DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) YEAR 1 PERFORMANCE METRICS

(version 10/24/17)

ID	DOMAIN	DESCRIPTION IN STCS/STATE & COUNTY IA	MEASURES	DATA SOURCE	COMMENTS	MANDATORY OR FLEXIBLE
1	Access	Enrollment information to include the number of DMC-ODS beneficiaries served in the DMC-ODS program	Clients Served: 1. Number of DMC-ODS beneficiaries served (admissions) by the DMC-ODS County with stratification for baseline and each year of the Waiver.	* Claims data-unduplicated client count per year. * Medi-Cal Eligibility Files (MMEF) data for demographics, preferred language, age, etc.	Breakdown will include stratification by ethnicity, age, sex, aid code groupings, and diagnoses (required for External Quality Review Organization (EQRO) Contract).	Mandatory
2	Access	Number of days to first DMC-ODS service at appropriate level of care after referral Timeliness of first initial contact to face-to-face appointment	Timeliness: 1. Number of days from initial call/contact to first face to face visit or triage detox visit (if both present which -ever is first contact). 2. Number of days from initial ASAM assessment contact to treatment admission (first treatment visit).	* County DMC-ODS Access Log (for calls/walk-ins). * Claims data with assessment and treatment visits. * ASAM data for assessment date and level of care disposition for treatment access.	Access and timeliness statistics can be stratified based on ethnicity, age, sex, aid code, diagnoses, and level of care (LOC).	Mandatory
3	Access/ Cost effectiveness	EQRO Contract - requirement related to cost effectiveness overall and funds spent on different populations	Costs of care: 1. Total and average costs per beneficiary served with demographic breakdown. Data will be compared across baseline years and each year of the DMC-ODS Waiver. Data will also be compared regionally, by county size, and statewide. 2. Total and average costs per beneficiary by LOC for each DMC-ODS Medi-Cal service level provided.	* Claims data linked to MMEF data set.	Measure is related to cost effectiveness of services and expanded access to services by LOC and demographic groups.	Mandatory

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4	Access	Access to DMC-ODS services with translation services in the prevalent non-English language(s) 42 CFR 438.10 and 438.206 written information for care, beneficiary rights	Cultural Competence of Services: 1. County shall adopt Federal Culturally & Linguistic Appropriate Services (CLAS) standards and develop cultural competence plan with regular updates. 2. Translation services shall be available for beneficiaries and services will be culturally competent and accessible. 3. Provide written information in all threshold languages based on county population.	* Quality Improvement (QI) Cultural Competency Plan data review: 1. Number and percentage of provider organizations that provide services in languages other than English. 2. Number and percentage of clients who prefer services in languages other than English (MMEF data file) preferred language data element. 3. Number of counselors/clinicians who provide services in languages other than English. * Provider/Staff Numbers speaking non-English languages. * Availability of translation lines and video conferencing translators as needed * EQRO Client Focus Group for non-English speakers for threshold languages	EQRO reviews Cultural Competence measures in the annual onsite visit and looks at utilization statistics as well as direct client feedback via focus groups. Requirements are similar for Substance Abuse Prevention Treatment (SAPT) grant.	Mandatory

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5	Access	Appropriate access for all clients including ethnic groups and non-English speakers	Access levels by special populations: 1. Penetration rates for clients getting services in all ethnic groups, age, preferred language, aid codes, and diagnoses.	* Claims data linked to MMEF eligibility data by ethnicity and preferred language as a percentage of total beneficiaries. Reports for baseline and all years of Waiver.	EQRO contract requires monitoring of access levels and trends for different ethnic groups and aid group groupings such as disabled, child/family, pregnancy, and foster care.	Mandatory
6	Quality	Coordination of Care with Physical Health and Mental Health.	Coordination of Care with Physical Health (PH) and Mental Health (MH) Plans: 1. Memorandum of Understandings (MOUs) with both MH and PH Plans addressing processes for (a) collaboration and referrals; (b) disputes; (c) key care navigation systems; (d) exchange of information; (e) systems to monitor provider access including assignment of Primary Care Physician.	* EQRO reviews MOUs and policies as well as minutes of meetings and data as available on referrals and shared clients, procedures and processes for sharing information, etc. * Focus groups with health plans, primary care and mental health to discuss care coordination, joint programs, and information exchange by EQRO. * Review of annual submission of Treatment Perceptions Survey (TPS) data, utilized to collect client experience of care. The TPS includes questions on coordination of care. Review data.	Measure is required in EQRO contract. UCLA evaluation activity linked to this measure as well.	Mandatory

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7	Access	Timeliness of services of the first medication dose for narcotic treatment program (NTP) services.	Timely NTP Treatment Access: 1. Average number of days from triage/assessment contact to the first dose of NTP services for opioid use disorder (OUD) diagnoses.	*Claims data.	This measure is critical to determine the benefit of NTP treatment for OUDs. This measure will be used to track timely access to care as well as successful engagement. Assessments can sometimes be done by Primary Care or Emergency Room (ER) Physicians under fee for service (FFS). These cannot be included as DMC claims and these visits will not be included in the assessment.	Flexible
8	Access & Quality Outcomes	MAT enhanced access to care * One of three Federal Priorities for Opioid Crisis.	Expanded medication assisted treatment (MAT) services in DMC-ODS funded programs: 1. Number and Percentage of clients receiving three or more MAT visits per year provided through DMC-ODS Providers. 2. Review improved MAT access in each year of the Waiver. 3. Total annual number of unduplicated clients with MAT visits with demographic breakdown.	* DMC-ODS only MAT Claims (not FFS claims on the healthcare side), including breakdown by type of medication provided if bundled payment.	Best practice per SUD outcome research is to offer treatment services with MAT if medically appropriate. Measure will track access to all DMC funded MAT services. Waiver goal is expanding known best practice to support sustained SUD recovery by expanding MAT.	Flexible

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9	Quality	Smooth transitions in ASAM care. Frequency of follow-up appointment by LOC. Frequency of follow-up appointments in accordance with individualized treatment plans.	ASAM Fidelity/Avoiding Relapse with smooth transitions between LOCs in ASAM continuum: 1. Average days until first clinical appointment in next LOC after discharge from another LOC. Monitor percentage within 7, 14 and 30 days. For the first year of the Waiver, this PM will focus on residential LOC transitions to all LOCs, including movement between ASAM levels of residential.	* Claims data by ASAM LOC and all Medi-Cal billable services. * EQRO client focus group feedback on transitions to other services.	Smooth transitions between LOC is important in ASAM fidelity to support best outcomes. Average days to next LOC is particularly important for withdrawal management and residential treatment. Clients at risk of relapse if not done in timely manner with transfer of therapeutic alliance. EQRO Contract requirement effectiveness of services and timely access.	Flexible
10	Access	Access Line Capacities are linked to access and quality. Details in STCs and contract language.	Access Call Center Quality & Timeliness: Access Call Center volumes by month including dropped calls, time to answer calls, numbers of referrals to treatment, and non-English calls.	* For each year of the Waiver: • County call center logs or data • Residential Authorizations • Access Center referrals to all DMC-ODS treatment sites * EQRO will provide form to complete a data summary of these access center elements.	EQRO visit review at the onsite visit. Each DMC-ODS will have data form to complete on call center. (This is ideal area for performance improvement projects (PIPs)).	Flexible

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11	Quality	High Cost/High Utilization Beneficiaries in DMC-ODS needing specialized care and coordination	Enhanced care coordination and individualized treatment for high cost/high complexity clients: 1. Measure the number and percentage of high cost/ high utilizer beneficiaries out of the total served 2. Enhanced analysis of clients by demographic groups. A comparison will also be completed regionally, by county size and statewide for each year of the Waiver. Reports by diagnoses and aid code groupings (Disabled, Foster Care, Families, Pregnancy, Criminal Justice) also available.	*Claims data linked to MMEF eligibility.	Measure identifies opportunities to improve care with case management and special treatment plans. Clients often have co-occurring disorders, health problems, and social disparities such as lack of housing. Counties can use risk factors for earlier intervention.	Flexible
12	Quality	Cost effective use of resources for treatment	Cost effectiveness & engagement: 1. Percentage of clients with three or more withdrawal management episodes in a year and no other DMC-ODS treatment.	* Claims data with MMEF for demographic breakdown.	This measure is a negative indicator. Measure shows lost opportunities for successful engagement and a questionable use of expensive resources. This measure is similar to MH Acute care measure for linkage to treatment after stabilization in inpatient care.	Flexible

Note: The EQRO team will bring the performance metrics data for your county and the data will be uploaded onto BOX

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Aid Code Categories – Medi-Cal has many categories of aid codes for Medicaid eligibility covered in CA. They include but are not limited to persons with disabilities, seniors, families, youth, foster care youth, persons eligible because of the Affordable Care Act or other unique programs. These categories are used in data analysis to determine the impact of services and programs on special populations.

ASAM Assessment (ASAM)– American Society of Addiction Medicine approved assessment structure which includes 6 dimensions and recommends a specific level of care based on the treatment model matching client needs with their optimal level of care.

Beneficiaries/Clients – persons eligible for Medi-Cal and getting services from DMC-ODS.

Center for Medicaid & Medicare Services (CMS) – federal agency overseeing health programs funded by the federal government, particularly Medicare and Medicaid.

CLAS standards (Cultural and Linguistically Appropriate Services)– Standards and cultural competence requirements set by the federal government for SAPT federal block grant program for substance use disorders.

DMC-ODS County (DMC-ODS) – Drug Medi-Cal Organized Delivery System for counties or groups of counties to deliver a set of substance use treatment services to Medi-Cal beneficiaries. Requirements are defined by the federal waiver in the STCs and specific policy letters and information notices.

External Quality Review Organization (EQRO) – an independent agency reviewing Medicaid plans and programs for several key components of care – access, timeliness, and quality and soon network adequacy. This is a federal requirement for specific programs under Medicaid.

Fee-for-Service Medi-Cal (FFS)– claiming system for Health Plan Medi-Cal providers including primary care clinics, hospitals, ancillary medical providers, and pharmacies, etc. They often serve individuals with SUD and provide some MAT and counseling, but this is not reflected in the DMC-ODS claims data.

Flexible Performance Measure (FPM) – a measure which could change with DHCS approve to address specific concerns related to access, timeliness, and quality of care for the DMC-ODS Program.

Mandatory Performance Measure (MPM)– a measure such as timely access which is required by federal government and part of the EQRO contract to fulfill mandated monitoring activities linked to quality. It will be measured each year of the Waiver.

Medication Assisted Treatment (MAT) – this treatment includes a range of medications to help individuals working on recovery from substance use disorders (SUD) and can be provided in a variety of treatment settings from inpatient to outpatients.

Memorandum of Understanding (MOU) – this is an agreement between two or more programs related to services and processes to coordinate care. This is required between the DMC-ODS counties and the Health Plans and Mental Health Plans. Other MOUs are also common with criminal justice, child protective services, and schools.

MMEF – Medi-Cal eligibility files which contain detailed information on ethnicity, preferred language, living situation, etc.

Narcotic Treatment Programs (NTP) which are part of the DMC-ODS continuum of care.

Performance Measure (PM)- metric to measure key indicators linked to quality of care by External Quality Review Organization (EQRO) as required by federal government for Medicaid beneficiaries.

Standard Terms and Conditions (STCs)- Standard terms and conditions for federal waiver for DMC-ODS.

State and County Intergovernmental Agreement (IA) – contract between DHCS and the DMC-ODS county, which includes requirements for the participation in the DMC-ODS Waiver.

Washington Circle Group – this is a national group of specialists in SUD treatment who have been working on national standards for measuring quality indicators and metrics for SUD treatment.

UCLA SUD program – special unit of the University of CA which is studying the impact of the waiver on SUD services and utilization.