

Residential Services

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a new health care services paradigm for Medi-Cal eligible youth and adults with substance use disorders (SUD). For adults (18 years and over), the American Society of Addiction Medicine (ASAM) Residential Services Level 3.1, 3.3, and 3.5 will be available as part of the benefit package. For adolescents, the residential benefits will be limited to ASAM Residential Services Level 3.1 and 3.5.

Residential services are 24-hour non-medical, short-term rehabilitation services for patients with a substance use disorder diagnosis. These services will be provided when they are determined to be medically necessary by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA)¹. Residential Treatment services may be provided by a certified or registered substance use disorder (SUD) counselor, LPHA, or trainee working under the supervision of a certified SUD counselor or a LPHA.

Residential treatment services must occur in a residential facility of any size that has an Alcohol and Drug license issued by California Department of Health Care Services (DHCS) for adults and has a Group Home license issued by California Department of Social Services (CDSS) for youth under 18. These residential facilities must also be DMC-certified and must have a designation from DHCS as capable of delivering care consistent with ASAM treatment criteria for the specific residential level of care. A residential facility may receive up to three designations (ASAM Level 3.1, 3.3, 3.5) depending on the services provided.

There is no wrong door for patients to be referred into one of the levels of care (LOC) (ASAM Level 3.1, 3.3, 3.5). Referrals can be made by the Beneficiary Access Line (BAL), or directly into the treatment program, or stepped up or down to a different level of care based on the clients' needs. The daily regimen and structured patterns of activities are intended to restore cognitive functioning and build behavioral patterns within a community. Each patient shall live on the premises and shall be supported in their efforts to restore, maintain and apply interpersonal and independent living skills and access community support systems. Providers and residents work collaboratively to define barriers (e.g., employment, housing, social support), set priorities, establish goals, create treatment plans, and solve problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care. Medication-Assisted Treatment (MAT) will be discussed and offered as a concurrent treatment option for all individuals receiving services in a residential setting with an alcohol and/or opioid use disorder, when clinically appropriate. Transitions between LOC will be documented to ensure successful connections with the new service location/provider, including the facilitation of warm hand-offs when possible.

¹ A Licensed Practitioner of the Healing Arts is defined as one of the following professional categories: Physician (MD or DO), nurse practitioner, physician assistant, registered nurse, registered pharmacist, licensed clinical psychologist, licensed clinical social worker, licensed professional clinical counselor, licensed marriage and family therapist, or license-eligible practitioner working under the supervision of licensed clinicians.

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The following is a description of service components, staffing requirements, and service expectations for Residential services for both adolescents² and adult populations.

Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1)

This LOC is appropriate for patients who need time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment (please refer to ASAM Dimensions 1 – 6 for detailed descriptions). The environment will provide 24-hour structure with trained personnel, at least five hours of clinical services a week, and preparation for step down into outpatient treatment. The facility must be designated by DHCS as an ASAM 3.1 LOC, and maintain a DHCS residential license (adults) or California Department of Social Services (CDSS) group home license (youth).

Service Components:

The components of Clinically Managed Low-Intensity Residential Services Residential Services (ASAM Level 3.1) include:

- *Intake:* The process of determining that a patient meets the medical necessity criteria, and then admitting a patient into a SUD treatment program. Intake includes the evaluation or analysis to determine whether or not an individual meets the current Diagnostic and Statistical Manual (DSM) of Mental Disorders criteria for an SUD diagnosis, and the assessment of treatment needs to provide medically necessary services using the SAPC-developed full ASAM assessment. Intake may include a physical examination and laboratory testing necessary for determining and providing appropriate SUD treatment.
- *Individual counseling:* Contact between a certified SUD counselor or LPHA and a patient that addresses psychosocial issues related to substance use using techniques such as Motivational Interviewing and Cognitive Behavioral Therapy. Services provided in-person, by telephone, or by telehealth qualify as Medi-Cal reimbursable units of service.
- *Group Counseling:* Face-to-face contacts between one or more certified SUD counselors or LPHAs, and two or more clients at the same time (with a maximum of 12 clients in the group), in which psychosocial issues related to substance use are addressed using techniques such as Motivational Interviewing and Cognitive Behavioral Therapy. Counseling and peer-support focus on the needs of the individuals served.
- *Patient Education:* Research-based education on addiction, treatment, recovery and associated health risks with the goal of minimizing the use of addictive substances, lowering the risk of dependence, and minimizing adverse consequences of substance use (with a maximum of 12 clients in the group).

² For youth, the benefit package is established as a developmentally-appropriate set of services. Not all Levels of Care or types of services available to adults are included in the benefit package for youth, such Withdrawal Management and Medication-Assisted Treatment because these services are generally not approved or appropriate for this population. However, such services will be made available to youth on a case-by-case basis as determined medically necessary with prior authorization by DPH-SAPC.

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- *Family Therapy*: Evidence-based practice of psychotherapy involving both the patient and their family members. The effects of addiction are far-reaching and patients' family members and loved ones also are affected by the disorder. By including family members in the treatment process, clinicians provide education about factors that are important to the patient's recovery as well as their own recovery. Family members can provide social support to the patient, help motivate the patient's loved ones to provide social support to the patient, help motivate the patient to remain in treatment, and receive help and support for their own family recovery as well. These services must be provided by an LPHA-level therapist.
- *Safeguarding Medications*: Facilities will safeguard medications by storing all resident medication and facility staff members may assist with resident's self-administration of medicine.
- *Medication Services*: MAT will be discussed and offered as a concurrent treatment option for all adults receiving services in a residential setting with an alcohol and/or opioid use disorder, when clinically appropriate. The prescription or administration of MAT, and the assessment of side effects and/or impact of these medications, should be conducted by staff lawfully authorized to provide such services within their scope of practice and licensure. However, MAT can and should be discussed by non-medical staff in residential settings as a treatment option. Youth under age 18 are eligible for MAT on a case-by-case basis with parental consent and authorization from SAPC.
- *Collateral Services*: Face-to-face, telephone, or telehealth sessions with a certified SUD counselor or LPHA and significant persons in the life of the patient. Sessions focus on the treatment needs of the patient in terms of supporting the achievement of the patient's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the patient.
- *Crisis Intervention Services*: Contact between a certified SUD counselor or LPHA and a patient in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance that presents to the patient an imminent threat of relapse, or a threat to physical and/or mental health and well-being. Crisis intervention services shall be limited to the stabilization of the patient's emergency situation, and should include appropriate linkage to services to ensure ongoing care following the crisis situation.
- *Treatment Planning*: The provider (certified SUD counselor or LPHA) shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed upon intake, updated at least every 30 days with reviews occurring as needed and appropriate, unless there is a change in the patient's situation or a change in treatment modality that would require a new or revised treatment plan. The treatment plan shall include:
 - A statement of problems to be addressed.
 - Goals to be reached which address each problem.
 - Action steps to be taken by the provider and/or patient to accomplish identified goals.
 - Target dates for accomplishment of action steps and goals.

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- A description of services, including the type of counseling to be provided and the frequency thereof.
 - Specific quantifiable goals and treatment objectives (e.g., SMART goals that are Specific, Measurable, Attainable, Realistic, and Time-bound) related to the patient's SUD diagnosis and multidimensional assessment.
 - The proposed type(s) of interventions/modalities that includes frequency and duration of intervention(s).
 - A treatment plan that is consistent with the qualifying diagnosis and must be signed by the patient and the LPHA or Medical Director.
- *Transportation Services*: Providing transportation or making arrangement for transportation to and from medically necessary treatment.
 - *Discharge Services*: The process to prepare the patient for referral into another LOC, between systems of care (physical health, mental health), post-treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services. The discharge service process should be initiated from the onset of treatment services to ensure sufficient time to plan for the patient's transition to subsequent treatment or recovery support services.

Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3)

This LOC is appropriate for patients with functional limitations that are primarily cognitive and that requires a slower pace to treatment and are unable to use full active setting or therapeutic community. These functional limitations may be either temporary or permanent. The individual's limitations may result in problems in interpersonal relationships, emotional coping skills, or comprehension. Level 3.3 programs generally are considered for the delivery of high-intensity services (please refer to ASAM Dimensions 1-6 for detailed descriptions). Services include 24-hour care provided in a facility setting with trained counselors to stabilize multidimensional imminent danger. This level of care is only available for adults and is not part of the adolescent SUD services benefit package.

Service Components:

The components of Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3) include:

- Intake
- Individual counseling
- Group counseling
- Patient education
- Family therapy
- Safeguarding medications

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- Medication services
- Collateral services
- Crisis intervention services
- Treatment planning
- Transportation services
- Discharge planning services

Please see the section above for specific definitions of the service components.

Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)

This LOC is appropriate for patients who have specific functional limitations, need safe and stable living environments in order to develop and/or demonstrate sufficient recovery skills so that they do not immediately relapse or continue to use substances in an imminently dangerous manner upon transfer to less intensive level of care (please refer to ASAM Dimensions 1 – 6 for detailed descriptions). Services include 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Patients in this level of care are able to tolerate and actively use full milieu or therapeutic community. The facility must be designated by DHCS as an ASAM 3.5 LOC, maintain DHCS residential licenses and DMC Certification (adults) or CDSS group home license (youth).

Service Components:

The components of Clinically Managed High-Intensity Residential Services (ASAM Level 3.5) include:

- Intake
- Individual counseling
- Group counseling
- Patient education
- Family therapy
- Safeguarding medications
- Medication services
- Collateral services
- Crisis intervention services
- Treatment planning
- Transportation services
- Discharge planning services

Please see the section above for specific definitions of the service components.

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Staffing

Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their respective scope of practice laws. Certified and Registered SUD counselors must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8, and must be certified by one of the National Commission for Certifying Agencies (NCCA) accredited organizations recognized by DHCS: Addiction Counselor Certification Board of California (affiliated with California Association for Alcohol/Drug Educators (CAADE); California Association of DUI Treatment Programs (CADTP); California Consortium of Addiction Programs and Professionals (CCAPP). A LPHA possesses a valid California clinical license in one of the following professional categories:

- Physician (MD or DO)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Registered Nurse (RN)
- Registered Pharmacist (RP)
- Licensed Clinical Psychologist (LCP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Marriage and Family Therapist (LMFT)
- License-Eligible Practitioners working under the supervision of licensed clinicians

Non-professional staff including clerical, billing, and facility management support shall receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff will be supervised by professional and/or administrative staff. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring.

Service Expectations

- *Physical Examinations:* Appropriate medical evaluation must be performed prior to initiating residential treatment services, including physical examinations when deemed necessary.
- *Culturally Competent Services:* Providers are required to provide culturally competent services that are culturally, linguistically, and developmentally appropriate in order to optimize treatment engagement (e.g., trauma-informed care, gender responsive treatment, etc.). Providers must ensure that their policies, procedures, and practices are consistent with the principles outlined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care and are embedded into the organizational structure and day-to-day operations of the agency.

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- *Medication-Assisted Treatment*: Providers must have procedures for linkage/integration of MAT services for patients to ensure adequate access to this core component of SUD treatment. Patients who are receiving MAT must not be discriminated against and must have equal access to services as patients who are not receiving MAT. The prescribing of MAT should follow established prescribing standards from the American Society of Addiction Medicine and the Substance Abuse and Mental Health Services Administration (SAMHSA). Provider staff will regularly communicate with prescribers of these medications to ensure coordination of care, assuming the client has signed a 42 CFR part 2 compliant release of information for this purpose.
- *Evidence-Based Practices (EBP)*: Providers will be expected to implement, at a minimum, the two EBPs of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT). Other EBPs that may be provided include relapse prevention, trauma informed treatment, and psychoeducation.
- *Case Management*: The initial treating provider will be responsible for providing case management services and communicating with the next provider along the continuum of care to ensure smooth transitions between levels of care. Once an individual has been successfully admitted for services at the next LOC the new treating provider (if a different agency) will assume responsibilities. Case Management will assist patients in navigating and accessing the mental health, physical health, and social service delivery systems.
- *Recovery Support Services*: Providers will be expected to deliver recovery support services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in recovery, and reengagement in SUD treatment and other services and supports as needed.
- *Documentation*: Services provided in the community, by telephone, or by telehealth require equivalent quality and comprehensiveness of documentation as in-person services provided within a certified facility. The SAPC will require that providers generate initial documentation based on the ASAM Criteria and that documentation provides justification for the care provided, including documentation of medical necessity. Documentation templates developed by SAPC shall be used for treatment plans, progress notes, and other documentation developed by the Quality Improvement/Utilization Management (QI/UM) Unit.

Treatment Authorization, Assessments, Lengths of Services, and Reimbursement

Treatment Authorization:

When the brief triage assessment and/or the full ASAM assessment indicates that placement in a residential treatment program (ASAM level 3.1, 3.3, 3.5) is needed, the selected provider will submit a preauthorization request to DPH-SAPC's Office of the Medical Director and Science Officer, which will conduct a preauthorization review, and then approve or deny the request within 24 hours of receiving the request. If relapse risk is deemed to be significant without immediate placement in residential care, a County-operated or community-based residential treatment provider may admit an individual prior to receiving residential authorization, with the

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understanding that authorization denials will result in financial loss (e.g., not billable to other state and federal sources) whereas authorization approvals will be retroactively reimbursed to the date of admission. Preauthorization by the County is not required for admission into other ASAM levels of care.

Residential preauthorizations pertain to the provision of all residential services, including youth, adults, perinatal patients, and criminal justice involved patients. Residential preauthorization is only required when initiating residential care or transitioning to a higher level of residential care. Preauthorization for residential services is not necessary if transitioning to a lower level of residential care.

Assessments:

Residential patients must receive regular assessments of their progress within their 60 and 30 calendar day residential authorizations for adult and youth populations, respectively. Given the fluid nature of clinical progression, the expectation will be that clinical progress note assessments are performed on a regular basis during residential treatment as clinically warranted and that certain patients will not require the full period of authorized residential services. In these instances, patients must be transitioned to a lower level of care as soon as clinically indicated. Required treatment plan updates every 30 days in the residential setting will help to facilitate these regular case reviews to ensure that patients receive care in the least restrictive setting that is clinically appropriate. Please see the Documentation section of the QI/UM plan for additional details on treatment plan requirements.

Lengths of Services:

Adults

- Initial residential preauthorizations for adults will authorize no more than 60 calendar days at the outset of residential services. In other words, residential services for all adult populations require reauthorization after 60 calendar days to assess for appropriate level of care utilization, if adult clients are determined to require longer lengths of residential care.
- The length of residential services range from 1 to 90 days with a 90 day maximum, unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis.
- One extension of residential services up to 30 days beyond the maximum length of stay of 90 days may be authorized for one continuous length of stay in a one-year period (365 days).
- Only two non-continuous 90-day residential admissions will be authorized in a one-year period.
- Special Adult Populations:
 - Perinatal clients: May receive longer lengths of stay in residential settings based on medical necessity. Following initial residential preauthorization, perinatal clients may be authorized for extensions of residential services every 30 days up to the length of the pregnancy and postpartum period, which is 60 days after the pregnancy ends, based on medical necessity.

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- Criminal justice clients: May receive longer lengths of stay in residential settings based on medical necessity. Following initial residential preauthorization, criminal justice clients may be authorized for extensions of residential services every 30 days up to 6-months or longer, based on medical necessity.

Youth

- Initial residential preauthorizations for youth will authorize no more than 30 calendar days at the outset of residential services.
- The length of residential services range from 1 to 30 days with a 30 day maximum, unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis.
- One extension of residential services up to 30 days beyond the maximum length of stay of 30 days may be authorized for one continuous length of stay in a one-year period (365 days).
- Only two non-continuous 30-day residential admissions will be authorized in a one-year period.
- In general, youth clients typically require shorter lengths of stay than adult clients and should be stabilized and then moved down to a less intensive level of care.

Reimbursement:

If upon clinical review, either during a focused or random retrospective review, an ongoing residential treatment case is determined to be unnecessary based on the aforementioned considerations, UM staff will have the authority to terminate/modify the current authorization and to deny ongoing reimbursement for residential services, and require transition to an appropriate lower level of care. In these instances, reimbursement for residential services that have already been provided will be maintained, but future reimbursement for the identified episode will be denied. Providers will be responsible for ensuring successful care coordination during all level of care transitions.

Final Note:

SUD treatment should be delivered across a continuum of services that reflect illness severity and the intensity of services required. One of the key goals of SAPC is to ensure that clients receiving SUD services in Los Angeles County receive the right service, at the right time, for the right duration, in the right setting. While the LOC are presented as discrete hierarchies, they should be viewed as points along a continuum of treatment services, each of which may be provided in a variety of settings.