



State of California—Health and Human Services Agency  
Department of Health Care Services



GAVIN NEWSOM  
GOVERNOR

DATE: December 17, 2021

Behavioral Health Information Notice No: 21-075

TO: California Alliance of Child and Family Services  
California Association for Alcohol/Drug Educators  
California Association of Alcohol & Drug Program Executives, Inc.  
California Association of DUI Treatment Programs  
California Association of Social Rehabilitation Agencies  
California Consortium of Addiction Programs and Professionals  
California Council of Community Behavioral Health Agencies  
California Hospital Association  
California Opioid Maintenance Providers  
California State Association of Counties  
Coalition of Alcohol and Drug Associations  
County Behavioral Health Directors  
County Behavioral Health Directors Association of California  
County Drug & Alcohol Administrators

SUBJECT: Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026

PURPOSE: To provide DMC-ODS program requirements pursuant to CalAIM, effective January 2022 through December 2026, including program updates, which replace the Section 1115 Standard Terms and Conditions used to describe the DMC-ODS program for the years 2015-2021.

SUPERSEDES: [MHSUDS IN 16-005](#); [MHSUDS IN 16-042](#); [MHSUDS IN 16-044](#); [MHSUDS IN 16-048](#); [MHSUDS IN 17-008](#); [MHSUDS IN 17-022](#); [MHSUDS 17-045](#); [MHSUDS IN 18-001](#); [MHSUDS IN 18-005](#); [MHSUDS IN 19-018](#); [MHSUDS IN 19-022](#)

REFERENCE: [Welfare and Institutions Code \(W&I\) section 14184.401](#); [W&I Code section 14184.402](#); [Medicaid State Plan](#) (Supplement 3 to Attachment 3.1-A, and Supplement 2 to Attachment 3.1-B)

#### BACKGROUND:

CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program. DHCS conducted broad stakeholder engagement to elicit county, provider and beneficiary feedback on how to improve Medi-Cal programs, including the DMC-ODS. As a result of that input, DHCS proposed to the Centers for Medicare and Medicaid Services (CMS) a set of updates to DMC-ODS, some of which CMS approved for the January – December 2021 extension period (see Behavioral Health Information Notices (BHINs) [21-019](#), [21-020](#), [21-021](#), and [21-024](#)), and others which will be effective January 2022. The following policy guidance implements those updates.

In addition, the following policy guidance updates and replaces the Section 1115 Standard Terms and Conditions (STCs) that were used to describe the DMC-ODS program for the years 2015-2021. In accordance with W&I § 14184.102(d), until county contract amendments are executed, DMC-ODS counties shall adhere to the terms of this Information Notice where current contracts are silent or in conflict with the terms of this Information Notice.

#### POLICY:

##### **Drug Medi-Cal Organized Delivery System**

DMC-ODS is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS. Since the DMC-ODS pilot program began in 2015, all California counties have had the option to participate in the program to provide their resident Medi-Cal beneficiaries with a range of evidence-based SUD treatment services in addition to those available under the Medi-Cal State Plan. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care.

Any county, or consortium of counties in a regional model, or Tribal or Indian managed care entity that elects to opt in to the DMC-ODS (hereinafter referred to as “DMC-ODS County”), that does not already have a DHCS-approved implementation plan, must submit an implementation plan using the template provided in Enclosure 4 to DHCS for approval. Upon DHCS approval, DHCS will enter into an intergovernmental agreement with the DMC-ODS County (or consortium of counties in a regional model, or Tribal or Indian managed care entity), to administer DMC-ODS through a Prepaid Inpatient

Health Plan as defined in 42 CFR 438.2 or 42 CFR 438.14 respectively. To receive services through the DMC-ODS, a beneficiary must be enrolled in Medi-Cal, reside in a participating county, and meet the criteria for DMC-ODS services established below in the “DMC-ODS Program Criteria for Services” subsection.

The DMC-ODS County (or consortium of counties through a regional model, or Tribal or Indian managed care entity) shall provide or arrange for all DMC-ODS services and all providers shall be Drug Medi-Cal certified. DMC-ODS Counties, consortia of counties through a regional model, and Tribal or Indian managed care entities may also contract with a Managed Care Plan (MCP) to provide services. DMC-ODS Counties, consortia of counties through a regional model, or Tribal or Indian managed care entities may request flexibility in delivery system design subject to DHCS approval.

### **EPSDT**

In accordance with the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under [Section 1905\(r\) of the Social Security Act](#), all Counties, irrespective of their participation in the DMC-ODS program, shall ensure that all beneficiaries under age 21 receive all applicable SUD services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act. Nothing in the DMC-ODS limits or modifies the scope of the EPSDT mandate. DMC-ODS counties are responsible for the provision of SUD services pursuant to the EPSDT mandate. Counties should refer to forthcoming DHCS guidance regarding Medi-Cal SUD treatment services for beneficiaries under age 21 for further compliance with EPSDT requirements.

### **DMC-ODS Program Criteria for Services**

Medi-Cal beneficiaries whose county of responsibility is a DMC-ODS county are able to receive DMC-ODS services consistent with the following assessment, access, and level of care determination criteria.<sup>1</sup>

#### ***Initial Assessment and Services Provided During the Assessment Process<sup>2</sup>***

Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if the beneficiary is under age 21, or if a provider documents that the client is experiencing homelessness and therefore requires

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<sup>1</sup> Counties should refer to forthcoming DHCS guidance regarding Medi-Cal SUD treatment services for beneficiaries under age 21 for further compliance with EPSDT requirements.

<sup>2</sup> This subsection of the BHIN supersedes [MHSUDS IN 16-044](#)

additional time to complete the assessment. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day time period starts over.

The initial assessment shall be performed face-to-face, by telehealth (“telehealth” throughout this document is defined as synchronous audio and video) or by telephone (synchronous audio-only) by an LPHA or registered or certified counselor and may be done in the community or the home.<sup>3</sup> If the assessment of the beneficiary is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

*DMC-ODS Access Criteria for Beneficiaries After Assessment*

- a. *Beneficiaries 21 years and older:* To qualify for DMC-ODS services after the initial assessment process, beneficiaries 21 years of age and older must meet one of the following criteria:
  - i. Have at least one diagnosis from DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, OR
  - ii. Have had at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.
- b. *Beneficiaries under the age of 21:* Beneficiaries under age 21 qualify to receive all medically necessary DMC-ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state’s Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable

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<sup>3</sup> Narcotic Treatment Programs (NTPs) shall conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies for the purpose of determining medical necessity under the DMC-ODS

substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

*Additional Coverage Requirements and Clarifications*

Consistent with [W&I Code section 14184.402\(f\)](#), covered SUD prevention, screening, assessment, and treatment services are reimbursable Medi-Cal services when:

- 1) Services are provided prior to determination of a diagnosis or prior to determination of whether DMC-ODS criteria are met, as described above;
- 2) The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or
- 3) The beneficiary has a co-occurring mental health condition.

Regarding (1), clinically appropriate and covered DMC-ODS services provided to beneficiaries over 21 are reimbursable during the assessment process as described above in the *“Initial Assessment and Services Provided During the Assessment Process”* subsection. In addition, DMC-ODS county(ies) shall not disallow reimbursement for clinically appropriate and covered DMC-ODS services provided during the assessment process if the assessment determines that the beneficiary does **not** meet the *DMC-ODS Access Criteria for Beneficiaries After Assessment*.

This does not eliminate the requirement that all Medi-Cal claims, including DMC-ODS claims, include a CMS approved International Classification of Diseases, Tenth Revision (ICD-10) diagnosis code<sup>4</sup> as described in forthcoming DHCS guidance. In cases where services are provided due to a suspected SUD that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS approved ICD-10 diagnosis code list, for example, codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services”.

Regarding (2), forthcoming guidance will provide clarification regarding new policies and criteria for DMC-ODS documentation standards and requirements. The existing documentation standards and requirements remain in effect until replaced. However, for dates of service on or after January 1, 2022, DMC-ODS counties shall not disallow reimbursement for clinically appropriate and covered SUD prevention, screening, assessment, and treatment services due to lack of inclusion in an individual treatment plan, or lack of client signature on the treatment plan.

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<sup>4</sup> The ICD 10 Tabular (October 1<sup>st</sup> thru September 30<sup>th</sup>) at <https://www.cms.gov/medicare/icd-10/2022-icd-10-cm>

Regarding (3), medically necessary covered DMC-ODS services delivered by DMC-ODS providers are covered and reimbursable Medi-Cal services whether or not the beneficiary has a co-occurring mental health condition. DMC-ODS counties shall not disallow reimbursement for covered DMC-ODS services provided to a beneficiary who has a co-occurring mental health condition if the beneficiary meets the *DMC-ODS Criteria for Beneficiaries After Assessment*.

#### Level of Care Determination

The ASAM Criteria shall be used to determine placement into the appropriate level of care for all beneficiaries, and is separate and distinct from determining medical necessity.

- a. For beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with an LPHA or registered/certified counselor.
- b. For beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or registered/certified counselor.
- c. A full ASAM Criteria Assessment is not required to deliver prevention and early intervention services for beneficiaries under 21; a brief screening ASAM Criteria tool is sufficient for these services (see below regarding details about ASAM level of care 0.5).
- d. If a beneficiary withdraws from treatment prior to completing the ASAM Criteria assessment and later returns, the time period starts over.
- e. A full ASAM assessment, or initial provisional referral tool for preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services.
- f. A full ASAM assessment does not need to be repeated unless the beneficiary's condition changes.

Beneficiary placement and level of care determinations shall ensure that beneficiaries are able to receive care in the least intensive level of care that is clinically appropriate to treat their condition.

#### Medical Necessity of Services

DMC-ODS services must be medically necessary. Pursuant to W&I Section 14059.5(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service is necessary to correct or ameliorate screened health conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services. (Section 1396d(r)(5) of Title 42 of the United States Code; W&I Section 14059.5(b)(1)).

All DMC-ODS counties shall update policies and procedures, provider contracts, beneficiary handbooks, and related material to ensure the medical necessity standard is accurately reflected in all materials consistent with [W&I section 14059.5](#) and the terms of this BHIN.

### **Covered DMC-ODS Services**

DMC-ODS services include the following comprehensive continuum of outpatient, residential, and inpatient evidence-based SUD services. Service components are defined in Enclosure #1. Additional guidance on how service components should be claimed can be found in the [DMC/DMC-ODS Billing Manual](#). Please see Enclosure 2 for a quick reference table that depicts required and optional services/levels of care within the DMC-ODS benefits.

DMC-ODS services must be recommended by licensed practitioners of the healing arts, within the scope of their practice. DMC-ODS services are provided by DMC-certified providers and are based on medical necessity.

### **1. Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5)**

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) (commonly known as Screening, Brief Intervention, and Referral to Treatment, or SBIRT) is not a DMC-ODS benefit. It is a benefit in Medi-Cal Fee-for-Service and Medi-Cal managed care delivery system for beneficiaries aged 11 years and older.

Early intervention services are covered DMC-ODS services for beneficiaries under the age of 21. Any beneficiary under the age of 21 who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. An SUD diagnosis is not required for early intervention services. As noted above, this does not eliminate the requirement that all Medi-Cal claims,

including DMC-ODS claims, include a CMS approved ICD-10 diagnosis code.<sup>5</sup> In cases where services are provided due to a suspected SUD that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS approved ICD-10 diagnosis code list. For example, these include codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services”. Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the beneficiary under age 21 is not participating in the full array of outpatient treatment services.

A full assessment utilizing the ASAM criteria is not required for a DMC beneficiary under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used. If the beneficiary under 21 meets diagnostic criteria for SUD, a full ASAM assessment shall be performed and the beneficiary shall receive a referral to the appropriate level of care indicated by the assessment.

Early intervention services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone.

Nothing in this section limits or modifies the scope of the EPSDT mandate.

## **2. Outpatient Treatment Services (ASAM Level 1)**

Outpatient treatment services are provided to beneficiaries when medically necessary (offering up to nine hours a week for adults, and six hours a week for adolescents). Services may exceed the maximum based on individual medical necessity. Outpatient Treatment Services may be provided in person, by telehealth, or by telephone. Providers are required to either offer medications for addiction treatment (MAT, also known as medication-assisted treatment) directly, or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving outpatient treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient). Outpatient treatment services (also known as Outpatient Drug Free or ODF) include the following service components:

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<sup>5</sup> The ICD 10 Tabular (October 1<sup>st</sup> thru September 30<sup>th</sup>) at <https://www.cms.gov/medicare/icd-10/2022-icd-10-cm>



- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for Opioid Use Disorder (OUD)
- MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

3. *Intensive Outpatient Treatment Services (ASAM Level 2.1)*

Intensive Outpatient Treatment Services are provided to beneficiaries when medically necessary in a structured programming environment (offering a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents). Services may exceed the maximum based on individual medical necessity. Intensive Outpatient Treatment Services may be provided in person, by telehealth, or by telephone. Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving intensive outpatient treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient). Intensive Outpatient Treatment Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

4. Partial Hospitalization Services (ASAM Level 2.5)

Partial Hospitalization Services are delivered to beneficiaries when medically necessary in a clinically intensive programming environment (offering 20 or more hours of clinically intensive programming per week). Partial Hospitalization Services are clinically intensive programming designed to address the treatment needs of beneficiaries with severe SUD requiring more intensive treatment services than can be provided at lower levels of care. Services may be provided in person, by synchronous telehealth, or by telephone. Level 2.5 Partial Hospitalization Programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs that warrant daily monitoring or management, but that can be appropriately addressed in a structured outpatient setting. Providing this level of service is optional for DMC-ODS Counties. Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving partial hospitalization services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient). Partial Hospitalization Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

5. Residential Treatment and Inpatient Services (ASAM Levels 3.1 – 4.0) (This section of the BHIN supersedes [MHSUDS IN 16-042](#) and [MHSUDS IN 18-001](#))

Residential Treatment Services are delivered to beneficiaries when medically necessary in a short-term residential program corresponding to at least one of the following levels:

- Level 3.1 - Clinically Managed Low-Intensity residential Services
- Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
- Level 3.5 - Clinically Managed High Intensity Residential Services

Inpatient Treatment Services are delivered to beneficiaries when medically necessary in a short-term inpatient program corresponding to at least one of the following levels:

- Level 3.7 - Medically Monitored Intensive Inpatient Services
- Level 4.0 - Medically Managed Intensive Inpatient Services

All Residential and Inpatient Treatment services provided to a client while in a residential or inpatient treatment facility may be provided in person, by telehealth, or telephone. Telehealth and telephone services, when provided, shall supplement, not replace, the in-person services and the in-person treatment milieu; most services in a residential or inpatient facility shall be in-person. A client receiving Residential or Inpatient services pursuant to DMC-ODS, regardless of the length of stay, is a “short-term resident” of the residential or inpatient facility in which they are receiving the services. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. 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. Providers are required to either offer MAT directly, or have effective referral mechanisms in place to clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving residential treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient).

#### *Residential Treatment Services*

Residential Treatment services for adults in ASAM Levels 3.1, 3.3., and 3.5 are provided by DMC-certified providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes residential facilities licensed by DHCS, residential facilities licensed by the Department of Social Services, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health (DPH), and Freestanding Acute Psychiatric Hospitals (FAPHs) licensed by DPH.

All facilities delivering Residential Treatment services under DMC-ODS must also be designated as capable of delivering care consistent with the ASAM Criteria.

Residential treatment facilities licensed by DHCS offering ASAM levels 3.1, 3.3, 3.5, and 3.2-WM must also have a DHCS Level of Care (LOC) Designation and/or an [ASAM LOC Certification](#) that indicates that the program is capable of delivering care consistent with the ASAM Criteria.

In order to participate in the DMC-ODS program and offer ASAM Levels of Care 3.1, 3.3, or 3.5, residential providers licensed by a state agency other than DHCS must be DMC-certified. In addition, facilities licensed by a state agency other than DHCS must have an ASAM LOC Certification for each level of care provided by the facility under the DMC-ODS program by January 1, 2024. DMC-ODS counties will be responsible for ensuring and verifying that DMC-ODS providers delivering ASAM Levels of care 3.1, 3.3 or 3.5 obtain an ASAM LOC Certification for each level of care provided effective January 1, 2024.

Residential Treatment services can be provided in facilities of any size. The statewide goal for the average length of stay for residential treatment services provided by participating counties is 30 days. The goal for a statewide average length of stay for residential services of 30 days is not a quantitative treatment limitation or hard “cap” on individual stays; lengths of stay in residential treatment settings shall be determined by individualized clinical need. Counties shall ensure that beneficiaries receiving residential treatment are transitioned to another level of care when clinically appropriate based on treatment progress. DMC-ODS Counties shall adhere to the length of stay monitoring requirements set forth by DHCS and length of stay performance measures established by DHCS and reported by the external quality review organization.

DMC-ODS counties shall implement coverage and ensure access for residential SUD treatment services as follows:

- At least one ASAM level of care upon implementation
- ASAM Level 3.5 available within two years of DMC-ODS implementation
- ASAM Levels 3.1-3.5 available within three years of DMC-ODS implementation

Residential Treatment Services include the following services:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

### *Inpatient Services*

DMC-ODS counties are able to voluntarily cover and receive reimbursement through the DMC-ODS program for inpatient ASAM Levels 3.7 and 4.0 delivered in general acute care hospitals, FAPs, or CDRHs. Regardless of whether the DMC-ODS county covers ASAM Levels 3.7 or 4.0, the DMC-ODS County implementation plan must describe referral mechanisms and care coordination for ASAM Levels 3.7 and 4.0. [DHCS All-Plan Letter 18-001](#) clarifies coverage of voluntary inpatient detoxification through the Medi-Cal Fee-For-Service program.

In order to participate in the DMC-ODS program and offer ASAM Levels of Care 3.7 and 4.0, inpatient providers licensed by a state agency other than DHCS must be DMC-certified.

Inpatient Treatment Services include the following services:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

6. *Narcotic Treatment Program (This section of the information notice supersedes MHSUDS IN 16-048)*

Narcotic Treatment Program (NTP), also described in the ASAM criteria as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), disulfiram, and naloxone. If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the beneficiary to a provider capable of dispensing the medication. The

NTP shall offer the beneficiary a minimum of fifty minutes of counseling services per calendar month. NTPs shall comply with all federal and state NTP licensing requirements. If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. NTP services are provided in DHCS-licensed NTP facilities pursuant to the California Code of Regulations, Title 9, Chapter 4, Division 4, and title 42 of the CFR. Counseling services provided in the NTP modality can be provided in person, by telehealth, or by telephone. However, the medical evaluation for methadone treatment (which consists of a medical history, laboratory tests, and a physical exam) must be conducted in-person. NTP Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medical Psychotherapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

7. *Withdrawal Management Services*

Withdrawal Management Services are provided to beneficiaries experiencing withdrawal in the following outpatient and residential settings:

- Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision)
- Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting)
- Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting)

- Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits)
- Level 4-WM: Medically managed intensive inpatient withdrawal management (Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability)

Withdrawal Management Services include the following service components:

- Assessment
- Care Coordination
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Observation
- Recovery Services

Withdrawal Management Services may be provided in an outpatient, residential or inpatient setting. If beneficiary is receiving Withdrawal Management in a residential setting, each beneficiary shall reside at the facility. All beneficiaries receiving Withdrawal Management services, regardless in which type of setting, shall be monitored during the detoxification process. Providers are required to either offer MAT directly, or have effective referral mechanisms to the most clinically appropriate MAT services in place (defined as facilitating access to MAT off-site for beneficiaries while they are receiving withdrawal management services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient).

Withdrawal management services are urgent and provided on a short-term basis. When provided as part of withdrawal management services, service activities, such as the assessment, focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where comprehensive treatment services are provided. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate. If it has not already been completed in relation to the Withdrawal Management episode, the full ASAM Criteria assessment shall

be completed within 30 days of the beneficiary's first visit with an LPHA or registered/certified counselor for non-Withdrawal Management services (or 60 days for beneficiaries under 21, or beneficiaries experiencing homelessness), as described above.

8. *Medications for Addiction Treatment (also known as medication-assisted treatment or MAT)*

Medications for addiction treatment include all FDA-approved medications and biological products to treat AUD, OUD, and any SUD. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed in this "Covered DMC-ODS Services" section. MAT may be provided with the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services
- Withdrawal Management Services

9. *Peer Support Services (This section of the information notice supersedes MHSUDS IN 17-008. For additional guidance regarding Peer Support Specialist Certification, please refer to [BHIN 21-041](#).)*

Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Peer support services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other people supporting the beneficiary (defined as collaterals) if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals. Peer Support Services are delivered and claimed as a standalone service. Beneficiaries may



concurrently receive Peer Support Services and services from other levels of care described in this “Covered DMC-ODS Services” section.

Peer support services are based on a plan of care approved by a Behavioral Health Professional (see definition of Behavioral Health Professional below; this term is specific to the administration of Peer Support Services). Peer Support Services consist of Educational Skill Building Groups, Engagement and Therapeutic Activity services as defined below:

- Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement services means activities and coaching led by Peer Support Specialists to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.
- Therapeutic Activity means a structured non-clinical activity provided by Peer Support Specialists to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary’s treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification. The individual must meet all other applicable California state requirements, including ongoing education requirements. Peer Support Specialists must provide services under the direction of a Behavioral Health Professional. Behavioral Health Professionals must be licensed, waived, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of DMC-ODS or

Specialty Mental Health Services.<sup>6</sup> Although Peer Support Services must be provided under the direction of a Behavioral Health Professional, Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements. For additional guidance regarding Peer Support Specialist Certification information and Peer Support Specialist Supervisor standards, please refer to [BHIN 21-041](#).

Peer Support Services will be implemented as a county option and have an effective date of July 1, 2022. Counties that choose to opt in to cover the Peer Support Services benefit will be required to notify DHCS of their implementation date. DHCS will issue forthcoming guidance regarding county implementation of Peer Support Services.

10. Recovery Services

Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary'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 beneficiaries. Beneficiaries may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services. Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD. Services may be provided in person, by telehealth, or by telephone. Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care described in this "Covered DMC-ODS Services" section, or as a service delivered as part of these levels of care.<sup>7</sup>

Recovery Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy

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<sup>6</sup> See [Supplement 3 to Attachment 3.1-A](#) of the California State Plan. DMC-ODS services are described in the "Expanded SUD Treatment Services" section.

<sup>7</sup> For additional information, see BHIN 21-020. Available at <https://www.dhcs.ca.gov/Documents/BHIN-21-020-DMC-ODS-Clarification-on-Recovery-Services.pdf>.

- Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the beneficiary's SUD.
- Relapse Prevention, which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary's SUD.

11. *Care Coordination* (This section of the information notice supersedes [MHSUDS IN 18-005](#) and in part [MHSUDS IN 17-045](#) regarding the Healthcare Common Procedure Coding System (HCPCS) codes for claiming Case Management) Care coordination was previously referred to as “case management” in the Section 1115 STCs that were used to describe the DMC-ODS program for the years 2015-2021. Per CMS feedback, DHCS has retitled and re-described this benefit as “care coordination.”

Care coordination shall be provided to a client in conjunction with all levels of treatment. It may also be delivered and claimed as a standalone service. DMC-ODS Counties, through executed memoranda of understanding, shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness.

Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care coordination can be provided in clinical or non-clinical settings (including the community) and can be provided face-to-face, by telehealth, or by telephone. Care coordination includes one or more of the following components:

- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
- Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, child care, child development, family/marriage education, cultural sources, and mutual aid support groups.

**12. Clinician Consultation (This section of the information notice supersedes, in part, [MHSUDS IN 17-045](#) regarding the Healthcare Common Procedure Coding System (HCPCS) codes for claiming Physician Consultation)**

Clinician Consultation replaces and expands the previous “Physician Consultation” service referred to in the Section 1115 STCs that were used to describe the DMC-ODS program during the years 2015-2021.

Clinician Consultation consists of DMC-ODS LPHAs consulting with LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care.

Clinician Consultation is not a direct service provided to DMC-ODS beneficiaries. Rather, Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS beneficiaries. DMC-ODS Counties may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services. These consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems.

**MAT Policy Clarifications<sup>8</sup>**

**Previous DMC-ODS MAT Policy**

Originally in the DMC-ODS 1115 Waiver, methadone, buprenorphine, naloxone and disulfiram were only available in the NTP setting. However, under the “MAT Delivered at Alternative Sites” option, DMC-ODS counties had the option to cover drug product costs for MAT when the medications are purchased and administered or dispensed outside of the pharmacy or NTP benefit (in other words, purchased by providers and administered or dispensed on-site or in the community, and billed to the county DMC-ODS plan). DMC-ODS counties that made this election could then reimburse providers for the medications, such as naloxone, trans-mucosal buprenorphine, and/or long-acting injectable medications (such as buprenorphine or naltrexone), administered in DMC facilities, justice settings, and non-clinical or community settings.

On December 29, 2020, DHCS obtained a one-year extension for the DMC-ODS 1115 Waiver. In the DMC-ODS one-year extension, the required MAT medications were expanded to include all medications and biological products Food and Drug administration (FDA)-approved to treat OUDs and AUDs. Additionally, DMC-ODS

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<sup>8</sup> See BHIN 21-024. Available at <https://www.dhcs.ca.gov/Documents/BHIN-21-024-DMC-ODS-Expanding-Access-to-Medications-for-Addiction-Treatment-MAT.pdf>.

counties were required to ensure that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanisms/process to MAT to beneficiaries with SUD diagnoses. Furthermore, under the “MAT Delivered at Alternative Sites” option, DMC-ODS counties had the option to cover drug product costs for MAT when the medications are purchased and administered or dispensed in a non-clinical setting (e.g. criminal justice settings or street-based outreach).

#### CalAIM DMC-ODS MAT Policy

Under CalAIM, DMC-ODS counties shall ensure that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanism to the most clinically appropriate MAT services for beneficiaries with SUD diagnoses that are treatable with medications or biological products (defined as facilitating access to MAT off-site for beneficiaries if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient). An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary is compliant whether or not that provider seeks reimbursement through DMC-ODS. DMC-ODS Counties shall monitor the referral process or provision of MAT services.

DMC-ODS counties still have the option to cover drug product costs for MAT when the medications are purchased and administered or dispensed outside of the pharmacy or NTP benefit (in other words, purchased by providers and administered or dispensed on-site or in the community, and billed to the county DMC-ODS plan). DMC-ODS counties that make this election could reimburse providers for the medications, including naloxone, trans-mucosal buprenorphine, and/or long-acting injectable medications (such as buprenorphine or naltrexone), administered in DMC facilities, and non-clinical or community settings.

However, consistent with the DMC-ODS State Plan and as described above in the “Covered DMC-ODS Services” section, even if DMC-ODS counties do not choose to cover the drug product costs for MAT outside of the pharmacy or NTP benefit, DMC-ODS counties are still required to reimburse for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a standalone service.

All medications and biological products utilized to treat SUDs, including long-acting injectables, continue to be available through the Medi-Cal pharmacy benefit without prior authorization, and can be delivered to provider offices by pharmacies.

Beneficiaries needing or utilizing MAT must be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program.

DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a beneficiary who declines counseling services. For patients with lack of connection to psychosocial services, more rigorous attempts at engagement in care may be indicated, such as using different evidence-based practices, different modalities (e.g., telehealth), different staff, and/or different services (e.g., peer support services). If the DMC-ODS provider is not capable of continuing to treat the beneficiary, the DMC-ODS provider must assist the member in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement.

#### **DMC-ODS Provider Qualifications**

DMC-ODS services are provided by DMC-certified providers. DMC certified providers providing DMC-ODS services must: 1) be licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations; 2) abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services; and 3) sign a provider agreement with the DMC-ODS county or counties in which DMC-ODS services will be rendered.

	DMC-ODS Services										
	Assessment*	Care Coordination**	Crisis Intervention	Family Therapy	Counseling (Individual & Group)	Medical Psychotherapy	Medication Services	Patient Education	Peer Support Services	Observation	Recovery Services
Practitioner Qualifications	C, L*	C, L	C, L	L	C, L	M	C, L	C, L	P	C, L***	C, L

C = Counselors

An Alcohol or other Drug (AOD) counselor that is 1) either certified or registered by an organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA), and 2) meets all California State education, training, and work experience requirements set forth in the Counselor Certification Regulations, Title 9, Division 4, Chapter 8.

L = Licensed Practitioner of the Healing Arts

A Licensed Practitioner of the Healing Arts (LPHA) includes any of the following: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioner registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician.

M = Medical director of a Narcotic Treatment Program

The medical director of a Narcotic Treatment Program is a licensed physician in the State of California.

P = Peer Support Specialist

A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and must meet all other applicable California state requirements, including ongoing education requirements. Peer Support Specialists provide services under the direction of a Behavioral Health Professional. For additional guidance, please refer to [BHIN 21-041](#).

**Notes**

\* The physical examination by an LPHA in accordance within their scope of practice and licensure. An SUD diagnosis may only be made by an LPHA.

\*\* Certified counselors may assist with some aspects of this service, however, a licensed provider is responsible for this service component.

\*\*\* All personnel performing observations must comply with applicable California State withdrawal management training requirements.

### Indian Health Care Providers

American Indian and Alaska Native individuals who are eligible for Medicaid and reside in counties that have opted in to the DMC-ODS can also receive DMC-ODS services through Indian Health Care Providers (IHCPs). Please refer to [BHIN 20-065](#) for additional guidance.

IHCPs include:

- *Indian Health Service (IHS) facilities* – Facilities and/or health care programs administered and staffed by the federal Indian Health Service.
- *Tribal 638 Providers* – Federally recognized Tribes or Tribal organizations that contract or compact with IHS to plan, conduct and administer one or more individual programs, functions, services or activities under Public Law 93-638.
  - Tribal 638 providers enrolled in Medi-Cal as an Indian Health Services-Memorandum of Agreement (IHS-MOA) provider must appear on the “[List of American Indian Health Program Providers](#)” set forth in [APL 17-020](#), Attachment 1 in order to qualify for reimbursement as a Tribal 638 Provider under this BHIN.
  - Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC provider, must do so consistent with the Tribal FQHC criteria established in the California State Plan, the Tribal FQHC section of the Medi-Cal provider manual, and [APL 21-008](#).<sup>9</sup> Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the “[List of Tribal Federally Qualified Health Center Providers](#)”
- *Urban Indian Organizations (UIO)* – A Nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of U.S. Code: Title 25, Chapter 18.

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<sup>9</sup> See Supplement 6 to Attachment 4.19-B of the California Medicaid State Plan. The Tribal FQHC section of the Medi-Cal provider manual is available [here](#).

APL 21-008 is available at:

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL-21-008.pdf>.



All American Indian and Alaska Native (AI/AN) Medi-Cal beneficiaries whose county of responsibility is a DMC-ODS county may choose to receive DMC-ODS services at any DMC-certified IHCP, whether or not the IHCP has a current contract with the beneficiary's county of responsibility and whether or not the IHCP is located in the beneficiary's county of responsibility. DMC-ODS counties must reimburse DMC-certified IHCPs for the provision of these services to AI/AN Medi-Cal beneficiaries, even if the DMC-ODS county does not have a contract with the IHCP. DMC-ODS counties are not obligated to pay for services provided to non-AI/AN beneficiaries by IHCPs that are not contracted with the DMC-ODS county.<sup>10</sup>

In order to receive reimbursement from a county or the state for the provision of DMC-ODS services (whether or not the IHCP is contracted with the county), an IHCP must be enrolled as a DMC provider and certified by DHCS to provide those services. As required by 42 CFR 438.14, DMC-ODS Counties must demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to DMC-ODS services. DMC-ODS Counties must adhere to all 42 CFR 438.14 requirements.<sup>11</sup>

### **Responsibilities of DMC-ODS Counties for DMC-ODS Benefits**

The responsibilities of DMC-ODS Counties for the DMC-ODS benefit shall be included in each DMC-ODS County's intergovernmental agreement with DHCS and shall require the DMC-ODS Counties to comply with the following.

#### **Selective Provider Contracting Requirements for DMC-ODS Counties (This section of the information notice supersedes [MHSUDS IN 19-018](#))**

DMC-ODS Counties select the DMC-certified providers with whom they contract to establish their DMC-ODS provider networks, with the exception of IHCPs as described above in the "Indian Health Care Providers" section. DMC-certified providers that do not receive a DMC-ODS County contract cannot receive a direct contract with the State to provide services to residents of DMC-ODS Counties.

#### **Contract Denial and Appeal Process**

Counties shall serve providers that apply to be a contract provider but are not selected a written decision including the basis for the denial.

Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision. Counties shall have a protest procedure for providers that are not awarded a contract. The protest procedure shall include requirements outlined in the State/County contract. Providers that submit a bid to be a contract provider, but

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<sup>10</sup> [See BHIN No. 20-065 for additional information.](#)

<sup>11</sup> [See BHIN No. 20-065 for additional information.](#)

are not selected, must exhaust the county's protest procedure if a provider wishes to challenge the denial to DHCS. If the county does not render a decision within 30 calendar days after the protest was filed with the county, the protest shall be deemed denied and the provider may appeal the failure to DHCS. A provider may appeal to DHCS as outlined in Enclosure 4.

*Residential and Inpatient Treatment Provider*

DMC-ODS counties will be responsible for ensuring and verifying that DMC-ODS residential treatment providers licensed by a state agency other than DHCS obtain an ASAM LOC Certification effective January 1, 2024. By January 1, 2024, all providers delivering Residential Treatment services Levels 3.1, 3.3, or 3.5 billed to DMC-ODS must have either a DHCS LOC Designation and/or an ASAM LOC Certification.

*Access*

Each DMC-ODS County must ensure that all required services covered under the DMC-ODS are available and accessible to enrollees of the DMC-ODS in accordance with the applicable state and federal time and distance standards for network providers developed by the DHCS, including those set forth in 42 CFR 438.68, and W&I Section 14197 and any Information Notices issued pursuant to those requirements. Access to medically necessary services, including all FDA-approved medications for OUD, cannot be denied for beneficiaries meeting criteria for DMC-ODS services nor shall beneficiaries be put on wait lists. DMC-ODS beneficiaries shall receive services from DMC-certified providers. All DMC-ODS services shall be furnished with reasonable promptness in accordance with federal Medicaid requirements and as specified in the State/DMC-ODS County Intergovernmental Agreement. If the DMC-ODS network is unable to provide medically necessary covered services, the DMC-ODS County must adequately and timely cover these services out-of-network for as long as the DMC-ODS County's network is unable to provide them.

*Authorization Policy for Residential/Inpatient Levels of Care*

DMC-ODS Counties shall provide prior authorization for residential and inpatient services (excluding withdrawal management services) within 24 hours of the prior authorization request being submitted by the provider. DMC-ODS Counties will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service.

*Authorization Policy for Non-Residential/Inpatient Levels of Care*

DMC-ODS Counties may not impose prior authorization or centralized DMC-ODS County-administered ASAM full assessments prior to provision of non-residential or non-inpatient assessment and treatment services, including withdrawal management

services. Brief ASAM-based screening tools may be used when beneficiaries call the DMC-ODS County's beneficiary access number to determine the appropriate location for treatment.

*Beneficiary Access Number*

All DMC-ODS Counties shall have a 24/7 toll free number for both prospective and current beneficiaries to call to access DMC-ODS services. Oral interpretation services and Text Telephone Relay or Telecommunications Relay Service (TTY/TRS) services must be made available for beneficiaries, as needed.

*DMC-ODS County of Responsibility*

The DMC-ODS County is responsible for ensuring that its residents with SUD receive appropriate covered treatment services. If a beneficiary is able to access all needed covered services, then the DMC-ODS County is not obligated to subcontract with additional providers to provide more choices for that individual beneficiary. However, in accordance with 42 CFR §438.206(b)(4), if the DMC-ODS County's provider network is unable to provide needed services to a particular beneficiary, the DMC-ODS County shall adequately and timely cover these services out-of-network for as long as the DMC-ODS County's network is unable to provide them.

42 CFR 438.62(b) requires that DHCS' transition of care policy ensures continued access to services during a transition from State Plan DMC to DMC-ODS or transition from one DMC-ODS county to another DMC-ODS county when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. As outlined in [MHSUDS 18-051](#), the DMC-ODS county must allow the beneficiary to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the beneficiary would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

Accordingly, the DMC-ODS County shall ensure that beneficiaries receiving NTP services and working in or travelling to a another county (including a county that does not opt in to the DMC-ODS program) do not experience a disruption of NTP services. In accordance with 42 CFR 438.206, if the DMC-ODS county's provider network is unable to provide necessary services to a particular beneficiary (e.g., when a beneficiary travels out of county and requires daily NTP dosing), the DMC-ODS county shall adequately and timely cover these services out-of-network for the beneficiary, for as long as the DMC-ODS county's provider network is unable to provide them. In these cases, the DMC-ODS county shall coordinate and cover the out-of-network NTP services for the beneficiary. If a beneficiary working in or travelling to another county is

not able to receive medically necessary DMC-ODS services, including NTP services, without paying “out of pocket”, the DMC-ODS county of responsibility has failed to comply with the requirements contained in 42 CFR 438.206.

If a beneficiary moves to a new county and initiates an inter-county transfer, the new county is immediately responsible for DMC-ODS treatment services and can claim reimbursement from DHCS through the Short Doyle Medi-Cal System, as of the date of the inter-county transfer initiation. Please see [BHIN 21-032](#) for policy clarifications on DMC-ODS County of Responsibility.

**Implementation Planning and Federal Approval Process *(This section of the information notice supersedes [MHSUDS IN 16-005](#), [MHSUDS IN 17-022](#), and [MHSUDS IN 19-022](#))***

New counties opting to become a DMC-ODS county must submit a DMC-ODS implementation plan to the State using the DMC-ODS implementation plan template included in Enclosure #3 to this BHIN. DMC-ODS Counties cannot commence services without an implementation plan being approved by the State and CMS, a readiness review being completed by the State, and their network being certified by the State. DMC-ODS Counties must also have an executed State/DMC-ODS County intergovernmental agreement with the DMC-ODS County Board of Supervisors and approved by CMS, as well as executed memoranda of understanding with all Medi-Cal MCPs operating within the DMC-ODS County.

In order to receive approval for their DMC-ODS County implementation plan, DMC-ODS counties shall implement coverage and ensure access for residential SUD treatment services as follows:

- At least one ASAM level of care upon implementation
- ASAM Level 3.5 available within two years of DMC-ODS implementation
- ASAM Levels 3.1-3.5 available within three years of DMC-ODS implementation

The DMC-ODS County implementation plan must describe referral mechanisms and care coordination for ASAM Levels 3.7 and 4.0 so beneficiaries can access those services, if not offered by the DMC-ODS County.

In addition, the DMC-ODS county implementation plan must implement coverage and ensure access for at least one level of withdrawal management upon implementation.

Upon CMS approval of an executed intergovernmental agreement, DMC-ODS Counties will be able to bill prospectively for all covered DMC-ODS services provided to their beneficiaries.

The intergovernmental agreement will provide further detailed requirements, including but not limited to service delivery, access, monitoring, appeals, and other state and federal requirements.

### **Practice Requirements**

DMC-ODS Counties shall ensure that providers implement at least two of the following evidenced-based treatment practices (EBPs) based on the timeline established in the DMC-ODS County implementation plan. The two EBPs are per provider, per service modality. DMC-ODS Counties shall ensure the providers have implemented EBPs and are delivering the practices to fidelity. The State will monitor the implementation of EBPs during reviews. The EBPs are:

- **Motivational Interviewing** – A beneficiary-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 beneficiaries’ 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.
- **Relapse Prevention** – A behavioral self-control program that teaches individuals with SUD 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 SUD treatment.
- **Trauma-Informed Treatment** – Services must 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 beneficiaries about substance abuse and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries’ lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

### **Intersection with the Criminal Justice System**

Beneficiaries involved in the criminal justice system are often harder to treat for SUD. While research has shown that the criminal justice population can respond effectively to treatment services, the beneficiary may require more intensive services. DMC-

ODS counties should recognize and educate staff and collaborative partners that Parole and Probation status is not a barrier to DMC-ODS. In addition, DMC-ODS counties shall ensure that beneficiaries may receive recovery services immediately after incarceration regardless of whether or not they received SUD treatment during incarceration.

### **DMC-ODS County Oversight, Monitoring, and Reporting**

In accordance with the intergovernmental agreement between the state and a DMC-ODS County, the DMC-ODS County shall have a Quality Improvement Plan that includes the DMC-ODS County's plan to monitor the capacity of service delivery as evidenced by a description of the current number, types, and geographic distribution of SUD treatment services. For DMC-ODS Counties that have an integrated mental health and SUD department, this Quality Improvement Plan may be combined with the Mental Health Plan (MHP) Quality Improvement Plan. DMC-ODS counties must oversee subcontractors' compliance through on-site monitoring reviews and monitoring report submissions to DHCS. DMC-ODS Counties are also required to comply with compliance monitoring reviews conducted by DHCS and are responsible to develop and implement Corrective Action Plans as needed. DMC-ODS requirements shall only apply to services provided to Medi-Cal beneficiaries and not to those provided to non-Medi-Cal patients receiving services in subcontractors' facilities.

### **DMC-ODS Financing**

January 1, 2022 through June 30, 2023

For claiming federal financial participation (FFP), Counties will certify the total allowable expenditures incurred in providing the DMC-ODS waiver services provided through county-operated providers (based on actual costs, consistent with a cost allocation methodology if warranted), contracted fee-for-service providers or contracted managed care plans (based on actual expenditures).

Participating counties shall propose county-specific interim rates for all covered DMC-ODS services that are provided by contracted providers, except for the NTP modality, and the State will approve or disapprove those rates. NTP reimbursement shall be set pursuant to the process set forth in Cal. Welf. & Inst. Code Section 14021.51. If during the State review process, the State denies the proposed rates, the county will be provided the opportunity to adjust the rates and resubmit to the State. The State shall retain all approval of the rates to assess that the rates are sufficient to ensure access to available DMC-ODS waiver services. For counties participating in a regional model, contracting with Medi-Cal MCPs to administer the DMC-ODS benefit, counties will reimburse the managed care organizations the contracted Per User Per Month (PUPM)

rate. The PUPM is reconciled to the lower of actual costs to the managed care plan or prevailing charges for the services rendered.

After services are provided, participating counties shall certify the total allowable public expenditures incurred in providing the DMC-ODS services provided, including costs incurred by county-operated providers (based on the county interim rate), or in payments to contracted fee-for-service (FFS) providers or contracted MCPs (based on actual expenditures by the county). Interim payments for county-operated providers will be settled based on the provider's allowable costs. All other interim payments are settled to the lower of actual cost or usual and customary charge. A CMS-approved Certified Expenditure Protocol (CPE) protocol, based on actual allowable costs, is required before Federal Financial Participation (FFP) associated with waiver services is made available to the State. This approved CPE protocol must explain the process the State will use to determine costs incurred by the counties.

SB 1020 (Statutes of 2012) created the permanent structure for the 2011 Realignment. It codified the Behavioral Health Subaccount that funds programs including Drug Medi-Cal. Allocations of Realignment funds run on a fiscal year of September 1 through August 30. The monthly allocations are dispersed to counties from the State Controller's Office. The Department of Finance develops schedules, in consultation with appropriate state agencies and the California State Association of Counties (CSAC), for the allocation of Behavioral Health Subaccount funds to the counties.

Subject to the participation standards and process to be established by the State, counties may also pilot an alternative reimbursement structure for a DMC-ODS modality if both the provider of that modality and the county mutually and contractually agree to participate, including use of case rates. The State and CMS will have the final approval of any alternative reimbursement structure pilot proposed by the county, and such pilot structure must continue to meet the terms and conditions expressed herein, including but not limited to the rate approval process described above. Counties may not utilize any alternative reimbursement structure until approval is received from DHCS and CMS.

July 1, 2023 and ongoing

DHCS will use intergovernmental transfers from all participating counties to finance the nonfederal share of all DMC-ODS payments. All participating counties receive a monthly allocation from the Local Revenue Fund 2011 (2011 Realignment) that is restricted to providing Medi-Cal Specialty Mental Health Services, Drug Medi-Cal Services, and other non-Medi-Cal SUD services. All participating counties must first meet the needs of Medi-Cal beneficiaries before spending these restricted funds on non-Medi-Cal services. All participating counties will make monthly transfers to DHCS

from these and any other funds eligible under federal law for federal Medicaid reimbursement to finance the nonfederal share of all DMC-ODS payments. Participating nonregional counties will be reimbursed pursuant to a fee schedule for all covered DMC-ODS services.

**External Quality Review**

DMC-ODS Counties will include in their implementation plan a strategy and timeline for meeting External Quality Review (EQR) requirements (438.310–370). For new DMC-ODS Counties opting into the ODS, EQR requirements must be phased in within 12 months of having an approved implementation plan.

**Network Adequacy Requirements**

DMC-ODS Counties are required to comply with network adequacy requirements. DMC-ODS Counties will be required to submit executed memoranda of understanding with county MCPs and complete the State's readiness review.

Please contact [countysupport@dhcs.ca.gov](mailto:countysupport@dhcs.ca.gov) for questions.

**List of Enclosures**

1. Definitions
2. ASAM Criteria Continuum of Care and the DMC-ODS Program
3. County Implementation Plan Template
4. Provider Appeals Process

Sincerely,

Original signed by

Shaina Zurlin, PsyD, LCSW, Chief  
Medi-Cal Behavioral Health

Enclosures (below)



## ENCLOSURE 1

### Definitions

“Adolescent” refers to beneficiaries under age 21.

“*Assessment*” consists of activities to evaluate or monitor the status of a beneficiary’s behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards.<sup>12</sup> Assessment may be initial and periodic, and may include contact with family members or other collaterals if the purpose of the collateral’s participation is to focus on the treatment needs of the beneficiary. Assessment services may include one or more of the following components:

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
- Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under the “Other laboratory and X-ray services” benefit of the California Medicaid State Plan).
- Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the beneficiary’s needs, planned interventions and to address and monitor a beneficiary’s progress and restoration of a beneficiary to their best possible functional level.

“*Family Therapy*” is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the beneficiary’s recovery as well as the holistic recovery of the family system. Family members can provide social support to the beneficiary and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.

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<sup>12</sup> As described above, NTPs conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies the purpose of determining medical necessity under the DMC-ODS

*“Group Counseling”* consists of contacts with multiple beneficiaries at the same time. Group Counseling shall focus on the needs of the participants. Group counseling shall be provided to a group that includes 2-12 individuals.

*“Individual Counseling”* consists of contacts with a beneficiary. Individual counseling can include contact with family members or other collaterals if the purpose of the collateral’s participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary’s treatment goals.

*“Medical Psychotherapy”* is a counseling service to treat SUDs other than OUD conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the beneficiary.

*“Medication Services”* includes prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication Services does not include MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and other Non-Opioid Substance Use Disorders. Medication Services includes prescribing, administering, and monitoring medications used in the treatment or management of SUD and/or withdrawal management not included in the definitions of MAT for OUD or MAT for AUD services.

*“Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Opioid Use Disorders (OUD)”* includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders.

MAT for OUD may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed below in the “Levels of Care” section. This service includes:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- Patient Education, which is education for the beneficiary on addiction, treatment, recovery and associated health risks.
- Prescribing and monitoring for MAT for OUD, which is prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT for OUD

- Recovery Services
- SUD Crisis Intervention Services
- Withdrawal Management Services

*“Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders”* includes all FDA-approved drugs and services to treat AUD and other non-opioid SUDs involving FDA-approved medications to treat AUD and non-opioid SUDs. MAT for AUD and other non-opioid SUDs may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed below in the “Levels of Care” section. This service includes:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- Patient Education
- Prescribing and monitoring for MAT for AUD and non-opioid SUDs, which is prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT for AUD and non-opioid SUDs
- Recovery Services
- SUD Crisis Intervention Services
- Withdrawal Management Services

*“SUD Crisis Intervention Services”* consists of contacts with a beneficiary in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the beneficiary's immediate situation, and be provided in the least intensive level of care that is medically necessary to treat their condition.

*“Withdrawal Management Services”* are provided to beneficiaries when medically necessary for maximum reduction of the SUD symptoms and restoration of the beneficiary to their best possible functional level. Withdrawal Management Services include the following service components:

- Assessment
- Care Coordination
- Medication Services

- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Observation, which is the process of monitoring the beneficiary's course of withdrawal. Observation is conducted at the frequency required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the beneficiary's health status.

## ENCLOSURE 2

### ASAM Criteria Continuum of Care Services and the DMC-ODS Program

Benefit	Medicaid authorities	Required or Optional for DMC-ODS Counties
Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) (commonly known as Screening, Brief Intervention, and Referral to Treatment, or SBIRT)	<p>State plan (individual services covered)</p> <p>SABIRT is delivered through fee-for-service (FFS) and Managed Care Plan (MCPs) delivery systems for individuals aged 11 and older</p> <p>Early intervention services in addition to SABIRT are available in DMC-ODS and Drug Medi-Cal for beneficiaries under age 21.</p>	<p>Required</p> <ul style="list-style-type: none"> <li>• Coordination with SABIRT delivered through FFS/MCPs</li> <li>• Additional early intervention services for beneficiaries under age 21</li> </ul>
Outpatient services (also known as Outpatient Drug Free)	State plan (individual services covered)	Required
Intensive outpatient services	<p>State plan (individual services covered)</p> <p>1115 expenditure authority for services provided to individuals in IMDs</p>	Required
Partial hospitalization services	<p>State plan (individual services covered)</p> <p>1115 expenditure authority for services provided to individuals in IMDs</p>	Optional

Residential/inpatient services	<p>State plan (individual services covered)</p> <p>1115 expenditure authority for services provided to individuals in IMDs</p>	<p>Required</p> <ul style="list-style-type: none"> <li>• At least one ASAM level of care upon implementation</li> <li>• ASAM Levels 3.5 available within two years</li> <li>• ASAM Levels 3.1 and 3.3 available within three years</li> <li>• Referral mechanisms and coordination with ASAM Levels 3.7 and 4.0 delivered through FFS/MCPs</li> </ul> <p>Optional</p> <ul style="list-style-type: none"> <li>• ASAM Levels 3.7 and 4.0</li> </ul>
Withdrawal management services	<p>State plan (individual services covered)</p> <p>1115 expenditure authority for services provided to individuals in IMDs</p>	<p>Required</p> <ul style="list-style-type: none"> <li>• At least one level (ASAM Levels 1-WM, 2-WM, 3.2-WM, 4.7-WM, 4-WM)</li> <li>• Referral mechanisms and coordination with ASAM Levels 3.7-WM and 4.0 delivered through FFS/MCPs</li> </ul> <p>Optional</p> <ul style="list-style-type: none"> <li>• Additional levels (ASAM Levels 1-WM, 2-WM, 3.2-WM, 4.7-WM, 4-WM)</li> </ul>

Narcotic Treatment Program services	State plan (individual services covered)  1115 expenditure authority for services provided to individuals in IMDs	Required
Recovery Services	State plan (individual services covered)	Required
Peer Support Specialist services	State plan (individual services covered)  1115 expenditure authority for services provided to individuals in IMDs	Optional
Care Coordination services	State plan  1115 expenditure authority for services provided to individuals in IMDs	Required
Clinician consultation services (N/A)	State plan (reimbursable activity; not a distinct service)  1115 expenditure authority for services provided to individuals in IMDs	Required

### **ENCLOSURE 3**

#### **County Implementation Plan Template**

##### **PART I PLAN QUESTIONS**

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

1. Identify the county agencies and other entities involved in developing the county plan. (Check all that apply.) Input from stakeholders in the development of the county implementation plan is required; however, all stakeholders listed are not required to participate.
  - ☐ County Behavioral Health Agency
  - ☐ County Substance Use Disorder Agency
  - ☐ Providers of drug/alcohol treatment services in the community
  - ☐ Representatives of drug/alcohol treatment associations in the community
  - ☐ Physical Health Care Providers
  - ☐ Medi-Cal Managed Care Plans
  - ☐ Federally Qualified Health Centers (FQHCs)
  - ☐ Clients/Client Advocate Groups
  - ☐ County Executive Office
  - ☐ County Public Health
  - ☐ County Social Services
  - ☐ Foster Care Agencies
  - ☐ Law Enforcement
  - ☐ Court
  - ☐ Probation Department
  - ☐ Education
  - ☐ Recovery support service providers (including recovery residences)
  - ☐ Health Information technology stakeholders
  - ☐ Other (specify) \_\_\_\_\_
2. How was community input collected?
  - ☐ Community meetings
  - ☐ County advisory groups
  - ☐ Focus groups
  - ☐ Other method(s) (explain briefly)



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

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

Review Note: One box must be checked.

4. Prior to any meetings to discuss development of this implementation plan, did representatives from Substance Use Disorders (SUD), Mental Health (MH) and Physical Health all meet together regularly on other topics, or has preparation for the Waiver been the catalyst for these new meetings?

- ☐ SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.
- ☐ There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.
- ☐ There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.
- ☐ There were no regular meetings previously, but they will occur during implementation.
- ☐ There were no regular meetings previously, and none are anticipated.

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

**REQUIRED**

- ☐ Withdrawal Management (minimum one level)
- ☐ Residential Services (minimum one level upon implementation; 3.5 within two years of implementation; 3.1, 3.3, and 3.5 within three years)
- ☐ Intensive Outpatient
- ☐ Outpatient
- ☐ Opioid (Narcotic) Treatment Programs
- ☐ Recovery Services
- ☐ Care Coordination
- ☐ Clinician Consultation

How will these required services be provided?

- ☐ All County operated
- ☐ Some County and some contracted
- ☐ All contracted.

**OPTIONAL**

- ☐ MAT at Alternative Sites (drug product costs)
- ☐ Partial Hospitalization
- ☐ Peer Support Specialist
- ☐ ASAM Level 3.7
- ☐ ASAM Level 4.0
- ☐ Recovery Residences (not a Medi-Cal benefit)
- ☐ Other (specify) \_\_\_\_\_

6. Has the county established a toll free 24/7 number with prevalent languages for prospective clients to call to access DMC-ODS services?

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

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

7. The county will participate in providing data and information to the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs for the DMC-ODS evaluation.

- ☐ Yes (required)
- ☐ No

8. The county will comply with all quarterly reporting requirements as contained in the STCs.

- ☐ Yes (required)
- ☐ No

9. Each county's Quality Improvement Committee will review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol:

- Number of days to first DMC-ODS service/follow-up appointments at appropriate level of care after referral and assessment

- Existence of a 24/7 telephone access line with prevalent non-English language(s)
- Access to DMC-ODS services with translation services in the prevalent non-English language(s)
- Number, percentage of denied and time period of authorization requests approved or denied

- ☐ Yes (required)
- ☐ No

## **PART II**

### **PLAN DESCRIPTION (Narrative)**

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

#### General Review Notes:

- Number responses to each item to correspond with the outline.
- Keep an electronic copy of your implementation plan description. After DHCS and CMS review the plan description, the county may need to make revisions. When making changes to the implementation plan, use track changes mode so reviewers can see what has been added or deleted.
- Counties must submit a revised implementation plan to DHCS when the county requests to add a new level of service.

### **Narrative Description**

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

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

2. **Client Flow.** Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, transitions to another level of care). Describe what entity or entities will conduct ASAM criteria interviews, the professional qualifications of individuals who will conduct ASAM criteria interviews and assessments, how admissions to the recommended level of care will take place, how often clients will be re-assessed, and how they will be transitioned to another level of care accordingly. Include the role of how the case manager will help with the transition through levels of care and who is providing the case management services. Also describe if there will be timelines established for the movement between one level of care to another. Please describe how you plan to ensure successful care transitions for high-utilizers or individuals at risk of unsuccessful transitions.

Review Note: A flow chart may be included.

3. **Beneficiary Notification and Access Line.** For the beneficiary toll free access number, what data will be collected (e.g., measure the number of calls, waiting times, and call abandonment)? How will individuals be able to locate the access number? The access line must be toll-free, functional 24/7, accessible in prevalent non-English languages, and ADA-compliant (TTY).

Review Note: Please note that all written information must be available in the prevalent non-English languages identified by the state in a particular service area. The plan must notify beneficiaries of free oral interpretation services and how to access those services.

4. **Treatment Services.** Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, care coordination, clinician consultation) and optional (MAT at alternative sites, peer support specialist services) to be provided. What barriers, if any, does the county have with the required service levels? Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county. Describe how the county plans to cover or ensure referrals and coordination to ASAM Levels 3.7 and 4.0.

Review Note: Include in each description the corresponding American Society of Addiction Medicine (ASAM) level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date. This list will be used for billing purposes for the Short Doyle 2 system.

5. **Coordination with Mental Health.** How will the county coordinate mental health services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored? Please briefly describe the county structure for delivering SUD and mental health services. When these structures are separate, how is care coordinated?
6. **Coordination with Physical Health.** Describe how the counties will coordinate physical health services within the waiver. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

7. **Coordination Assistance.** The following coordination elements are listed in the STCs. Based on discussions with your health plan and providers, do you anticipate substantial challenges and/or need for technical assistance with any of the following? If so, please indicate which and briefly explain the nature of the challenges you are facing.
- Comprehensive substance use, physical, and mental health screening;
  - Beneficiary engagement and participation in an integrated care program as needed;
  - Shared development of care plans by the beneficiary, caregivers and all providers;
  - Collaborative treatment planning with managed care;
  - Care coordination and effective communication among providers;
  - Navigation support for patients and caregivers; and
  - Facilitation and tracking of referrals between systems
8. **Availability of Services.** Pursuant to 42 CFR 438.206, the pilot County must ensure availability and accessibility of adequate number and types of providers of medically necessary services. At minimum, the County must maintain and monitor a network of providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract. In establishing and monitoring the network, describe how the County will consider the following:
- The anticipated number of Medi-Cal clients.
  - The expected utilization of services by service type.
  - The numbers and types of providers required to furnish the contracted Medi-Cal services.
  - A demonstration of how the current network of providers compares to the expected utilization by service type.
  - Hours of operation of providers.
  - Language capability for the county threshold languages.
  - Specified access standards and timeliness requirements, including number of days to first face-to-face visit after initial contact and first DMC-ODS treatment service, timeliness of services for urgent conditions and access afterhours care, and frequency of follow-up appointments in accordance with individualized treatment plans.
  - The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities
  - How will the county address service gaps, including access to MAT services?

- As an appendix document, please include a list of network providers indicating, if they provide MAT, their current patient load, their total DMC-ODS patient capacity, and the populations they treat (e.g., adolescent, adult, perinatal).

9. **Access to Services.** In accordance with 42 CFR 438.206, describe how the County will assure the following:

- Meet and require providers to meet standards for timely access to care and services, taking into account the urgency of need for services.
- Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal patients.
- Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.
- Establish mechanisms to ensure that network providers comply with the timely access requirements.
- Monitor network providers regularly to determine compliance with timely access requirements.
- Take corrective action if there is a failure to comply with timely access requirements.

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

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

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

12. **Quality Assurance.** Describe the County's Quality Management and Quality Improvement programs. This includes a description of the Quality Improvement (QI) Committee (or integration of DMC-ODS responsibilities into the existing MHP QI Committee). The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:

- Timeliness of first initial contact to face-to-face appointment
- Frequency of follow-up appointments in accordance with individualized treatment plans

- Timeliness of services of the first dose of NTP services
- Access to after-hours care
- Responsiveness of the beneficiary access line
- Strategies to reduce avoidable hospitalizations
- Coordination of physical and mental health services with waiver services at the provider level
- Assessment of the beneficiaries' experiences, including complaints, grievances and appeals
- Telephone access line and services in the prevalent non-English languages.

Review Note: Plans must also include how beneficiary complaints data shall be collected, categorized and assessed for monitoring Grievances and Appeals. At a minimum, plans shall specify:

- How to submit a grievance, appeal, and state fair hearing
- The timeframe for resolution of appeals (including expedited appeal)
- The content of an appeal resolution
- Record Keeping
- Continuation of Benefits
- Requirements of state fair hearings.

13. **Evidence Based Practices.** How will the counties ensure that providers are implementing at least two of the identified evidence based practices? What action will the county take if the provider is found to be in non-compliance?
14. **Regional Model.** If the county is implementing a regional model, describe the components of the model. Include service modalities, participating counties, and identify any barriers and solutions for beneficiaries. How will the county ensure access to services in a regional model (refer to question 7)?
15. **Memorandum of Understanding.** Submit a signed copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in Section 152 "Care Coordination" of the STCs. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s).



Review Note: The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

- Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Collaborative treatment planning with managed care;
- Delineation of case management responsibilities;
- A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;
- Availability of clinical consultation, including consultation on medications;
- Care coordination and effective communication among providers including procedures for exchanges of medical information;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals.

16. **Telehealth Services.** Describe how the telehealth and telephone delivery of services will be structured for providers and how will the county ensure confidentiality.

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

18. **Residential Authorization.** Describe the county's authorization process for residential services. Continued stay authorization requests for residential services must be addressed within 24 hours.

**County Approval**

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

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County Behavioral Health Director

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Date

## **ENCLOSURE 4**

### **Provider Appeals Process**

1. Following a county's contract protest procedure, a provider may appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.
2. A provider may appeal to DHCS, following an unsuccessful contract protest, if the provider meets all objective qualifications and it has reason to believe the county has an inadequate network of providers to meet beneficiary need and the provider can demonstrate it is capable of providing high quality services under current rates, and:
  - A. It can demonstrate arbitrary or inappropriate county fiscal limitations; or
  - B. It can demonstrate that the contract was denied for reasons unrelated to the quality of the provider or network adequacy.
3. DHCS does not have the authority to enforce State or Federal equal employment opportunity laws through this appeal process. If a provider believes that a county's decision not to contract violated Federal or State equal employment opportunity laws, that provider should file a complaint with the appropriate government agency.
4. A provider shall have 30 calendar days from the conclusion of the county protest period to submit an appeal to the DHCS. Untimely appeals will not be considered. The provider shall serve a copy of its appeal documentation on the county. The appeal documentation, together with a proof of service, may be served by certified mail, facsimile, or personal delivery.
5. The provider shall include the following documentation to DHCS for consideration of an appeal:
  - A. County's solicitation document;
  - B. County's response to the county's solicitation document;
  - C. County's written decision not to contract
  - D. Documentation submitted for purposes of the county protest;
  - E. Decision from county protest; and
  - F. Evidence supporting the basis of appeal.
6. The county shall have 10 working days from the date set forth on the provider's proof of service to submit its written response with supporting documentation to DHCS. In its response, the County must include the following documentation:

- A. the qualification and selection procedures set forth in its solicitation documents;
- B. the most current data pertaining to the number of providers within the county, the capacity of those providers, and the number of beneficiaries served in the county, including any anticipated change in need and the rationale for the change; and
- C. the basis for asserting that the appealing Provider should not have been awarded a contract based upon the County's solicitation procedures. The county shall serve a copy of its response, together with a proof of service, to the provider by certified mail, facsimile, or personal delivery.