcomes and even a decreased life expectancy. A central element of Sacramento County's philosophy of care is to provide a whole person approach that meets an individual's behavioral health and primary care needs where a client accesses services. All SUD treatment providers, regardless of DMC certification status, must consider client physical health information when developing SUD treatment plan goals. Requirements for physical examination guidelines can be found in the document section titled Physical Examinations.

## **SUBSTANCE USE DISORDER MEDICAL DIRECTOR ROLE AND MEDICAL OVERSIGHT**

While SUD treatment providers may have more than one physician or Medical Director on staff, the Medical Director has medical responsibility of *all* clients and must be available on a regularly scheduled basis. The SUD Medical Director is a physician who is licensed by the Medical Board of California. Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a Provider representative and the physician. Duties of the Medical Director may vary, but at a minimum, DMC-ODS certified treatment provider Medical Directors must:

- Ensure medical care provided by physicians, registered nurse practitioners, and physician assistants meet the applicable standard of care.
- Ensure physicians do not delegate their duties to non-physician personnel.
- Establish, review, and maintain medical policies and standards.
- Ensure the medical decisions made by physicians are not influenced by fiscal considerations.
- Ensure provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for clients and determine the medical necessity of treatment for clients.
- Ensure provider's physicians are adequately trained to perform other physician duties.
- Ensure the quality of medical services provided to all clients.
- Ensure a physician has assumed medical responsibility for all clients treated by the provider.

## **MEDICATION MANAGEMENT**

It is the expectation that medication prescribers evaluate the benefits-to-risk ratio and identify accepted guidelines when prescribing medications. The purpose of medication management is to:

- Increase the effectiveness of medication use to reflect a high quality of care and reduce serious side effects such as abuse and dependency.
- To assure appropriate laboratory work is obtained at the onset and during the course of treatment.
- Increase the likelihood that related physical examinations occur and are documented.
- To follow accepted medical guidelines when prescribing habituating medications to ensure the medication is the optimum treatment.

Medication monitoring is a critical quality improvement function, intended to ensure the quality of medication treatment for clients served by Sacramento County contracted DMC-ODS providers. DMC-ODS providers are responsible for implementing their own internal and/or subcontracted review process to ensure consistent medication practices adhere to all State and Federal regulations. Furthermore, they are responsible for implementing mechanisms and adhering to standards monitoring safety and effectiveness of medication practices while in compliance with the most current Sacramento County formulary. Sacramento County's quality management will review each site's medication monitoring practice, policies and procedure, and clinical charts as part of their scheduled reviews.



## **PHYSICAL EXAMINATIONS**

For DMC certified programs, all clients must be assessed for whether they have had a physical examination within the twelve-month period prior to admission to treatment. Consistent with the Sacramento County philosophy of care, Alcohol and Drug Services is adopting this DMC physical examination standard for all SUD treatment providers regardless of their DMC certification status. If documentation of a physical examination cannot be obtained, providers must describe in the client record efforts taken to obtain documentation.

For all clients in DMC certified programs that had physical exams within the twelve months prior to treatment admission, a physician, registered nurse practitioner or physician's assistant, may perform a physical examination of the client within 30 days of admission to treatment, and must review the exam within 30 calendar days of the treatment admission date to determine whether the client has any significant medical illnesses. A copy of physical exam must be included in the client record. For any significant medical illnesses, the client's initial and updated treatment plans must incorporate a goal to obtain appropriate treatment for the illnesses. For non-DMC certified providers, program staff must consider client physical health information in developing and updating client treatment plans.

When there is no documentation of a client physical exam within the last twelve months from the admission to treatment date, DMC certified providers must either incorporate a physical exam as a client goal in the initial and updated treatment plans or conduct a physical exam of the client within 30 calendar days of the admission to treatment date. A physician, registered nurse practitioner or physician's assistant may conduct the exam. A copy of the exam must be included in each client record. It is not sufficient to include a progress note alone that the exam was completed. Sacramento County is adopting this DMC standard for all SUD treatment providers regardless of their DMC certification status.

## **MODALITIES COVERED BY PROVIDER MANUAL**

The Sacramento County Provider Manual covers the following SUD treatment modalities:

- Outpatient Drug Free (ODF)
- Narcotic Treatment Program (NTP)
- Naltrexone Treatment
- Intensive Outpatient Services
- Withdrawal Management

Residential Substance Use Disorder Services (incorporates Perinatal Residential Substance Use Disorder Services).

While intake/assessment and treatment plans are standardized across SUD treatment modalities, there are some differences in the type and frequency of required client services by modality.

### **OUTPATIENT TREATMENT**

Outpatient Services (ASAM Level 1.0) consist of up to 9 hours per week of medically necessary services for adults and less than 6 hours per week of services for adolescents. Providers will offer ASAM Level 1 services including: assessment, treatment planning; individual and group counseling; family therapy; client education; medication services; collateral services; crisis intervention services; and discharge planning and coordination. Services may be provided in-person, by telephone, or by tele-health in any appropriate setting in the community.

Intensive Outpatient Services (ASAM Level 2.1) involves structured programming provided to clients as medically necessary for a minimum of nine (9) hours and a maximum of 19 hours per week for adult perinatal and non-perinatal clients. Adolescents are provided a minimum of six (6) and a maximum of 19 services per week. Services include assessment, treatment planning, individual and/or group counseling, client education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, and discharge planning and coordination. Services may be provided in-person, by telephone, or by telehealth in any appropriate setting in the community.

### **INDIVIDUAL COUNSELING**

Individual Counseling sessions are designed to support direct communication and dialogue between the staff and client and focus on psychosocial issues related to substance use and goals outlined in the client's individualized Treatment Plan. Individual Counseling sessions need to incorporate Motivational Interviewing and Cognitive Behavioral Therapy techniques.

Individual Counseling sessions are available at all levels of care and are defined as face-to-face or telephone contact between one (1) registered counselor, certified counselors or LPHA, and one (1) client at the same time. Sessions range from 15 to 60 minutes. Individual Counseling sessions less than 15 minutes cannot be billed as they are less than the minimum requirement. If Individual Counseling sessions exceed 60 minutes, the Progress Note for that encounter must substantiate exceeded time. If the counseling session is split into different services (e.g. Case Management,

Crisis Intervention, etc.), a Progress Note must be written for each session and documented in the chart/EHR.

The frequency of Individual Counseling sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized client needs rather than a prescribed program required for all participants.

Individual counseling sessions between a LPHA or Registered/Certified Counselor and a client are to be conducted in a confidential setting where individuals not participating in the counseling session cannot see or hear the comments of the client, LPHA or Counselor. Individual counseling sessions can be provided in person in an office, home or community setting or via telephone or telehealth as long as confidentiality and informed consent requirements are met.

### **GROUP COUNSELING**

Group counseling sessions are designed to support discussion among clients, with guidance from the facilitator to support understanding and encourage participation, on psychosocial issues related to substance use. This does not include recreational activities, skill building sessions (e.g., employment, education, tutoring), or time spent viewing videos/DVDs (although discussion time is generally allowable). Group Counseling sessions need to incorporate Motivational Interviewing and Cognitive Behavioral Therapy techniques.

Group Counseling sessions are available at all levels of care and are defined as face-to-face contact between up to two (2) registered or certified SUD counselors or LPHAs, and between two (2) to twelve (12) clients at the same time. Sessions ranging from 60 to 90 minutes in length. A separate Progress Note must be written for each participant and documented in the chart/EHR. Group sign-in sheets must include signatures and printed names of all participants and group facilitators, date, start/end times, location, and group topic.

The frequency of Group Counseling sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized client needs rather than a prescribed program required for all participants.

### **GROUP COUNSELING CONFIDENTIALITY**

Group counseling sessions must be face-to-face and conducted in a confidential setting where individuals not participating in the counseling session cannot see participants or hear the comments of the client or LPHA/Counselor.

### **GROUP COUNSELING AGE REQUIREMENTS**

Sacramento County System of Care is adopting the DMC standard for age considerations for all SUD treatment providers, regardless of DMC certification status. A client who is seventeen years of age or younger cannot participate in group counseling with clients who are eighteen years of age or older *unless* the counseling occurs at a DMC certified program's school site.

## **WITHDRAWAL MANAGEMENT AND RESIDENTIAL PROVIDERS**

Withdrawal Management Services (ASAM Levels 2-WM, 3.2-WM) are provided as medically necessary to clients and include: assessment, observation, medication services, and discharge planning and coordination.

Clients receiving residential withdrawal management, 3.2-WM shall reside at the facility for monitoring during the detoxification process. Alcohol and Drug Services will also offer ASAM Levels 2-WM: Ambulatory Withdrawal Management with Extended On-Site Monitoring.

Residential Treatment Services (ASAM Levels 3.1, 3.3, 3.5) are a 24-hour, non- institutional, non-medical, short-term service that provides residential rehabilitation services to youth, adult, and perinatal beneficiaries. Residential services are provided in facilities designated by DHCS as capable of delivering care consistent with ASAM Level 3.1: Clinically-Managed Low-Intensity Residential, ASAM Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services (Adult only), and ASAM Level 3.5: Clinically-Managed High-Intensity Residential.

Clients are approved for residential treatment through a prior authorization process based on the results identified by the ASAM assessment. The length of stay for residential services may range from 1-90 days, unless a reassessment of medical necessity justifies a one-time services reauthorization/extension of up to 30 days. Only two non-continuous 90-day regimens will be authorized in a one- year period. Perinatal and criminal justice involved clients may receive a longer length of stay based on medical necessity. Residential treatment services includes assessment, treatment planning, individual and group counseling, client education, family therapy, collateral services, crisis intervention services, treatment planning, transportation to medically necessary treatments, and discharge planning and coordination. All providers are required to accept and support clients who are receiving medication-assisted treatments.

Sacramento County Alcohol and Drug Services System of Care personnel are the only staff authorized to place a client in withdrawal management or residential treatment. This is in accordance with Department of Health Care Services (DHCS) information notice 16-042, withdrawal management or residential placement guidelines. Withdrawal Management and Residential Providers are required to submit Bed Availability Reports daily through email ([ADSSOC@saccounty.net](mailto:ADSSOC@saccounty.net)) to identify available bed slots for the day.

The Sacramento County personnel will complete the SAPT Placement Referral Form and forward it to the Provider.

Providers are to collaborate and work closely with County staff to ensure engagement, re-engagement and warm hand-offs are present as the client proceeds through treatment.

## **NON-DMC RESIDENTIAL TREATMENT ADMISSION REQUIREMENTS**

For non-DMC residential treatment providers, initial client treatment plan requirements include:

- For short-term residential treatment programs (a program during of 30 days or less), the initial treatment plan must be developed within 10 days from the client's admission to treatment date;
- For long-term residential programs (a program duration of 31 days or more), the initial treatment plan must be developed within 14 days of the client's admission to treatment date.

## **NON-DMC RESIDENTIAL UPDATED TREATMENT PLAN REQUIREMENTS**

Residential treatment programs must meet the following updated treatment plan requirements:

- For short-term residential programs (a program duration of 30 days or less), the initial treatment plan must be updated within 10 days after signing the initial treatment plan and not later than every 10 days thereafter;
- For long-term residential programs (a program duration of 31 days or more), the initial treatment plan must be updated within 14 days of after signing the initial treatment plan and not later than every 14 days thereafter.

**Medical Psychiatric Clearance Form**  
**SAPT Placement Referral Form**  
**DHCS Information Notice 16-042**  
**Bed Availability Report**

## **MEDICATION ASSISTED TREATMENT (MAT)**

Medication Assisted Treatment is the use of prescription medications, in combination with counseling and behavioral health therapies to treat substance use disorders. As part of the DMC-ODS pilot program there are required MAT services as outlined below:

- Narcotic Treatment Program (NTP) Services.
- Access to buprenorphine, naloxone, disulfiram, and methadone in a NTP setting.

Optional additional MAT Services include:

- FDA approved medications (any DMC setting).
- Ordering, prescribing, administering, and monitoring of MAT.
- Utilization of long-acting injectable naltrexone at DMC facilities, including NTPs.
- County-proposed interim rates for additional MAT outside of a NTP setting, including buprenorphine, disulfiram, naloxone, and long-acting injectable naltrexone.

**DHCS MAT Info Notice**  
**DHCS MAT FAQ**  
**Release of Information**

## **OPIOID TREATMENT PROGRAM/NARCOTIC TREATMENT PROGRAM ADMISSION REQUIREMENTS**

Opioid Treatment Programs (OTPs) are treatment settings that provide MAT, including methadone, buprenorphine, naloxone (for opioid overdose prevention), and disulfiram for individuals with opioid and alcohol use disorders. OTPs may also offer other types of MAT to address co-morbid SUD in addition to opioid use disorder. A distinguishing feature of OTPs compared to other SUD levels of care is that OTPs are the *only* setting that can legally provide methadone treatment for addiction. OTPs also offer a broad range of other services including medical, perinatal and/or other, psychosocial services.

An OTP is identified as a level of care and as such, medical necessity for OTP services must be established, including a DSM-5 diagnosis of a SUD and an appropriate level of care designation via an SUD assessment.

Clinicians, such as counselors and non-prescriber LPHAs play an important role in identifying who may benefit from MAT and treatment at an OTP. For example, non-prescriber SUD service providers should explain potential MAT benefits alongside other services and refer clients to appropriate health professionals for further assessment. SUD providers from across disciplines will need to work together to ensure familiarity with, and access to, MAT both in OTP and other SUD treatment settings.

Opioid (Narcotic) Treatment Program (OTP/NTP, ASAM OTP Level 1). Services are provided in accordance with an individualized client care plan determined by a licensed prescriber. An opioid maintenance criterion is a two year history of addiction, two treatment failures and one year of episodic or continued use pursuant to Title VIII regulations. Prescribed medications offered currently include methadone, buprenorphine, naloxone, disulfiram and other medications covered under the DMC- ODS formulary through contracted service providers.

OTP/NTP programs will be required to offer and record proof of beneficiary understanding on choices of medications and treatment without medications. Services provided as part of an Opioid Treatment Program include: assessment, treatment planning, individual and group counseling, client education; medication services; collateral services; crisis intervention services; treatment planning; and discharge services. Clients receive between 50 and 200 minutes of counseling per calendar month with a therapist or certified/registered counselor.

All OTP providers must have a complete initial SUD Assessment for all clients.

Reimbursement for cases in which SUD assessments were not completed by this date will be subject to recoupment.

- Consistent with Title 9 requirements, OTP providers must re-verify DMC eligibility and perform justification every 12 months from treatment admission date, for clients who need ongoing OTP care. An annual SUD assessment/LOC determination is not required. To re-establish medical necessity, a narrative justification of the ongoing need for OTP services is sufficient.

For DMC certified programs providing OTP/Narcotic Treatment Program services, the following DMC regulations must be met before an individual may be admitted into detoxification or maintenance treatment.

The Medical Director, licensed physician, (Physician Assistant or Nurse Practitioner for NTP's) must conduct a medical evaluation or document the review and concurrence of a medical evaluation for each client which includes at a minimum:

- A medical history, including the individual's history of illicit drug use;
- Laboratory tests for determination of narcotic drug use, tuberculosis and syphilis (unless the medical director has determined the individual's subcutaneous veins are severely damaged to the extent that a blood specimen cannot be obtained); and
- A physical examination including, at minimum, the following:
  - a. an evaluation of the individual's organ systems for possibility of infectious diseases; pulmonary, liver or cardiac abnormalities; and negative dermatologic impacts of addiction;
  - b. A record of the individual's vital signs (temperature, pulse, blood pressure and respiratory rate);
  - c. An examination of the individual's head, ears, eyes, nose, throat (including thyroid), chest (including heart, lungs, and breasts), abdomen, extremities, skin and general appearance;
  - d. An assessment of the individual's neurological system; and
  - e. A record of the physician's overall impression which identifies any medical condition or health problem for which treatment is warranted.

In addition, before a client can be admitted to detoxification or to maintenance treatment, the Medical Director or licensed physician must:

- Document the evidence or review and concur with the documentation of evidence used from the medical evaluation to determine physical dependence and addiction to opiates; and
- Document the final determination concerning physical dependence and addiction to opiates.

### **NARCOTIC TREATMENT PROGRAM—MEDICAL PSYCHOTHERAPY SESSIONS**

For clients in NTP programs, medical psychotherapy sessions are defined as face-to-face discussions between the Medical Director and/or physician and the client on issues identified in the client treatment plan.

### **NARCOTIC TREATMENT PROGRAM UPDATED TREATMENT PLAN REQUIREMENTS**

For NTP providers, updated treatment plans must be reviewed and signed within 14 calendar days from the effective date by the certified/registered counselor or LPHA and by the medical director. Client updated treatment plans also must include:

- A summary of the client's progress or lack of progress toward each goal identified on the previous treatment plan,
- New goals and behavioral tasks for any newly identified needs or related changes in the type and frequency of counseling services to be provided to the client; and
- An effective date based on the day the primary counselor signed the updated treatment plan.

## **NARCOTIC TREATMENT PROGRAM DISCHARGE REQUIREMENTS**

NTP LPHAs or Registered/Certified Counselors must develop a discharge summary for each client who is voluntarily or involuntarily discharged from the program that includes at a minimum:

- Client name;
- Date of discharge;
- Reason for discharge, and
- Summary of the client's progress during treatment.

## **NARCOTIC TREATMENT PROGRAM CONTINUING SERVICE REQUIREMENTS**

For NTP programs, the Medical Director and/or physician must discontinue a client's maintenance treatment within two consecutive years after treatment began unless the Medical Director and/or physician complete the following:

- Evaluates client progress or lack of progress in achieving treatment goals in the progress notes; and
- Determines through clinical judgment that the client status indicates such treatment should be continued for a longer period of time as discontinuance from treatment would lead to a return to opiate addiction.

Client status in treatment must be re-evaluated *at least annually* after *two consecutive years* of maintenance treatment. The Medical Director and/or physician must document the facts justifying the decision to continue client treatment in the client record.

## **NALTREXONE TREATMENT ADMISSION REQUIREMENTS**

All Naltrexone treatment providers must comply with the following requirements in addition to client intake and admission requirements listed in the prior section above. Naltrexone providers must confirm that each client meets all of the following requirements:

- Has a documented history of opiate addiction;
- Is at least 18 years of age;
- Has been opiate free for a period of time to be determined by a licensed physician based on the physician's clinical judgment (this includes the administration of a body specimen test to confirm the opiate free status of the client); and
- Is not pregnant (a client must be discharged from treatment if she becomes pregnant during treatment).

In addition, a licensed physician must certify each client's eligibility for treatment is based on the client's physical examination, medical history, and laboratory results. The physician also must advise each client of the overdose risk should he or she return to opiate use while taking Naltrexone and the ineffectiveness of pain relievers while on Naltrexone.



## **PERINATAL TREATMENT ADMISSION REQUIREMENTS**

SUD treatment providers serving pregnant and postpartum women must meet additional admission criteria that include:

- Confirming the client is eligible for and received Medi-Cal during the last month of pregnancy;
- Having medical documentation that substantiates the client's pregnancy and last day of pregnancy;
- Receiving enhanced reimbursement rate only during pregnancy and for the 60-day postpartum period beginning on the last day of pregnancy; and
- Terminating eligibility for perinatal treatment services on the last day of the month in which the 60<sup>th</sup> day occurs.

## **COLLATERAL SERVICES**

Collateral Services are sessions between significant persons in the life of the client (i.e., personal, not official or professional relationship with client) and SUD counselors or LPHAs used to obtain useful information regarding the client to support the client's recovery. The focus of Collateral Services is on better addressing the treatment needs of the client.

For all SUD treatment providers, regardless of DMC certification status, collateral services must be provided by an LPHA or Registered/Certified Counselors. Collateral services are defined as face-to-face contact with significant persons in the life of the client. Significant persons are defined as individuals that have a personal, not official or professional, relationship with the client. For example, a client's social worker would not meet the "*significant persons*" criteria.

Each collateral service must focus on the treatment needs of the client to support the achievement of treatment plan goals. A client does not need to be present at the collateral service for the service to be billable to DMC.

## **CRISIS INTERVENTION COUNSELING**

Crisis Intervention sessions include direct communication and dialogue between the staff and client and are conducted when:

1. A threat to the physical and/or emotional health and well-being of the client arises that is perceived as intolerable and beyond the client's immediately available resources and coping mechanisms; or
2. An unforeseen event or circumstance occurs that results in or presents an imminent threat of serious relapse.

These sessions are immediate and short-term encounters that focus on (1) stabilization and immediate management of the crisis, often by strengthening coping mechanisms and (2) alleviating a client's biopsychosocial functioning and well-being after a crisis. Crisis Intervention sessions need to incorporate Motivational Interviewing and Cognitive Behavioral Therapy techniques.

A component of this service includes linkages to ensure ongoing care following the alleviation of the crisis. Crises that are not responsive to intervention need to be escalated to urgent (e.g., urgent care clinic) or emergent (e.g., medical or psychiatric emergency room) care. Crisis situations should not be confused with emergency situations, which require immediate emergency intervention, such as calling 911.

Crisis Intervention sessions are available at all levels of care and are defined as face-to-face or telephone contact between one (1) registered/certified counselor or LPHA, and one (1) client at the same time. Services may, however, involve a team of care professionals. Sessions ranging from 15 to 60 minutes. A Progress Note must be written for each session and documented in the chart/EHR.

## **CASE MANAGEMENT**

Case Management is a collaborative and coordinated approach to the delivery of health and social services that links clients with appropriate services to address specific needs and achieve treatment goals. Case Management is a client-centered service that is intended to complement clinical services, such as individual and group counseling, to address areas in an individual's life that may negatively impact treatment success and overall quality of life. Case Management offers support services to clients to increase self-efficacy, self-advocacy, basic life skills, coping strategies, self-management of biopsychosocial needs, benefits and resources, and reintegration into the community.

Case Management Services support clients as they move through the DMC- ODS continuum of care from initial engagement and early intervention, through treatment, to recovery supports. Case management services are provided for clients who may be challenging to engage, requiring assistance connecting to treatment services or other supportive services, and/or those clients stepping down to lower levels of care and support.

Case management services are defined as a service that assists a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Case Management services may be provided by a LPHA or a Registered/Certified Counselor. Case Management must focus on coordination of SUD care, integration around primary care especially for clients with a chronic substance use disorder, and interaction with the criminal justice system, if needed. Case Management is available to all clients who enter the SUD treatment system. This service is available throughout the treatment episode and may be continued during recovery support services. Case Management services may be provided face-to-face or by telephone with the client. Case Management services require pre-authorization by System of Care personnel.

## **CASE MANAGEMENT CONSIDERATIONS FOR PEOPLE IN VULNERABLE GROUPS**

People with special needs require more intensive Case Management activities. Moreover, County agencies (DCFS, Law Enforcement, Superior Court, etc.) may require providers to submit additional documentation and perform additional activities (e.g. attending court hearings or meeting with case workers to advocate on the clients' behalf).

These groups include people with HIV/AIDS, mental illnesses, homelessness, perinatal women, adolescents, and the criminal justice-involved. Each population will require coordination activities to help an individual effectively navigate, access, and participate in an appropriate SUD level of care, access health and mental health services, secure housing, and obtain other supportive services.

### **CLIENTS EXPERIENCING HOMELESSNESS**

Housing and an individual's living environment are oftentimes a critical component of the ability to achieve and maintain recovery from SUDs. Therefore, case managers should identify clients in need of housing assistance and perform connection and coordination activities according to available resources. Activities may include:

- Completing the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) for adults
- Entering and updating client information in **HMIS**.
- Connecting clients to community agencies for adults, youth and families
- Coordinating housing activities with Housing Navigators, such as gathering necessary documents, completing housing applications, choosing potential housing sites, applying for move-in resources and re-integration into the community.

### **CRIMINAL JUSTICE-INVOLVED CLIENTS**

Case managers should communicate with criminal justice staff (i.e., Probation, Sheriff, Superior Courts, etc.) to ensure that Case Management activities meet criminal justice supervision requirements. As needed, case managers may be asked to perform the following activities:

- Attend court hearings to report progress in treatment.
- Arrange letters, phone calls, and/or direct face-to-face meetings with law enforcement agencies (Probation Department, Sheriff's Department, and Parole) and courts (Superior Courts) about clients.

### **CHILDREN AND FAMILY SERVICES**

For clients that participate in County funded programs for children and family services, one of the primary focuses for providers should be the family unit (e.g., helping clients meet requirements set forth in their family reunification plan). Therefore, Case Management activities should help clients gain access to services and resources that take into account family needs. Case Management activities for this group may include linkage to parenting classes, child care, food and clothing assistance, and family planning services.

When working with children, families, and perinatal women, the case manager should confer with the client's DHA worker, DCFS social worker, MH worker, etc., at least once to ensure that the objectives and activities developed in Case Management are consistent and don't unintentionally overwhelm the client.

## **RECOVERY SERVICES**

Recovery Support Services (RSS) are aftercare support services designed to help individuals become and stay engaged in the recovery process and reduce the likelihood of relapse. RSS emphasizes the clients' central role in managing their health and recovery and promotes the use of effective self-management and coping strategies, as well as internal and community resources to support ongoing self-management. Medical necessity is considered established for any individual transitioning directly into RSS from treatment. If there is a lapse between treatment discharge and receipt of RSS, or RSS is discontinued, a screening needs to occur to determine if RSS is still the appropriate service level.

Recovery Services are important to clients in the recovery and wellness process. Recovery services are available once a client has completed the primary course of treatment and are no longer engaged in any ASAM Level of Care services. Clients accessing recovery services are supported to manage their own health and health care, use effective self-management support strategies, and rely on community resources for ongoing support.

RSS is available for youth (ages 12 – 17), young adult (ages 18 – 20), and adult (age 21+) clients who have completed treatment or left treatment with satisfactory progress and are in recovery. This applies to clients discharging from any level of care, provided they are not concurrently enrolled in treatment services. The last treatment provider of care will serve as the default provider of RSS, unless necessary services are not offered, or the client prefers a change in provider. These services can be delivered by either an experienced registered or certified SUD counselor or LPHA and will be offered when they are deemed medically necessary by an LPHA (e.g., after completion of a treatment episode). RSS must be conducted face-to-face in a contracted DMC-certified treatment facility or at an approved field-based services location, and/or by telephone, with the call being made from a DMC-certified facility.

RSS may include participation in group meetings and/or individual counseling to assist clients in meeting the goals contained in their RSS plans. Individuals who are released from custody, or those who will soon be released from custody and have completed treatment while incarcerated, are eligible for RSS. While in custody, ideally the client's SUD counselor should refer the client into RSS prior to release from incarceration.

Medical necessity for RSS aligns with the DMC eligibility period (6 months for non-OTP treatment and 12 months for OTP treatment). All clients transitioning directly from any SUD treatment to RSS already meet medical necessity based on their DMC eligibility. Therefore, a new screening or ASAM Continuum is not required upon admission. Continued RSS participation is based on continued DMC eligibility.

Recovery services may be provided face-to face, by telephone, via the internet, or elsewhere in the community. Services may include: outpatient individual or group counseling to support the stabilization of the client or reassess the need for further care; recovery monitoring/recovering coaching; peer-to-peer services and relapse prevention, education and job skills; family support; support groups and linkages to various ancillary services. Any eligible DMC provider within the network may provide medically necessary recovery services to beneficiaries. Linkages to these services are provided by a certified/registered SUD counselor, licensed clinician or peer support specialist.

## SPECIAL POPULATIONS AND CONDITIONS

### CO-OCCURRING DISORDERS

For clients who have co-occurring disorders (have a significant mental health disorder co-occurring with a substance use disorder), mental health screening is required in addition to coordination of services with Sacramento County Mental Health (Adult Access Team) staff or other psychiatric or mental health support as necessary. Specialized treatment issues include specific screening techniques, ability to address both issues in the treatment plan, coordination with other services as appropriate, accommodation of the mental health disability as appropriate, style of interventions and use of group and individual counseling sessions.

For the purposes of this document, co-occurring disorders (COD) are defined as when an individual has a combination of any SUD or any mental health condition, though individuals with COD can have physical health conditions as well. The COD must meet the diagnostic criteria independently from the other condition and cannot simply be a cluster of symptoms resulting from a single disorder. The significant co-morbidity of SUDs and mental illness (typically reported as 40 percent to 80 percent depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population.

Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to the process of ensuring that treatment interventions for COD are combined within a primary treatment relationship or service setting.

According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse Treatment for Persons with Co-Occurring Disorders," consensus panel members recommend the following guiding principles in the treatment of clients with CODs:

- **Employ a recovery approach** – The recovery perspective essentially acknowledges that recovery is a long-term process of internal change that requires continuity of care over time and recognizes that these internal changes proceed through various stages, and that treatment approaches need to be specific to the goals and challenges of each stage of the COD recovery process.
- **Adopt a multi-problem viewpoint** – Treatment comprehensively addresses the immediate and long-term needs of the multidimensional problems typically presented by clients with COD. (e.g., housing, work, health care, a supportive network).
- **Develop a phased approach to treatment** – Treatment phases generally include engagement, stabilization, treatment, and continuing care, which are consistent with, and parallel to, the various stages of recovery. Treatment through these phases allows providers to develop and use effective, stage-appropriate treatment interventions.
- **Address specific real-life problems early in treatment** – Given that CODs often arise in the context of social and personal problems, addressing such problems is often an important first step toward achieving client engagement in continuing treatment.

- **Plan for the client’s cognitive and functional impairments** – Clients with a COD often display cognitive and functional impairments that affect their ability to comprehend information or complete tasks. As a result, services need to be tailored to and compatible with the need and functional level of COD clients.
- **Use support systems to maintain and extend treatment effectiveness** – Given that many clients with a COD have strained support systems, and the central importance of supportive people and environments in the recovery process, a vital element of effective treatment of the COD population is ensuring that clients are aware of available support systems and motivated to use them effectively.

While SUD counselors and staff are not expected to diagnose mental health disorders, it is important that they familiarize themselves with the terminology, criteria, and how to identify if there may be mental health concerns that may benefit from referral to other health providers. In order to meet the needs of this population, SUD counselors and clinicians need to receive training designed to help them better understand the signs and symptoms of mental disorders and how and when to access medical or mental health support.

Appropriate staffing is a key element of effectively addressing the needs of the COD population. An organizational commitment to professional development, skills acquisition, values clarification, and competency attainment is necessary to implement integrated care programs successfully and to maintain a motivated and effective staff. Ideally, enhanced staffing for clients with a COD at SUD treatment sites would include mental health professionals, and vice versa at mental health treatment sites. Alternatively, establishing appropriate referral relationships and referral processes and protocols can also help to ensure comprehensive and necessary care for individuals with a COD.

Psychosocial interventions that have been demonstrated to be effective for the COD population include motivational enhancement, contingency management, relapse prevention, and cognitive behavioral techniques. These strategies need to be tailored to the client’s unique stage of recovery and can be helpful even for clients whose mental disorder is severe. For clients with functional and cognitive deficits in areas such as understanding instructions, repetition and skill-building strategies can aid progress. Finally, 12-Step and other dual recovery mutual self-help groups may be valuable as a means of supporting individuals with COD, and counselors and clinicians often play an important role in facilitating participation in such groups. In general, the ability to balance the need for empathy and support, and the need to be firm, is essential in maintaining the therapeutic alliance with a client who has a COD.

The use of appropriate psychotropic medications and medications for addiction treatment are an essential component of the treatment of individuals with a COD. Oftentimes the appropriate use of medications can help clients with a COD stabilize and control their symptoms so that they can better focus on their recovery for either their SUD or mental health condition. Research had clearly demonstrated that medications used in conjunction with psychosocial interventions for both SUDs and mental illness is preferable and leads to better outcomes than either intervention alone. An important component of the treatment of clients with a COD is thus ensuring a recovery environment that is supportive of the various and individualized paths to recovery that many clients with CODs take. This includes ensuring that staff is receptive to the use of medications for both

SUDs and mental health conditions when determined to be necessary and appropriate by counselors and clinicians practicing within their scope of practice.

In summary, the treatment of clients with a COD requires a comprehensive and flexible treatment approach, in addition to coordination with other systems of care.

## **PREGNANT AND PARENTING WOMEN**

Substance use while pregnant can result in significant maternal, fetal, and neonatal morbidity. SUD providers offering services funded by DMC shall address specific treatment and recovery needs of pregnant and parenting women of up to 60 calendar days following birth. Research indicates that targeted interventions to pregnant women with SUDs increases the incidence of prenatal visits, improves birth outcomes, and lowers overall health care costs for both mother and baby. The unique needs of pregnant and parenting women must be considered in the provision of services for this special population.

Motivational therapies are critical to the engagement and recovery process. While there is overlap between treatment approaches for the general population and pregnant and parenting women, ideal therapies for this special population incorporate treatment elements that are unique to this group. These include promoting bonding with the expected child, reproductive health planning, and targeted case management and care coordination to address the material and physical/mental health needs that accompany pregnancy. The initial assessment, treatment plan, and reassessments of progress need to take into account the varied needs related to the health and well-being of both woman and fetus/infant.

Federal priority guidelines for SUD treatment admission give preference to pregnant substance use users, pregnant injecting drug users, and any parenting female substance and injection drug users. However, a specific level of care is not prescribed and thus the appropriate setting and level of care for this population needs to be consistent with the ASAM criteria, with consideration of the ability to accommodate the physical stresses of pregnancy (e.g., climbing stairs, performing chores, bed rest when medically required, etc.) and the need for safety and support during this period. Level of care determinations need to be based on individualized and multidimensional SUD assessments and may lead to placement recommendations in the residential or outpatient setting, depending on clinical need.

Staff working in settings that provide services for pregnant and parenting women need to be trained in proper procedures for accessing medical services related to prenatal care, labor and delivery, and therapeutic responses to the varied positive and negative outcomes of pregnancy.

Services need to be provided in a non-judgmental, supportive, and open environment.

The use of MAT during pregnancy needs to include careful and individualized consideration of the potential impact of both treatment and lack of treatment on mother and baby. Though there is some risk in using medications during pregnancy, there is also known risk in the inadequate treatment of addiction during pregnancy, and this needs to be considered and discussed with clients. For pregnant women with opioid use disorders, MAT such as methadone and buprenorphine are the standard of care. In these instances, informed consent needs to be obtained,



including discussions regarding Neonatal Abstinence Syndrome and what to expect at delivery. Opioid detoxification should also be reserved for selected women because of the high risk and potential consequences of relapse on both mother and baby. The risks and benefits of breastfeeding while clients are receiving medication-assisted treatments need to be weighed on an individual basis. Methadone and buprenorphine maintenance therapy are not contraindications to breastfeeding.

Given that women may be at increased risk of resuming substance use following delivery, treatment should not end with delivery. Post-delivery treatment services include, but are not limited to: support for parenting a newborn, education about breast feeding, integration with other children and family members, case management for practical needs such as legal assistance, equipment and clothing, coordination of physical and mental health services as needed, coping with the physical and psychosocial changes of the postpartum period, reproductive health planning, and encouragement of the continued pursuit of recovery goals.

Perinatal services must also be in accordance with the most recent version of the Perinatal Practice Guidelines released by the Department of Health Care Services (DHCS).

## **ADOLESCENT CLIENTS**

Adolescence represents an opportunity to influence risk factors that are still dynamic and not yet entrenched in their influence on development and addiction. Adolescent SUD treatment needs to be approached differently than adults because of differences in their stages of psychological, emotional, cognitive, physical, social, and moral development. Examples of these developmental issues include their newly formed independent living skills, the powerful influence of interactions between adolescent and family/peers, and the fact that a certain degree of limit-testing is a normal feature of adolescence.

These unique characteristics of the adolescent population are reflected in both clinical practices as well as in the ASAM criteria, as adolescents tend to require more intensive levels of care than their adult counterparts. As a result, the client-to-counselor ratio for adolescent cases is ideally less than the ratio for adult cases to accommodate for this increased treatment intensity.

Due to the rapid progression of adolescent substance use, particular attention must be paid to streamlining the treatment admission process so that adolescent SUD needs are identified and addressed as soon as possible. Strategies to engage adolescents, hold their attention, channel their energy, and retain them in treatment are especially critical. Adolescent treatment needs to also address their increased rates of co-occurring disorders, highlighting the need to coordinate care with the mental health system, as clinically indicated.

Treatment Planning needs to begin with a comprehensive assessment based on the ASAM criteria. The assessment includes all the dimensions and biopsychosocial components of the complete adult assessment, the nuances of the adolescent experience, and their unique needs and developmental issues. Strengths and weaknesses need to be identified and adolescents need to be involved in setting their treatment objectives. Comprehensive adolescent assessments include information obtained from family, and when the appropriate releases are obtained, members of the community who are important to the adolescent client, such as school counselors, peers, and mentors. The

support of family members is important for an adolescent's recovery and research has shown improved outcomes for interventions that seek to strengthen family relationships by improving communication and improving family members' ability to support abstinence from drugs.

During treatment of the adolescent population, every effort needs to be made to support the adolescent's larger life needs in order to maximize the likelihood of treatment success, for example by having flexible weekend and evening hours to accommodate continued engagement with school and appropriate social activities. These larger life issues may be related to medical, psychological, and social well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues. Failing to address such needs simultaneously could sabotage the adolescent's treatment success.

Behavioral therapies, delivered by trained counselors and clinicians practicing within their scope of practice, need to be employed to help adolescent clients strengthen their motivation to change. Effective psychosocial interventions may provide incentives for abstinence, build skills to resist and refuse substances and deal with triggers or craving, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

The use of MAT for adolescents is promising, but the current and emerging knowledge is that the routine use of MAT for adolescents is premature and requires further study. With the exception of methadone and buprenorphine, which can be prescribed in youth age 16 and above if specific criteria are met and if they are under the treatment of a licensed prescriber, there are currently no FDA-approved medications for the treatment of addictions in adolescents. As a result, the use of MAT for adolescents should be considered and used cautiously and only on a case-by-case basis when deemed clinically appropriate by a licensed prescriber. While most adolescents do not develop classic physical dependence or well-defined withdrawal symptoms as a result of shorter durations of substance use compared with adults, youth opioid addiction is an exception that at times may require MAT when clinically indicated, particularly for severe withdrawal symptoms.

The ASAM level of care criteria for adolescents are distinct from that of adults and are tailored to the particular needs of this population. In general, the ASAM criteria tends to place adolescents in more intensive levels of care than their adult counterparts.

Treatment services for adolescents occur in a setting that is clinically appropriate and comfortable for this population. The adolescent treatment environment should be physically separate from that of adult clients. Staff also need to be familiar and appropriately trained to address the developmental nuances of caring for this unique population.

Similar to other groups, treatment of the adolescent population is regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue into adulthood, with a gradual transition to adult SUD services.

Adolescent clients should be referred to a qualified adolescent/youth outpatient treatment agency where they will receive a full assessment and referral to an appropriate level of care, as necessary. If the individual initially presents at a SUD treatment provider that does not offer the appropriate provisional level of care, that agency will identify alternate referral options and assist the individual in connecting with the selected agency, or the individual may elect to remain with the initial provider if clinically appropriate. All Medi-Cal eligible beneficiaries will be referred to, and/or served by, a DMC-certified agency for DMC-reimbursable services.

## **OLDER ADULTS**

Given the chronic nature of substance use disorders and the expanding population of older adults, it is increasingly important to modify treatment approaches to the unique needs of this population. In general, older adults include individuals over the age of 65, but this definition should be individualized based on clinical need. For example, some individuals younger than age 65 may have cognitive deficits, medical conditions, or social situations that necessitate the utilization of treatment approaches that are more typical for individuals of more advanced age.

Key differences between older and younger populations necessitate different approaches toward treatment. Due to altered metabolism and brain function, and the medical conditions that often accompany advanced age, the quantity and frequency of substance use in older adults may underestimate the functional impact in this population and create diagnostic challenges. In addition to the fact that many older adults are retired, limiting the sensitivity of using work or social impairment as a diagnostic indicator, a smaller amount of alcohol or substances may impact older adults more severely than younger counterparts. Health care providers also sometimes overlook substance use in this population, mistaking symptoms and indications of substance use for dementia, depression, or other problems common to older adults.

Social isolation, lack of transportation, and heightened levels of shame and guilt in this group may make accessing services for the older adult population more difficult than other age groups. As a result, older adults may be more likely to attempt to hide their substance use and less likely to seek professional help. Older adults are also more likely to be primary caregivers for a spouse who has greater needs than their own, which may limit their willingness to enter into treatment due to their caregiving responsibilities.

Research has demonstrated that age-specific assessment and treatment is associated with improved outcomes when compared with mixed-aged treatment. Assessments need to be age-specific and multidimensional, given the various physical and mental health needs, as well as social needs, of the older adult population. The treatment of older adults needs to be paced to the individual's physical and cognitive capabilities and limitations. The schedule of programs and expectations, and the overall timeframe for clinical progression and change is typically slower for older adults than other age groups. As such, treatment programs should be realistically designed to accommodate these anticipated differences.

Studies have generally indicated that cognitive-behavioral techniques are effective for older populations, particularly those that address negative emotional states that pose significant risk for relapse (e.g., self-management approaches for overcoming depression, grief, or loneliness). In general, confrontational therapy in this population has been shown to be less effective than in other

age groups and should be avoided. Educational treatment approaches should be geared toward the specific needs of older adults (e.g., coping strategies for dealing with loneliness, general problem-solving). Older adults may absorb presented information better if they are given a clear statement of the goal and purpose of the session and an outline of the content to be covered. Repetition of educational information may also be helpful (e.g., simultaneous visual and audio).

Given that social isolation is a common problem in this population, group therapies and skill building around establishing social support networks are often beneficial, in addition to family therapy. According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse among Older Adults," consensus panel members recommend limiting involvement of family members or close associates to one or two members to avoid overwhelming or confusing older adults. Panel members also suggest that the involvement of grandchildren may lead to obstacles for open communication, as older adults may at times resent their problems being aired in the presence of younger relatives.

Medications used in older populations, including MAT, should be used with caution due to the physiological changes that occur with advanced age. Dosages of medications may need to be lowered, particularly if co-morbid medical conditions are involved. In cases where medications are used for withdrawal management, dosages for older populations should often be one-third to one-half the usual adult dosage. Concerns or questions regarding the safe use of medications in the older adult populations need to be directed toward appropriately trained medical professionals.

Staff working with older adults should ideally have training in aging and geriatric issues. Staff should also have an interest in working with this population and the skills required to provide age-specific services for individuals of more advanced age. The best results are typically achieved when staff is experienced in dealing with the physical, psychological, social, and spiritual issues unique to older adults. Staff who interacts with older clients need to receive regular trainings on empirically demonstrated principles and techniques effective for older populations.

## **CRIMINAL JUSTICE INVOLVED**

The criminal justice system includes accused or adjudicated who require various SUD services. Parole and probation status is not a barrier to SUD treatment services provided that the parolees and probationers meet the DMC eligibility verification and medical necessity criteria. For many people in need of alcohol and drug treatment, contact with the criminal justice system is their first opportunity for treatment. Services can be provided through courts, probation or parole agencies, community-based or institutional settings, or in sex offender programs. In each of these situations, the individual is accountable to comply with a criminal justice sanction. Legal incentives to enter SUD treatment at times motivate individuals to pursue recovery, whereas for other offenders, arrest and incarceration are part of a recurring cycle of drug abuse and crime.

Ingrained patterns of maladaptive coping skills, criminal values and beliefs, and a lack of job skills may require a more intensive treatment approach for the criminal justice population, particularly among offenders with a prolonged history of substance abuse and crime. However, strong empirical evidence over the past several decades has consistently shown that the criminal justice population can be effectively treated, and that SUD treatment can reduce crime.

Staff working with criminal justice populations need to be specifically trained in working with criminogenic risk, need, and responsivity (RNR), as well as substance use disorders (SUDs) and Co-Occurring disorders (CODs). Staff also need to be capable of integrating identified treatment goals with the goals of the involved agencies. As a result, it is critical for treatment providers to have a strong working relationship with probation and parole officers, judges, the court, and other legal entities involved in the client's care.

The first step in providing SUD treatment to people under criminal justice supervision is to identify offenders in need of treatment. Comprehensive assessments incorporate issues relevant to criminal justice involved individuals, such as assessment of criminogenic RNR, anger management, impulse control, values and behaviors, family structure and functioning, criminal lifestyle, and antisocial peer relationships. Assessments also pay particular attention to CODs, developmental and cognitive disorders, and traumatic brain injury.

In general, clinical approaches and the use of MAT need to be consistent with those utilized for individuals who are not involved with the criminal justice system, and a qualified counselor/clinician should determine the appropriate level of placement and interventions rather than court/probation requirements. Treatment interventions need to be based on a multidimensional assessment and individualized needs. However, working with the criminal justice population does have unique requirements that necessitate modified treatment approaches in order to meet their specific needs. Additionally, it is essential to collaborate with correctional staff to ensure that the treatment goals align with correctional and supervision case planning and/or release conditions (particularly involving the prescription of certain MAT).

## **CLIENTS EXPERIENCING HOMELESSNESS**

Homelessness is an issue that impacts many individuals with SUDs as a result of the socioeconomic decline that oftentimes accompanies addictions. Conservative estimates of the prevalence of substance use among homeless individuals are approximately 20-35 percent but much higher percentages in various areas in Sacramento. Although homeless clients typically require more intense treatment and have greater and more varied needs than housed individuals, homeless clients pose significant challenges to the SUD treatment community because of the various structural, interpersonal, and biopsychosocial barriers they face in accessing care. Some of these obstacles include social isolation, safety concerns, fear or distrust of authorities, lack of mobility and/or transportation, and multiplicity of needs.

Stable housing is often critical to attaining treatment goals and is an important component of necessary services. Services that link clients to secure housing early in treatment tend to produce better outcomes, emphasizing the importance of case management in order to meet the varied needs of homeless clients.

Psychosocial interventions and MAT for homeless clients need to mirror the approaches that are successfully used in other populations, with modifications to meet the unique needs of this population. Mobile outreach services are ideal, along with motivational enhancement interventions, in order to encourage continued treatment engagement. Counselors and clinicians also need to be mindful of the physical and mental health needs of this population, given high rates of co-morbidity for many homeless individuals. Medications should be used when clinically

indicated, with prescribing practices that take into consideration the environment in which these medications will be used and stored (for example, care is to be taken to ensure that medications that require refrigeration are not prescribed when the client has no way to store such medications). Integrated interventions that concurrently address the multitude of medical, psychiatric, substance use, and psychosocial needs of homeless persons tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

Successful counselors and clinicians who work with people experiencing homelessness tend to have a particular interest and comfort level in working with this challenging and rewarding population. Staff need to be experienced with the various aspects of care involved in working with people who are homeless and need to be familiar with the resources available in the community so that appropriate referrals and linkages can be made in order to best address the varied needs of clients. Ideally, care teams work collaboratively and include interdisciplinary staff comprised of medical, mental health, substance use, and social service providers.

In general, treatment for people experiencing homelessness with SUDs is challenging, but successful outcomes can be achieved by prioritizing access to appropriate housing and providing comprehensive, well-integrated, client-centered services with uniquely qualified staff.

### **LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUESTIONING POPULATION**

Lesbian, gay, bisexual, transgender, questioning (LGBTQ) populations tend to experience higher rates of substance use than the general population. The stigma and discrimination of being a member of a marginalized community causes some LGBTQ individuals to cope with these additional stressors by using substances. Furthermore, research has also shown that once LGBTQ clients do meet the criteria for a diagnosable SUD, they are less likely to seek help. These findings may be due to the various barriers the LGBTQ population faces in seeking treatment, and unique needs LGBTQ clients have that may not be addressed by SUD programs.

Although there are various protections in place that are intended to shield recovering substance abusers from many forms of discrimination, LGBTQ individuals are vulnerable and oftentimes not afforded the same protections. As a result of homophobia, heterosexism, and/or transphobia, some may find it difficult or uncomfortable to access treatment services and be afraid to speak openly about their sexual orientation or gender identity. Many LGBTQ clients may also internalize the effects of society's negative attitudes, which can result in feelings of sadness, doubt, confusion, and fear. Problems in traditional health care systems may lead to distrust of health care professionals, requiring extra sensitivity from SUD providers.

In many ways, psychosocial and pharmacologic interventions (e.g., MAT) geared toward LGBTQ clients are similar to those for other groups. An integrated biopsychosocial approach takes into account the various individualized needs of the client, including the societal effects on the client and their substance use. Unless SUD providers carefully explore each client's individual situation and experiences, they may miss important aspects of the client's life that may affect recovery (e.g., social scenes that may contribute to substance use, prior experiences being discriminated against, a history of antigay violence and hate crimes such as verbal and physical attacks, etc.).

As with any client, substance use providers need to screen for physical and mental health conditions in LGBTQ persons due to the risk of co-morbid health conditions. As a result of previously discussed challenges confronted by the LGBTQ community, members of this group do have higher rates of certain mental health conditions and are also at greater risk for certain medical conditions. Comprehensive screening and assessments can assist LGBTQ clients in accessing appropriate care for their physical and mental health concerns.

The methods of best practice outlined in the counseling competency model apply to all populations, particularly in working with LGBTQ clients. In this model, a counselor respects the client's frame of reference; recognize the importance of cooperation and collaboration with the client; maintain professional objectivity; recognize the need for flexibility and be willing to adjust strategies in accordance with client characteristics; appreciate the role and power of a counselor as a group facilitator; appreciate the appropriate use of content and process therapeutic interventions; and be non-judgmental and respectfully accepting of the client's cultural, behavioral, and value differences.

Family dynamics are also important in working with LGBTQ individuals and SUD providers need to be aware that family therapy may be difficult because of alienation owing to the client's sexual/gender identity. However, inclusion of family in the treatment process may also result in more positive outcomes. Given common concerns regarding living environments (in terms of recovery and safety), social isolation, employment and finances, and ongoing issues related to homophobia and transphobia, particular attention needs to be paid to discharge planning.

Elements of treatment that promote successful treatment experiences for the LGBTQ client include cultural sensitivity, an awareness of the impact of cultural victimization, and addressing issues of internalized shame and negative self-acceptance. Cognitive-behavioral therapies challenge internalized negative beliefs and promote emotional regulation, which can be helpful for relapse prevention. Motivational enhancement techniques may also encourage treatment engagement in this population. Providers who understand and are sensitive to the issues surrounding LGBTQ issues such as culture, homophobia, heterosexism, and sexual and gender identity can help LGBTQ clients feel comfortable and safe while they start their recovery journey.

Because each client brings their unique history and background into treatment, furthering our understanding of individuals different from ourselves helps to ensure that clients are treated with respect and improve the likelihood of positive outcomes. At times, SUD treatment staff may be uninformed or insensitive to issues of special populations, may have preconceived biases toward particular clients/populations, or may false beliefs that cause substance abuse or can be changed by therapy. In these cases, providers need to be aware of these beliefs in order to prevent them from becoming barriers to effective treatment of the client. A substance abuse treatment program's commitment to promote sensitive care for all clients can be included in its mission statement and administrative policies and procedures. Providing staff training and education are oftentimes valuable and include sensitivity training to promote better understanding of issues of special populations, trainings that assist staff in better understanding the needs of individuals and the role they have in providing cultural competent treatment services, and other educational areas to ensure that quality care is provided.

## **VETERANS**

According to U.S. Census estimates, there are over 87,000 veterans who live in Sacramento County. Although veterans share commonalities, their experiences are as varied and unique as their needs. Some veterans may have experienced combat in one or more wars, while others may have served in non-combat roles. Likewise, some veterans may have experienced injury, including traumatic brain injuries (TBI), loss of limb, or other physical injury, while others may have emotional scars. In particular, gender may also influence veteran experiences, as reports of women veterans who have experienced sexual harassment and/or physical and sexual trauma are becoming more common. As a result of the cumulative effects of these events and experiences, veterans and family members may develop SUDs and present to treatment with a unique set of needs and circumstances that must be addressed.

Under certain circumstances, veterans may be ineligible for Veteran's Administration (VA) benefits due to a dishonorable discharge or discharge "under other than honorable conditions," among other circumstances. Additionally, some veterans and family members may attempt to secure services from SUD treatment programs due to the long wait times at the VA. Regardless of the situation, SUD treatment providers should work to ensure that the services provided address the varied and unique needs of individuals.

While substances of abuse vary, veterans may abuse sedating substances such as prescription drugs in efforts to address untreated/under-treated anxiety or other mental health conditions. Additionally, co-occurring physical health conditions and injury may increase rates of prescription drug and opioid abuse, including the use of heroin, and thus certain veterans may be at higher risk for fatal overdoses and may be appropriate candidates for MAT.

In summary, treatment providers may need additional training to fully understand the nuances of the veteran population and how their experiences impact their behaviors in order to adequately treat veterans and their families.

## **MEDICATION ASSISTED TREATMENT (MAT)**

MATs are approved medications in combination with behavioral therapies to provide a whole client approach to treating substance use disorders. Clients seeking Outpatient treatment, Residential treatment or Recovery Residences/Sober Living that have concurrent MAT shall not be delayed access to substance use disorder treatment and recovery services due to the client's medical status as it relates to MAT. Providers shall include the assessment of a client's MAT needs and a process for administration and storage of medications. Provider staff shall be trained in the area of MAT protocols to include all portions of these Standards pertaining to monitoring of persons undergoing detoxification. If, while in treatment, a client exhibits signs and symptoms of withdrawal or behaviors that is a cause for concern for the provider and is believed to be attributable to the client's medication, the SUD treatment staff should address this clinically with the client and the client prescriber. Treatment plans shall be flexible and adjusted as required with review and consult by the prescribing physician.



## CONTINUING SERVICES

Sacramento County Alcohol and Drug Services is adopting DMC standards for continuing service for all SUD treatment providers, regardless of DMC certification status.

The need for continued treatment must be determined no sooner than *five months and no later than six months* after treatment admission or the date of completion of the most recent justification for continuing services,. A client's LPHA or Registered/Certified Counselor must review the client's progress and eligibility to continue to receive SUD treatment and recommend whether the client should continue to receive treatment services. All of the following continuing service justification areas must be considered in making a recommendation for continuing services:

- A client's personal, medical and substance use history;
- Documentation of a client's most recent physical examination;
- A client's progress notes and treatment plan goals; and
- A client's prognosis.

For DMC certified sites, the Medical Director or LPHA must determine whether continued services are medically necessary. The determination of medical necessity must be documented in the client record and shall include all of the above continuing service justification areas in addition to the LPHA's or Registered/Certified Counselor's recommendation for continuing services. A Medical Director or LPHA-signed, updated treatment plan at the six month point of treatment services, *does not* meet the continuing service requirement. There must be an actual determination by the Medical Director or LPHA of the need for continued treatment based on medical necessity documented separately from the treatment plan.

The LPHA or Registered/Certified Counselor must discharge the client from treatment if it is determined that continuing treatment for the client is not medically necessary.

For all SUD treatment providers, regardless of DMC certification status, all billings submitted after the date that the justification is due may be disallowed if the justification to continue services is missing from a client record.

## CLIENT CONTACTS

All SUD treatment providers must meet a set of treatment plan implementation requirements governing client contact, including the type, number and length of counseling sessions, and client participation in treatment. These requirements may vary depending upon the SUD modality of service and DMC requirements.

For SUD providers other than NTP providers, client contact requirements can be waived if a physician determines fewer contacts are clinically appropriate or the client is making progress toward treatment plan goals. Any exceptions must be noted in the individual client record by a physician, and the physician must type or print legibly his or her name, sign and date the record.

For Narcotic Treatment Programs, the Medical Director (physician) may adjust or waive this minimum number of minutes of counseling services per calendar month by medical order. The Medical Director must also document his or her rationale for the medical order within the individual client record.

## **CLINICAL DOCUMENTATION**

Clinical documentation refers to anything in the client's Electronic Health Record (EHR) that describes the care provided to the client and the reasoning for any services delivered. All progress notes are to be observational and narrative in content as they tell the story of the client that is being served. Clinical documentation is a critical component of quality care delivery and serves multiple purposes including but not limited to helping to ensure comprehensive and quality care, ensures an efficient way to organize and communicate with other providers, protects against risk and minimizes liability, complies with legal, regulatory and institutional requirements and helps to facilitate quality improvement and application of utilization management. The Provider shall establish, maintain, and update as necessary, an individual client record for each client admitted to treatment and receiving services. Each client's individual record shall include documentation of personal information.

Documentation of personal information includes all of the following:

- Information specifying the client's identifier (i.e., name, number).
- Client's date of birth, sex, race and/or ethnic background, address and telephone number, next of kin or emergency contact.

Documentation of treatment episode information shall include documentation of all activities, services, sessions and assessments, including but not limited to all of the following:

- ASAM
- Intake and admission data, including, if applicable, a physical examination
- Treatment plans
- Progress notes
- Continuing services justifications
- Laboratory test orders and results
- Referrals
- Counseling notes
- Discharge plan
- Discharge summary
- Contractor authorizations for residential services
- Monthly Medi-Cal eligibility print-outs
- Any other information relating to the treatment services rendered to the client

For pregnant and postpartum women, medical documentation also must substantiate a client's pregnancy and the last day of pregnancy.

## TREATMENT PLAN

Sacramento County Alcohol and Drug Services is adopting DMC initial treatment plan requirements for all SUD treatment providers regardless of their DMC certification status. An initial treatment plan must be completed, signed and dated for each client *within 30 calendar days* of a client's treatment admission date by an LPHA or Registered/Certified Counselor and the client. If a client refuses to sign the treatment plan, providers must document in the client record the reason for refusal and the strategy to engage the client to participate in treatment.

The initial treatment plan serves as a guide and must be individualized and based on the information obtained during the intake and assessment process. The initial treatment plan must be completed within:

- 30 days of admission for Outpatient /IOT.
- 28 days of admission for OTP/NTP.
- 10 days of admission for Residential.

For each client admitted to treatment services, the LPHA or counselor shall prepare an individualized written initial treatment plan based upon the information obtained in the intake and assessment process. The LPHA or counselor shall attempt to engage the client to meaningfully participate in the preparation of the initial or updated treatment plan.

In assessing treatment needs, all SUD treatment providers must consider, at a minimum, client needs in the following areas:

- Educational opportunity/attainment
- Vocational counseling and training
- Job referral and placement
- Legal services
- Medical and dental services
- Social/recreational services
- Individual and group counseling

The initial and subsequent treatment plans shall include:

- A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation;
- Goals to be reached which address each problem;
- Action steps that will be taken by the Provider and/or client to accomplish identified goals;
- Target dates for accomplishment of actions steps and goals;
- A description of services, including the type of counseling, to be provided and the frequency thereof;
- Assignment of a primary counselor;
- The client's DSM-5 diagnosis language as documented by the Medical Director or LPHA;
- The treatment plan shall be client-driven;
- If a client has not had a physical examination within the 12-month prior to the treatment admission date, a goal to have a physical examination should be present on the treatment plan; and

- If documentation of a client's physical examination, which was performed during the prior 12 months, indicates a client has a significant medical illness, a goal that the client obtains appropriate treatment for the illness shall be included on the treatment plan.

The Provider shall ensure the LPHA or Registered/Certified Counselor types or legibly prints their name, signs and dates the initial treatment plan within 30 calendar days of the admission to treatment date. The client shall review, approve, type or legibly print their name, sign and date the initial treatment plan within 30 calendar days of the admission to treatment date.

If the client refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the client to participate in treatment in a progress note. If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review it to determine whether services are medically necessary and appropriate for the client. If the Medical Director or LPHA determines the services in the initial treatment plan are medically necessary, the Medical Director or LPHA shall type or legibly print their name, sign and date the treatment plan within 15 days of the counselor's signature.

The LPHA or Registered/Certified Counselor shall complete, type or legibly print their name, sign and date updated treatment plans no later than 90 calendar days after signing the initial treatment plan, and no later than every 90 calendar days thereafter or when there is a change in treatment modality or significant event, whichever comes first. The client shall be encouraged to review, approve, type or legibly print their name and, sign and date the updated treatment plan. If the client refuses to sign the updated treatment plan, the Provider shall document the reason for refusal and any strategies used to engage the client to participate in treatment. After the counselor and client complete the updated treatment plan, the Medical Director or LPHA shall review each plan to determine whether continuing services are a medically necessary and appropriate. If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, he or she shall type or legibly print their name, sign and date the updated treatment plan, within 15 calendar days of the counselor's signature.

For NTP providers, all initial maintenance treatment plans must include:

- Short-term goals tied to client needs based on intake and admission date (specific time 90 days or less for a client to achieve);
- Long-term goals tied to client needs based on intake and admission data (specified time in excess of 90 days for the client to achieve);
- Specific behavioral tasks the client must accomplish to complete each short-term and long-term goal;
- A description of the type and frequency of counseling services to be provided; and
- An effective date based on the day the primary counselor signed the initial treatment plan.

## **PROGRESS NOTES**

Sacramento County Alcohol and Drug Services is adopting the DMC standards for progress notes for all SUD treatment providers regardless of DMC certification status. Progress notes tell a client's treatment story. While progress note requirements vary depending on the treatment modality, a client's therapist or counselor must document, sign and date each progress note. For ODF, residential treatment and Naltrexone treatment, each progress note must include the following elements:

- The topic of the session or purpose of the service.
- A description of the client's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
- Information on the client's attendance shall be documented including the date, start/end times of each individual and group counseling session or treatment service.
- Documentation shall identify if services were provided in-person, by telephone, or by telehealth.
- If services were provided in the community, documentation shall identify the location and how the provider ensured confidentiality was upheld.

For Narcotic Treatment Programs, the counselor conducting the counseling session must document for each client participating in the counseling session the:

- Date of the counseling session;
- Type of counseling format (e.g. individual or group);
- Duration of counseling session in ten-minute intervals excluding the time required to document the session; and
- Summary of the session including one or more of the following:
  - a. Client progress toward one or more treatment plan goals;
  - b. Response to a drug-screening specimen which is positive for illicit drugs or negative for the replacement narcotic therapy medication dispensed under the program;
  - c. New issue or challenge that affects the client's treatment;
  - d. Nature of prenatal support provided by the program or other appropriate health care providers; and
  - e. Goal and/or purpose of the group session, the subjects discussed, and a brief summary of the client's participation.

Progress note updates shall be documented for each individual and group counseling session and the counselor or LPHA shall record a progress note for each client in the session. LPHA/counselor must type or legibly print their name, sign and date (includes electronic signatures).

Progress notes for outpatient, MAT, and recovery treatment services require a minimum of one progress note for each client participating in structured activities including counseling sessions. The LPHA or counselor must type or legibly print their name, sign and date (include electronic signatures). All individual services must be documented by the staff providing the service within seven days of the service being provided.

Progress notes for residential services require the physician, LPHA, or counselor to type or legibly print their name, sign and date (includes electronic signatures) the progress note. Individual services shall be documented by the LPHA or counselor. At a minimum, group services shall be documented weekly by the LPHA or counselor.

Progress notes for case management services shall be documented by the LPHA or counselor who provided the treatment service as follows:

- Client's name.
- The purpose of the service.
- A description of how the service relates to the client's treatment plan problems, goals, action steps, objectives, and/or referrals.
- Contain the date, start and end times of each service.
- Identify if services were provided in-person, by telephone, or by telehealth.
- If services were provided in the community, the note shall identify the location and how the provider ensured confidentiality was upheld.

For physician consultation services, additional MAT, and withdrawal management, the Medical Director or LPHA working within their scope of practice which provided the treatment service shall ensure documentation is present in a progress note in the client's file.

## **SIGN-IN SHEETS**

All SUD treatment providers, regardless of DMC certification status, must document the focus of group counseling sessions and must have a sign-in sheet, which includes all of the following:

- A sign-in sheet is required for every group counseling session.
- The typed or legibly printed name and signature of the LPHA(s) and/or counselor(s) conducting the counseling session. By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.
- Must include date, topic, and start and end time of the counseling session.
- A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

## **DISCHARGE AND TRANSITION**

Discharge or transition planning is available at all levels of care and is the process of preparing the client for referral into another level of care. This ensures client continuum of care, post-treatment return, reentry into the community, and/or other linkages necessary for greater success with long term recovery.

Clients should always be referred to recovery services at the very least when transitioning through the Alcohol and Drug Services continuum of care.

Discharge planning is openly discussed between staff and client at the onset of treatment services to ensure sufficient time to plan for the client's transition to additional levels of care if determined medically necessary.

A discharge plan is a planned discharge that takes place while the client is still in treatment and must be completed within thirty (30) days prior to the final face-to-face service.

If a client is transferred to a higher or lower level of care based on the ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a thirty (30) calendar day lapse in treatment services.

During the LPHA's or counselor's last face-to-face treatment with the client, the LPHA or counselor and the client shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the client and documented in the client record.

A discharge plan must, at minimum, include a list of triggers, specific coping skills to address each trigger and a support plan.

The counselor and the client must document their names legibly, sign and date the discharge plan.

A copy of the discharge plan must be provided to the client and must become part of the client record.

A discharge plan should include recommendations for the next level of treatment based on ASAM re-assessment. As with all planning related to treatment, county staff should be included and kept informed.

## **DISCHARGE SUMMARY**

A discharge summary is to be completed for all clients regardless of level of care or successful/unsuccessful completion.

For a client with whom a provider has lost contact or who does not attend treatment for more than thirty (30) days, Providers must discharge the client and complete a discharge summary within thirty (30) calendar days of the date of the provider's last face-to-face treatment contact with the client.

The discharge summary must include:

- The duration of the client's treatment, as determined by dates of admission to and discharge from treatment,
- The reason for discharge,
- A narrative summary of the treatment episode, and
- The client's prognosis.

A client's exit planning shall begin at intake. Providers should collaborate with other substance use disorders treatment providers, and with relevant County and community-based organizations to maximize discharge planning using the continuum of care model. A final exit conference with the client will be conducted, one-on-one, to review the plan that will include, at a minimum involvement with collaborative partner agencies in planning (as necessary), identification of continuing services and referral sources to support sobriety, appropriate housing, employment, or other financial means of self-sufficiency, client's most pressing social, criminogenic, and/or medical needs still to be addressed, and a plan for acquiring these services, continuing care plan as needed.

In the event of unanticipated termination, providers shall contact the county contact *before* discharging the client from the program (whenever possible).



## **REGULATIONS**

### **QUALITY ASSURANCE – REGULATIONS**

In health care, quality assurance refers to activities and programs intended to achieve improvement and maintain quality of care. Oftentimes, these activities involve ensuring compliance with regulations established by governmental and/or administrative entities. In all cases, key components of quality assurance involve:

- Assessing or evaluating quality
- Identifying problems or issues with care delivery and designing quality improvement activities to overcome them
- Follow-up monitoring to make sure activities achieve their intended aims

In addition to the requirements outlined in this manual, all SUD treatment programs must operate in accordance with Federal and state laws and regulations including those identified below, as well as those outlined in the Mental Health and Substance Use Disorder Services (MHSUDS) Information Notices and relevant All Providers Letters.

### **CONFIDENTIALITY**

Maintaining appropriate confidentiality is of paramount importance. All ADS contracted providers are required by contract to establish policies and procedures regarding confidentiality and must ensure compliance with Title 42, Chapter I, Subchapter A, Part 2 of the Code of Federal Regulations, Part 2 (42 CFR Part 2), the Health Insurance Portability and Accountability Act (HIPAA) standards, and California State law regarding confidentiality for information disclosure of alcohol and drug use, and other medical records.

### **42 CFR PART 2 – CONFIDENTIALITY OF ALCOHOL AND DRUG CLIENT RECORDS**

Covers all records relating to the identity, diagnosis, and/or treatment of any client in a SUD program that is conducted, regulated, and/or assisted in any way by any federal agency.

### **HIPAA – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

Provides data privacy and security provisions for safeguarding medical information.

These laws and regulations must not be used as barriers to provide coordinated and integrated care. Provided that the appropriate client releases and/or consents for treatment are obtained, every effort should be made to share clinical information with relevant providers across the continuum of SUD care, and also across systems of care (physical and mental health, etc.).

Within the requirements of the laws and regulations governing confidentiality in the provision of health services, all providers within the specialty SUD system must cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information for the purposes of improving the effectiveness, integration, and quality of health services.

## **42 CFR PART 438 – MANAGED CARE**

As a participant in Sacramento County’s Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, the administrative entity that is ADS becomes a specialty managed care plan responsible for overseeing the specialty SUD system. As a component of becoming a managed care entity, Sacramento County SUD network must abide by the 42 Code of Federal Regulations (CFR) Part 438 managed care requirements.

In general, one of the primary aims of 42 CFR Part 438 is to achieve delivery system and payment reforms by focusing on the following priorities:

- Network adequacy and access to care standards (e.g., timeliness of services, distance standards)
- Client/consumer protections
- Quality of care

## **CALIFORNIA CODE OF REGULATIONS (CCR) TITLE 9 COUNSELOR CERTIFICATION**

CCR Title 9, section titled Counselor Certification provides minimum requirements on the level of credentials counseling staff secure prior to conducting services. The minimum standards are designed to ensure a baseline quality of treatment services and effectiveness. The County has built on these requirements and established minimum staffing standards specific to Sacramento County.

## **CCR TITLE 22 DRUG MEDI-CAL AND THE DMC-ODS SPECIAL TERMS AND CONDITIONS**

Title 22 specifies a framework for the expectations and requirements of services delivered through the Drug Medi-Cal (DMC) system. With implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver, the Special Terms and Conditions (STCs) of the DMC-ODS specify the new requirements and expectations of the DMC system. Where there is conflict between Title 22 and the DMC-ODS STCs, the DMC-ODS STCs override Title 22. However, Title 22 remains as the regulatory requirements in all other areas that are not in conflict with and not addressed by the DMC-ODS STCs.

## **OPERATING STANDARDS**

New DMC regulations cover documentation requirements for DHCS reviews, clarify existing regulations, and make programmatic changes to DMC regulations that impact individual and group counseling sessions, physical examination requirements, physician review requirements, client treatment plans, progress notes, and discharge planning. Following is a summary of DMC regulatory changes:

- Strengthening physical examination requirements during the intake process (physical examination waivers are no longer allowed);
- Requiring licensed practitioners of the healing arts (LPHA) or the Medical Director to review client personal, medical and substance use histories gathered during the intake process in a face to face meeting with the client or counselor who conducted the intake;
- Allowing LPHAs or nurse practitioners to evaluate clients to diagnose whether a client has a DSM 5 Substance Use Disorder, subject to a physician's review and written confirmation of diagnosis;
- Prohibiting minors from participating in group counseling sessions with adults except at certified school sites;
- Establishing a group counseling size of two to twelve participants (with at least one Medi-Cal eligible participant) for Outpatient Drug-Free, Intensive Outpatient, and Narcotic Treatment Program services;
- Revising requirements for group counseling session sign-in sheets;
- Requiring individual and group counseling sessions be conducted in confidential settings;
- Requiring clients, Registered/Certified Counselors, and LPHSAs to type or legibly print their name and date treatment plans, progress notes and discharge plans;
- Requiring client treatment plans to include client diagnoses and goals related to physical exams and medical illnesses;
- Requiring clients to participate in the preparation and review of their treatment plans and sign their treatment plans;
- Specifying when Registered/Certified Counselors and LPHAs must prepare progress notes;
- Requiring a Medical Director or LPHA to review additional documents in determining whether continued services are medically necessary for a client; and
- Establishing a requirement for providers to prepare client discharge plans including plan content and documentation requirements.

Substance Use Services administered in Sacramento County are held to varying, and at times overlapping, regulations depending on, but not limited to, the service modality, activities being performed, and funding source. The Sacramento County DMC-ODS will operate according to the regulations set forth by the Federal Government, the State of California, as well as its own provisions outlined in specific provider contracts. It is common for providers in Sacramento County to offer a variety of services each of which with their own set or multiple sets of regulations to follow. No one set of regulations addresses all components of the provision of Substance Use Services and at times differences in regulatory language may create multiple interpretations on how regulations may apply. Whenever questions regarding regulation interpretation arise, the more stringent regulation applicable shall apply as this is how Sacramento County Quality Management and the Department of Health Care Services will evaluate providers. The following links will direct providers on where to access specific requirements to their programs:

**CMS Final Rule (42 CFR Part 438)**  
**DMC-ODS Special Terms and Conditions (STC)**  
**Title 22**  
**Title IX**  
**Minimum Quality Drug Treatment Standards for DMC**  
**Substance Abuse Block Grant (formally SAPT)**  
**2017 Alcohol and/or Other Drug Program Certification Standards**  
**Facility Licensing Standards**

## **CONTINUITY OF CARE**

The coordination of care for Sacramento County DMC-ODS clients will be managed through the use of the ASAM criteria and in collaboration with various providers (i.e. county-operated or contracted DMC-ODS programs, primary health care, the criminal justice system, mental health and other community and social support providers) to ensure appropriate delivery of services to help clients achieve optimal functioning in the least restrictive environment. DMC-ODS providers will have a point of contact responsible for coordinating clients' step-up or step-down in SUD treatment to ensure a warm hand-off to medically necessary services. Additionally, all clients will need to be informed on how to access the individual point of contact for their service coordination. Both discharging and admitting provider agencies will be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care. When a client moves out of Sacramento County, the new County of Residence will assume responsibility for continuing the client's treatment, but it is expected that the discharging Sacramento County DMC-ODS program do their diligence to ensure as seamless a transition as possible.

## **PROGRAM COMPLIANCE AND PROGRAM INTEGRITY**

To comply with DMC and SUD treatment and documentation requirements and to ensure access to high quality and cost effective treatment services, Sacramento County Quality Management conducts, at a minimum, annual site visits at SUD provider sites.

The County reserves the right to broaden or narrow the scope of any compliance audit but generally the audit will consist of a site visit to review a sampling of client charts at a provider's site and billing claims. Client charts will be reviewed for compliance with treatment program standards and requirements found in Title 22 and Title 9 (Narcotic Treatment Program) of the California code of Regulations.

The compliance review will verify at a minimum:

- Client records are maintained for a minimum of 10 years for DMC certified providers;
- Each client meets admission criteria including documentation of the client's DSM 5 substance use disorder diagnosis and medical necessity;
- Each client for which reimbursement was claimed has a treatment plan documenting services claimed for reimbursement;
- Services claimed for reimbursement were provided;
- For DMC certified providers, services were provided at a certified location;
- SUD treatment requirements were met that are contained in CCR, Title 22, Section 51341.1;
- Good cause codes and procedures that were used were not erroneous, incorrect or fraudulent;
- Multiple billing codes and certification processes that were used were not erroneous, incorrect or fraudulent;
- Reimbursement was not received in excess of daily limits;
- Individual counseling sessions met confidentiality requirements, and for ODF, individual counseling limitations to intake, crisis intervention, collateral services and treatment and discharge planning were met;

- Group counseling sessions met in group size requirements (2 to 12 with at least one Medi-Cal eligible client for DMC providers), confidentiality requirements, and age restrictions for clients 17 and under;
- Intensive Outpatient services were not less than three hours of services on calendar days billed.
- Additionally, for narcotic treatment programs the following requirements under Title 9, CCR will be reviewed at a minimum:
  - Section 10270 (admission criteria time frames);
  - Section 10305 (treatment plan completion and review time frames);
  - Section 10410 (continuing treatment time frames);
  - Section 10345 (minimum counseling session requirements); and
  - Section 10305 (counseling session type and frequency).

A sample compliance audit tool can be found on our website or on request by contacting Sacramento County Quality Management at [1-888-881-4881](tel:1-888-881-4881).

Sacramento County, as a DMC-ODS pilot county, is responsible for complying with The Centers for Medicare and Medicaid Services (CMS) Final Rule (42 CFR, Section 438) and Mental Health Parity and Addiction Equity Act (MHPAEA) requirements. DHCS began implementing policy changes resulting from the Final Rule requirements on July 01, 2017 and will continue to implement regulatory changes on a rolling basis. DMC-ODS pilot counties will be responsible for adhering to these changes upon going live with DMC ODS Waiver implementation. *The following sections summarize some of the key areas of the CMS Final Rule implementation, but are not inclusive of all elements as this a multi-year rollout and guidance may be pending from DHCS.* Please contact Sacramento County Alcohol and Drug Services at 1-916-875-2050 or Quality Management for any questions at [1-888-881-4881](tel:1-888-881-4881).

## **CREDENTIALING AND EXCLUSION CHECKS**

Code of Federal Regulations requires States to establish, and subsequently providers under county Mental Health Plans and pilot DMC-ODS programs to adhere to, a uniform credentialing and re-credentialing policy. Individuals delivering services will need to have their eligibility to deliver services verified as either licensed, licensed-waived, registered, and/or certified prior to hire and monthly thereafter.

Additionally, providers are required to have staff checked against four exclusion lists: Office of Inspector General (prior to hire and monthly thereafter), System for Award Management (prior to hire and monthly thereafter), Medi-Cal Suspension and Ineligible Provider List (prior to hire and monthly thereafter), and the Social Security Death Master List (once prior to hire). Sacramento County Quality Management will provide oversight to the ongoing credentialing and exclusion checks to both county-operated and contracted DMC-ODS County and contracted providers.

## **PERSONNEL SPECIFICATIONS**

The following requirements shall apply to providers and their staff, county-operated or contracted. The professional staff shall be licensed, registered, certified or recognized under California 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. LPHAs include:

- Physician
- Nurse Practitioners
- Physician Assistants
- Registered Nurses
- Registered Pharmacists
- Licensed Clinical Psychologists
- Licensed Clinical Social Worker
- Licensed Professional Clinical Counselor
- Licensed Marriage and Family Therapists
- Licensed Eligible Practitioners working under supervision of Licensed Clinicians

Non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff shall supervise non-professional staff.

Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hire. Documentation of trainings, certifications and licensure shall be contained in personnel files. Professional staff (LPHAs) shall receive a minimum of five (5) hours of continuing education related to addiction medicine each year. Registered and certified AOD counselors shall adhere to all requirements in Title 9, Chapter 8.

Providers will ensure personnel are competent, trained and qualified to provide any services necessary. Providers will maintain records of current certification and NPI registration and fidelity reviews for all staff providing evidenced-based practice (EBP) interventions. Providers shall maintain proof of participation in all County and State mandated training. Providers shall employ and utilize staff who are culturally and ethnically representative of the population being served.

Providers will ensure that all staff members working with individuals receiving services are fingerprinted (LiveScan), and pass Department of Justice (DOJ), and/or Federal Bureau of Investigations (FBI) background checks.

Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:

- Application for employment and/or resume;
- Signed employment confirmation statement/duty statement;
- Job description;
- Performance evaluations;
- Health records/status as required by Provider, AOD certification or Title 9;
- Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries);
- Training documentation relative to substance use disorders and treatment;

- Current registration, certification, intern status, or licensure;
- Proof of continuing education required by licensing or certifying agency and program; and
- Provider's Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well.

Job descriptions shall be developed, revised as needed and approved by the Provider's governing body. The job descriptions shall include:

- Position title and classification;
- Duties and responsibilities;
- Lines of supervision; and
- Education, training, work experience, and other qualifications for the position.

Written Provider code of conduct for employees and volunteers/interns shall be established which addresses the following:

- Use of drugs and/or alcohol.
- Prohibition of social/business relationship with client's or their family members for personal gain.
- Prohibition of sexual conduct with clients.
- Conflict of interest.
- Providing services beyond scope.
- Discrimination against client's or staff.
- Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff.
- Protection client confidentiality.
- The elements found in the code of conduct(s) for the certifying organization(s) the program's counselors are certified under.
- Cooperation with complaint investigations.

If a Provider utilizes volunteers and/or interns, procedures shall be implemented which address:

- Recruitment;
- Screening;
- Selection;
- Training and orientation;
- Duties and assignments;
- Scope of practice;
- Supervision;
- Evaluation; and
- Protection of client confidentiality.

**SUP02-2015 Bulletin County Contract Exhibit A Staffing**  
**SUP09-2016 Bulletin Substance Use Disorder MD**



## CLIENT NOTIFICATION

### INFORMING MATERIALS

DMC-ODS providers are required to post informing materials in the lobby of their service sites, in ALL Sacramento County threshold languages. Materials will be in 18 point font to accommodate CMS Final Rule requirements for individuals who may be visually impaired. The informing materials are as follows:

- Grievance Information Notice
- Appeals Information Notice
- “Help Reading These Papers” Notice
- “Guide to Medi-Cal Services” Notice
- Language Tagline Notice
- “Appeal/Grievance” Forms
- “Request for change of Service Provider/Request for Second Opinion” Forms
- Prepaid return envelopes for Appeal/Grievance and Change of Provider/2nd Opinion Forms

Providers may access the informing materials on the Sacramento County website. Please contact Sacramento County Quality Management for any questions or additional materials at **1-888-881-4881**.

### CLIENT RIGHTS

Client rights assure that the basic rights of independence of expression, decision and action, concern for personal dignity, and human relationships are preserved for all clients. As a cornerstone of a client-centered and effective treatment system, specialty SUD providers must share an individual’s client rights with them in writing, either collectively or individually.

### CLIENT HANDBOOK

The County’s *Substance Use Services Client Handbook* outlines the benefit package for Medi-Cal, and individuals participating in the other County funded services. It also includes information on eligibility, accessing network providers that meet client needs and preferences, client rights and responsibilities and the grievances/appeals process. This document must be provided within five (5) days of first service by one of the following ways and at no-charge to the client:

1. Provide a printed copy or mail it to the client’s mailing address.
2. Email a copy after obtaining the client’s agreement to communicate by email.
3. Direct the client to the County’s website for viewing.

Regardless of the selected scenario, Network Providers are required to provide the client with a copy of the County’s Client Handbook Summary and document the distribution format selected. If at any time the client requests a printed copy, the Network Provider must provide it at no-charge. The Client Handbook will be available on the Sacramento County website in all threshold languages.

## **NOTICE OF PRIVACY PRACTICES**

Sacramento County's Notice of Privacy Practices explains client rights and the treatment agency's legal duties with respect to client health information. It must be made available to all new and continuing clients within five (5) business days of first services.

## **CONFIDENTIALITY / RELEASE OF INFORMATION**

SUD treatment providers within the specialty SUD system must thoroughly explain confidentiality options to clients and have them sign the necessary confidentiality forms (e.g., Release of Information Form, both within the SUD provider network and with external providers). All confidentiality and release of information forms must comply with 42 C.F.R. Part 2, HIPAA, and other pertinent regulations.

As indicated on the Release of Information Form, clients can elect to consent to share information with the entire SUD network of providers or consent only to specific SUD providers. The benefits, risks, and alternatives to these options, must be discussed with clients to allow them to make informed decisions about their care. Clients must sign the Release of Information Form for it to be finalized.

If the client is transferring from a new location, providers must ensure that consent forms are signed and appropriately utilized to ensure information exchange while maintaining compliance with applicable confidentiality regulations.

SUD treatment providers within the SUD system must update the Release of Information and consent forms that clients sign.

**If clients revoke consent to disclose information to a specific SUD provider within the network, SUD treatment providers must notify involved entities of this update.**

## **CLIENT INFORMING – CONSENT FOR TREATMENT AND INFORMATION SHARING**

The foundational principle of consent for treatment is that individuals must give permission before they receive any type of health treatment, test, or examination.

Informed consent generally includes:

- The nature of the decision, treatment, and/or procedure
- Reasonable alternatives to the proposed intervention
- The relevant risks, benefits, and uncertainties related to each alternative
- Assessment of client understanding
- The acceptance of the intervention by the client

It is critical that SUD providers thoroughly describe and explain the services that are recommended to give clients the information necessary to make informed decisions regarding the care that is being proposed.

Additionally, the intake process needs to include consenting clients for information sharing purposes. Sharing information with other SUD and physical/mental health providers is essential in order to provide coordinated care that is in the best interests of clients. As such, thorough information regarding confidentiality (HIPAA and 42 CFR Part 2) needs to be provided to clients in order to obtain informed consent for information sharing purposes that balances the need to maintain necessary privacy and the need to share information to provide high-quality and coordinated care.

In order to be valid, the consent process must be free of coercion, voluntary, and the client giving consent must have decision-making capacity and be deemed competent to make the decision at hand.

### **NOTICE OF ADVERSE CLIENT DETERMINATION (NOABD)**

As consistent with Mental Health Plans (MHPs), DMC-ODS providers are to adopt federal regulations for processing grievances and appeals. Using uniform notice templates (includes a Notice of Grievance Resolution (NGR), Notices of Adverse Benefit Determination (NOABD), Notices of Appeal Resolution (NAR), a “Your Rights” attachment, a client non-discrimination notice, and language assistance taglines) DMC-ODS providers are to provide to client advisement of a determination that has taken place regarding their case. There are 9 types of NOABDs:

- *Authorization Delay*: Given to a client when a DMC-ODS provider fails to make a decision about a service request in a timely manner.
- *Delivery System*: Given to a client following an assessment when the client does not meet medical necessity criteria and no DMC-ODS services will be provided.
- *Denial*: Given to a client when denial for authorization is sent.
- *Financial Liability*: Given to a client when we deny their dispute of financial liability.
- *Grievance/Appeal Resolution*: Given to a client when a client has filed a Grievance or Appeal and we have failed to respond in a timely manner.
- *Modification*: Given to a client when a DMC-ODS provider denies a request for change in treatment, and approve instead a different treatment.
- *Payment Denial*: Given to a client when a DMC-ODS provider denies, in whole or in part, payment for a service post-service delivery.
- *Termination*: Given to a client when a service they are receiving is terminated.
- *Timely Access*: Given to the client when the DMC-ODS provider fails to provide services in a timely manner.

### **PROBLEM RESOLUTION**

Medi-Cal clients may file a Grievance or Appeal (in response to any NOABD), request a change of provider, or request a second opinion by utilizing Sacramento County problem resolution procedures.

## **CLIENT FAIR HEARING RIGHTS**

In addition to other appeal processes that may be required, DMC providers must advise clients of their Medi-Cal fair hearing rights upon the denial, reduction or termination of DMC services as these relate to their eligibility or benefits. This requirement applies to all clients who discharge involuntarily as well. This notification must be in writing at least 10 calendar days prior to the effective date of the intended action to terminate or reduce services. The written notification must include:

- A statement of the action the provider intends to take;
- The reason for the intended action;
- A citation of the specific regulation(s) supporting the intended action;
- An explanation of a client's right to a fair hearing for the purpose of appealing the intended action;
- A statement that the provider must continue treatment services pending a fair hearing decision only if the client appeals in writing within 10 calendar days of the mailing or personal delivery of the notice of intended action to the Department of Social Services; and
- The address where the client must submit his or her request for a fair hearing:

Department of Social Services State Hearing Division  
P.O. Box 944243, MS 9-17-37  
Sacramento, California 94244-2430  
1 (800) 952-5253  
TDD 1 (800) 952-8349

## **INTERPRETER AND TRANSLATION SERVICES**

### **LANGUAGE ASSISTANCE**

It is the intent of all Sacramento County services, county-operated and contracted, to fully inform Medi-Cal clients (and potential clients) on how to access services in an easy to understand and culturally responsive manner through the use of interpreter and translation services that are in compliance with all state and federal regulation. With the implementation of the CMS Final Rule, information is to be made available in the State identified 16 prevalent languages upon request within five business days. Language assistance, such as over-the-phone translators or in-person interpreters may be utilized to meet this need in the event the request is not for written material to be available in a prevalent language. Additionally, posters and flyers with the identified prevalent language taglines are to be posted in provider lobbies and included in the informing materials that will instruct individuals on how to access language assistance services.

### **PROVIDER DIRECTORY AND POSTING REQUIREMENTS**

Each Plan's provider directory must make available in electronic form, and paper form upon request, the following information for all network providers, including each licensed, waived, registered or certified individual employed by the Plan, each provider organization or individual practitioner contracting with the Plan, and each licensed, waived, registered or certified individual employed by a provider organization to deliver Medi-Cal services:

- The provider's name and group affiliation, if any.
- Street address(es).
- Telephone number(s).
- Email address(es), as appropriate.
- Website URL, as appropriate.
- Specialty, in terms of training, experience and specialization, including board certification (if any).
- Services / modalities provided, including information about populations served (i.e., perinatal, children/youth, adults).
- Whether the provider accepts new clients.
- The provider's cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender).
- The provider's linguistic capabilities (including American Sign Language), including languages offered by the provider or a skilled medical interpreter at the provider's office.
- Whether the provider's office / facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.

In addition, the provider directory must include the following information for individuals employed by or contracting with Sacramento County or a network provider:

- Type of practitioner, as appropriate.
- National Provider Identifier number.
- California license number and type of license.
- An indication of whether the provider has completed cultural competence training.

DMC-ODS contracted providers shall submit required updates to their Sacramento County contract monitor no later than the 30th of each month. The SUD Provider Directory for Sacramento County is located on the Sacramento County website.

## **NETWORK ADEQUACY**

In order to strengthen access to services, the Final Rule requires states to establish network adequacy standards in Medicaid (Medi-Cal) managed care. These standards are to:

- Develop and implement time and distance standards to care;
- Develop and implement timely access standards for long-term services and supports; and
- Assess and certify the adequacy of a managed care plan's provider network.

The Network Adequacy requirements take effect July 01, 2018 for live DMC-ODS pilot counties and counties pending must demonstrate their ability to meet network adequacy standards 90 days prior to going live. Time and distance standards are based on the designated size of each county. Sacramento County is categorized as a medium size county, which means Network Adequacy Certification will be based on a client's ability to access DMC-ODS services within a 30 mile and 60 minutes of drive time. Each county must renew their DMC-ODS Network Adequacy certification on an annual basis. DMC-ODS providers will be responsible for updating the Network Adequacy Certification Tool (NACT) and submitting to Sacramento County Quality Management (QM) at the minimum *annually*, as requested by the QM team or in the event changes are made to a DMC-ODS program that either increase or decrease the provider's ability to meet service time, distance, and/or access standards.

## **RECORD RETENTION**

All SUD providers regardless of DMC certification status must maintain the following documentation in the individual client record in accordance with 42CFR Section 438. Client records are maintained for a minimum of 10 years for Drug Medi-Cal certified providers. If an audit takes place during the designated retention period, the provider must maintain the following records until the audit is completed:

- Evidence that the client met admission criteria;
- Treatment plan(s);
- Progress notes;
- Evidence that the client received counseling with any exceptions or waivers noted, signed and dated by the physical in the client's treatment plan;
- Justification for continuing services;
- Discharge summary;
- Evidence of compliance with specific treatment service requirements; and
- Evidence that the provider complied with multiple same day service billing requirements.

## **BILLING AND CODING**

Sacramento County has developed a matrix of provider service codes that incorporates definitions of service codes, DMC units to be billed, allowable service staff, allowable location of services, advanced billing rules and units, and EPSDT eligible services. These new service codes will be implemented as part of the DMC-ODS program in compliance with instructions from DHCS.

## **MULTI-SERVICE BILLINGS, MAXIMUM SERVICE UNITS AND LOCKOUTS**

In order to facilitate the correct placement for clients, DHCS will allow a client to receive more than one service per day by various providers. Sacramento County will not be required to use a multiple billing override code when submitting their claim for reimbursement. A client may receive different services on the same day from the same provider, and at the same time, could receive other services on the same day from a different provider. For example, this would allow methadone dosing for a client who resided in a residential treatment facility.

## **DMC CLIENT SHARE OF COST**

All DMC clients cannot be charged any fees for treatment services except where a share of cost requirement exists (Section 50090). All DMC providers must accept proof of eligibility for Drug Medi-Cal as payment in full for treatment services provided. DMC providers cannot charge fees to a DMC client for access to DMC substance use disorder treatment services or for admission to a DMC treatment program.

## **GOOD CAUSE CODES**

All DMC-funded claims are to be submitted within 30 days of the end of the month that a service was provided. There are limited reasons that are considered “good cause” to submit late claims.

## **BILLABLE/NON-BILLABLE TIME**

### **Travel and Documentation time**

DMC-ODS contracted providers may claim for staff travel time to and from providing direct services under the DMC-ODS program. Travel and documentation time is to be included in the service time and must not be claimed separately. Travel and documentation time must be linked to the service provided, documented in the treatment notes, and subject to federal reasonableness standards. This does not apply to NTP.

## **BILLING RESOURCES**

The DMC-ODS Same Day Billing Matrix is shown in and is available online at: [http://www.dhcs.ca.gov/provgovpart/Documents/DMC\\_ODS\\_Same\\_Day\\_Billing\\_Matrix\\_07.22.16.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/DMC_ODS_Same_Day_Billing_Matrix_07.22.16.pdf)

For the complete charging information, please reference the 2017 Drug Medi-Cal Billing Manual. The requirements specific to the Waiver are found in Chapter 6.

[http://www.dhcs.ca.gov/formsandpubs/Documents/DMC\\_Billing\\_Manual\\_2017-Final.pdf](http://www.dhcs.ca.gov/formsandpubs/Documents/DMC_Billing_Manual_2017-Final.pdf)

## **CALIFORNIA OUTCOMES MEASUREMENT SYSTEM (CALOMS) CalOMS-TREATMENT DATA SUBMISSION AND REPORTING REQUIREMENTS**

California Outcomes Measurement System (CalOMS) is California's data collection and reporting system for SUD treatment. By entering SUD and recovery data in California, CalOMS provides information for improving treatment client outcomes, supporting cost effective services, and meeting legally mandated federal and state reporting requirements. Regardless of DMC certification status, all SUD treatment providers must input client treatment data which is sent to DHCS each month.

Outcome data is necessary in order to identify what is working well for SUD service recipients and what is not. Therefore, collecting outcomes information facilitates the improvement of service delivery. In this respect development of an outcomes measurement system is the key to ensuring continuous quality improvement and thus to positively impacting the lives of SUD service recipients and their families, communities, and public health and social systems.

All Sacramento County SUD treatment providers, regardless of DMC certification status, must enter required CalOMS Treatment data into the SACPRS-CalOMS system. In addition to client demographic data, data entered into this system builds a comprehensive picture of client behavior including data for alcohol and drug use, employment and education, criminal justice, medical and physical health, mental health, and family and social life. Providers will collect client data at admission and at discharge or administrative discharge from the same treatment program. Data will also be collected annually, as an annual update, for clients in treatment for over twelve months.

Summary reports created from CalOMS outcome data contribute to the understanding of treatment and the improvement of substance use disorder treatment programs in the continuum of prevention, treatment and recovery services.

The Department of Health Care Services (DHCS) has established the following data compliance standards for California Outcomes Measurement System –Treatment (CalOMS Tx) reporting. These data standards are intended to provide counties, their providers and direct providers with clear direction on submitting complete and accurate CalOMS Tx data in a timely manner:

- Standard: Counties and direct providers shall submit CalOMS Tx data to DHCS within 45 days after the end of the report month.
- Standard: Total late submissions or re-submissions shall not exceed five percent (5%) for any report month.
- Standard: The rate of fatal record errors detected shall not exceed five percent (5%) for each CalOMS Tx data batch file submitted.

Refer to the CalOMS Tx website at CalOMS Treatment for updates and information about CalOMS Tx.



## **DATAR REPORTING REQUIREMENTS**

The Drug and Alcohol Treatment Access Report (DATAR) is the Department of Health Care Services (DHCS) system to collect data on treatment capacity and waiting lists and is considered a supplement to the California Outcomes Measurement System (CalOMS) client reporting system. DATAR assists in identifying specific categories of individuals awaiting treatment and identifies available treatment facilities for these individuals.

DATAR has information on the program's capacity to provide different types of Substance Use Disorder (SUD) treatment to clients and how much of the capacity was utilized that month. If the provider has a waiting list for publicly funded SUD treatment services, DATAR includes summary information about the people on the waiting list. These are the applicants who cannot be admitted due to the facility's lack of capacity.

All SUD treatment providers that receive SUD treatment funding from DHCS are required to submit the one-page DATAR form to DHCS each month. In addition, certified Drug Medi-Cal providers and Licensed Narcotic Treatment Programs (NTP) must report, whether or not they receive public funding.

DATAR is a web based system accessed through the DHCS website. To access DATAR, please visit the following website: <https://adpapps.dhcs.ca.gov/datar/UserLogin.aspx?o=1>

## **ASAM LEVEL OF CARE REPORTING REQUIREMENTS**

The DMC-ODS is a Pilot program approved by the Centers for Medicare and Medicaid Services to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with substance use disorders (SUDs). The DMC-ODS will demonstrate how organized SUD care increases the success of DMC clients while decreasing other system health care costs. A critical element of the DMC-ODS Pilot includes providing a continuum of care modeled after the ASAM criteria for SUD treatment services.

A primary goal underlying the ASAM Criteria is for the client to be placed in the most appropriate level of care (LOC). For both clinical and financial reasons, the preferable LOC is that which is the least intensive while still meeting treatment objectives and providing safety and security for the client. The ASAM Criteria is a single, common standard for assessing client needs, optimizing placement, determining medical necessity, and documenting the appropriateness of reimbursement.

DMC-ODS Waiver counties, including Sacramento County, are required to use the ASAM Criteria to ensure that eligible clients have access to the SUD services that best align with their treatment needs. Waiver counties are required to have a Utilization Management Program to ensure that clients have appropriate access to SUD services, medical necessity has been established, the client is in the appropriate ASAM LOC, and that the interventions are appropriate for the diagnosis and LOC. Waiver counties are also required to have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at the appropriate ASAM LOC following initial request or referral for all DMC-ODS services.

Counties participating in the DMC-ODS are required to provide DHCS with data and information in order to comply with the evaluation and quarterly reporting established by the DMC-ODS special terms and conditions. This includes information from ASAM criteria-based screenings and assessments. DHCS will utilize this data to monitor appropriate use of ASAM criteria in the DMC-ODS.

DMC-ODS Waiver counties are required to submit their ASAM LOC data for all DMC clients to DHCS' Behavioral Health Information Systems (BHIS), which is the same system counties use to submit data to the California Outcomes Measurement System (CalOMS). Although ASAM LOC and CalOMS data must be submitted in separate files, submission rules will be similar. ASAM LOC data submission will be cumulative and must be submitted at least once monthly, no later than 45 days after the month of service. Sacramento County staff will compile and submit ASAM LOC data for all providers within the Organized Delivery System.

## **TRAINING**

The County will require all contracted DMC service providers to participate in mandatory trainings to ensure compliance with DMC regulations and County contracting requirements. Compliance with training will be monitored through the contract monitoring process.

Trainings will be mandatory and offered on an annual basis for DMC/Title 22 regulations, ASAM, ADA, CLAS standards and related cultural and linguistic competence training, co-occurring disorder symptoms and diagnoses, the DSM 5 and Motivational Interviewing, 42 CFR Part 2. Additional required training will be provided to the provider network to ensure that, at a minimum, every program/provider offers evidence-based practices and community defined practices, where appropriate, to address the specific needs of diverse communities. Examples of these trainings include, but are not limited to, Cognitive Behavioral Therapy, Contingency Management, Seeking Safety, 12 Step Facilitation Therapy, The Matrix Model, and Relapse Prevention. All training information will be maintained in a training log by the provider and provided to County during contract monitoring compliance reviews. The log contains information about the training, including title of training, description of training, duration and frequency of the training, number of attendees by function, training date, and name of presenter(s). All network providers will be required to establish a training plan for employees and submit information to the County regarding cultural competence trainings they attended. All providers will be monitored for compliance with this contract requirement.

## **TERMINOLOGY**

Abuse: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes client practices that result in unnecessary cost to the Medicaid program.

Adolescents: means clients between the ages of twelve and under the age of twenty-one.

Administrative Costs: means the Provider's direct costs, as recorded in the provider's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the client. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit reviews, and activities related to billing. Administrative costs may include provider's overhead per approved indirect cost rate proposal pursuant to OMB Omni-Circular and the State Controller's Office Handbook of Cost Plan Procedures.

Appeal: is the request for review of an adverse benefit determination.

Authorization: is the approval process for DMC-ODS Services prior to providing Detoxification or Residential services.

Available Capacity: means the total number of units of service (bed days, hours, slots, etc.) that a provider actually makes available.

Client: means a person who:

- a) has been determined eligible for Medi-Cal;
- b) is not institutionalized;
- c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria; and
- d) meets the admission criteria to receive DMC covered services.

Client Handbook: is the state developed model enrollee handbook.

Calendar Week: means the seven day period from Sunday through Saturday.

Case Management: means a service to assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

Certified Provider: means a substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the state to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

Collateral Services: means sessions with therapists or counselors and significant persons in the life of a client, focused on the treatment needs of the client in terms of supporting the achievement of the client's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the client.

Complaint: means requesting to have a problem solved or have a decision changed because you are not satisfied. A complaint is sometimes called a grievance or an appeal.

Corrective Action Plan (CAP): means the written plan of action document which the provider develops and submits to County and/or DHCS to address or correct a deficiency or process that is non-compliant with contract, laws, regulations, or standards.

County: means the county in which the provider physically provides covered substance use treatment services.

Crisis Intervention: means a contact between a therapist or counselor and a client in crisis. Services shall focus on alleviating crisis problems. Crisis means an actual relapse or an unforeseen event or circumstance, which present to the client an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the client's emergency situation.

Delivery System: DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. 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 Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn contract 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.

Discharge Services: means the process to prepare the client 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 other supportive services.

DMC-ODS Services: means those DMC services authorized by Title XIX or Title XXI of the Social Security Act. Title 22 Section 51341.1. W&I Code, Section 14124.24 and California's Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver special terms and conditions.

Drug Medi-Cal Program: means the state system wherein clients receive covered services from DMC-certified substance use disorder treatment providers.

Drug Medi-Cal Termination of Certification: means the provider is no longer certified to participate in the Drug Medi-Cal program upon the state's issuance of a Drug Medi-Cal certification termination notice.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT): means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal covered client less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

Education: means providing research based education on addiction, treatment, recovery and associated health risks.

Education and Job Skills: means linkages to life skills, employment services, job training, and education services.

Emergency Medical Condition: means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, for a pregnant woman, the health of the woman of her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Services: means covered inpatient and outpatient services that are as follows:

- Furnished by a provider that is qualified to furnish these services under this title.
- Needed to evaluate or stabilize an emergency medical condition.

Excluded Services: means services that are not covered under the DMC-ODS Waiver.

Face-to-Face: means a service occurring in person.

Family Support: means linkages to childcare, parent education, child development support services, and family and marriage education. Family support is only available under Recovery services.

Family Therapy: means including a client's family members and loved ones in the treatment process, and education about factors that are important to the client's recovery as well as their own recovery can be conveyed. Family members may provide social support to clients, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

Fair Hearing: means the state hearing provided to clients upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6 Fair hearings shall comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

Final Settlement: means permanent settlement of the Provider's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the state. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement.

Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or state law.

Grievance: means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the County to make an authorization decision.

Grievance and Appeal System: means the processes the County implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

Group Counseling: means 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. A client that is 17 years of age or younger shall not participate in-group counseling with any participants who are 18 years of age or older. However, a client who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.

Hospitalization: means that a client needs a supervised recovery period in a facility that provides hospital inpatient care.

Individual Counseling: means contact between a client and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.

Intake: means the process of determining a client meets the medical necessity criteria and a client is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders, and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g. body specimen screening) necessary for substance use disorder treatment and evaluation.

Intensive Outpatient Treatment: means (ASAM Level 2.1) structured programming services consisting primarily of counseling and education about addiction-related problems a minimum of nine (9) hours with a maximum of 19 hours per week for adults, and a minimum of six (6) hours with a maximum of 19 hours per week for adolescents. Services may be provided in any appropriate setting in the community. Services may be provided in-person, by telephone or by telehealth.

Licensed Practitioners of the Healing Arts (LPHA) includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Work (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

Medical Necessity and Medical Necessary Services: means those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

Medical Necessity Criteria: means adult clients must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Youth under 21 may be assessed to be at risk for developing a substance use disorder, and if applicable, must meet the ASAM adolescent treatment criteria. Clients under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, clients under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

Medical Psychotherapy: means a type of counseling service that has the same meaning as defined in 9 CCR § 10345.

Medication Services: means the prescription or administration of medication 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.

Opioid (Narcotic) Treatment Program: means an outpatient clinic licensed by the state to provide narcotic replacement therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.

Naltrexone Treatment Services: means an outpatient treatment service directed at serving detoxified opiate addicts by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

Network: means the group of entities that have contracted with the County to provide services under the DMC-ODS Waiver.

Network Provider: means any provider, group of providers, or entity that has a network provider agreement with the County and receives Medicaid funding directly or indirectly to order, refer or render covered services.

Non-Perinatal Residential Program: services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

Notice of Adverse Benefit Determination: means a formal communication of any action and consistent with 42 CFR 438.404 and 438.10.

Observation: means the process of monitoring the client's course of withdrawal. It is to be conducted as frequently as deemed appropriate for the client and the level of care the client is receiving. This may include but is not limited to observation of the client's health status.

Outpatient Services: means (ASAM Level 1.0) outpatient service directed at stabilizing and rehabilitating persons up to nine hours of service per week for adults, and less than six hours per week for adolescents.

Overpayment: means any payment to a network provider by County to which the network provider is not entitled to under Title XIX of the Act or any payment to County by State to which the County is not entitled to under Title XIX of the Act.

Provider: means a provider that is engaged in the continuum of services under this Agreement.

Perinatal DMC Services: means covered services as well as mother/child habilitative and rehabilitative services, services access (i.e., provision or arrangement of transportation to and from medically necessary treatment), education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant and coordination of ancillary services (Title 22, Section 51341.1(c)(4).

Physician: as it pertains to the supervision, collaboration, and oversight requirements. A doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed.

Physician Services: means services provided by an individual licensed under state law to practice medicine.

Postpartum: as defined for DMC purposes, means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility for perinatal services shall end on the last day of the calendar month in which the 60th day occurs.

Postservice Postpayment (PSPP) Utilization Review: means the review for program compliance and medical necessity conducted by the state after service was rendered and paid. DHCS may recover prior payments of Federal and State funds if such a review determines that the services did not comply with applicable statutes, regulations, or terms under the DMC-ODS Waiver.



Preauthorization: means approval by County that a covered service is medically necessary.

Prescription Drugs: means simple substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

- Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law;
- Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and
- Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

Primary Care: means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Physician (PCP): means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to clients and serves as the medical home for members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist.

Primary Care Provider: means a person responsible for supervising, coordinating, and providing initial and Primary Care to clients, for initiating referrals and, for maintaining the continuity of client care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

Projected Units of Service: means the number of reimbursable DMC units of service, based on historical data and current capacity, the Provider expects to provide on an annual basis.

Provider: means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

Re-Certification: means the process by which the DMC certified clinic is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.

Recovery Monitoring: means recovery coaching, monitoring via telephone and internet. Recovery monitoring is only available in Recovery services.

Recovery Services: are available after the client has completed a course of treatment. Recovery services emphasize the client'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 clients.

Rehabilitation Services: includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a client to his best possible function level.

Relapse: means a single instance of a client's substance use or a client's return to a pattern of substance use.

Relapse Trigger: means an event, circumstance, place or person that puts a client at risk of relapse.

Residential Treatment Services: means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to clients. Each client 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. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five (5) hours of clinical service a week to prepare client for outpatient treatment.

Safeguarding Medications: means facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

Service Authorization Request: means a client's request for the provision of a service.

Short-Term Resident: means any client receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential facility in which they are receiving the services.

State: means the Department of Health Care Services or DHCS.

Subcontract: means an agreement between the County and its subcontractors (Providers). A subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct client services.

Subcontractor (Provider): means an individual or entity that is DMC certified and has entered into an agreement with the County to be a provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the County to provide any of the administrative functions related to fulfilling the County's DMC-ODS Waiver obligations.

Substance Abuse Assistance: means peer-to-peer services and relapse prevention. Substance abuse assistance is only available in Recovery Services.

Substance Use Disorder Diagnosis: are those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

Support Groups: means linkages to self-help and support, spiritual and faith-based support.

Support Plan: means a list of individuals and/or organizations that can provide support and assistance to a client to maintain sobriety.

Telehealth between Provider and Client: means office or outpatient visits via interactive audio and video telecommunication systems.

Telehealth between Providers: means communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems.

Temporary Suspension: means the provider is temporarily suspended from participating in the DMC program as authorized by W&I Code, Section 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.

Threshold Language: means a language that has been identified as the primary language, indicated on the Medi-Cal Eligibility System (MEDS), of 3000 clients or five percent of the client population whichever is lower, in an identified geographic area. Sacramento County's threshold languages include Spanish, Hmong, Vietnamese, Russian, Cantonese and Arabic.

Transportation Services: means provision of or arrangement for transportation to and from medically necessary treatment.

Unit of Service Description:

- For case management, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a client in 15-minute increments on a calendar day.
- For additional medication assisted treatment, physician services that includes ordering, prescribing, administering, and monitoring of all medications for substance use disorders per visit or in 15-minute increments.
- For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with 9 CCR § 10000.
- For physician consultation services, consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists in 15-minute increments.
- For residential services, providing 24-hour daily service, per client, per bed rate.
- For withdrawal management per client per visit/daily unit of service.

Urgent Care: means a condition perceived by a client as serious, but not life threatening. A condition that disrupts normal activities of daily necessary, treatment within 24-72 hours.

Utilization: means the total actual units of service used by clients and participants.

Withdrawal Management: means detoxification services provided in either an ambulatory or non-ambulatory setting