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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 6, 2023

Behavioral Health Information Notice No: 23-001

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 Special Terms and Conditions used to describe the DMC-ODS program for the years 2015-2021.

SUPERSEDES: BHIN 20-074E, BHIN 21-075

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); BHIN 22-005; BHIN 22-011; BHIN 22-013; BHIN 22-019, BHIN 22-026.

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 were effective January 2022-and BHIN 21-075 implemented those updates. This BHIN aligns the DMC-ODS program requirements with the CalAIM behavioral health initiatives that are effective July 2022, including the policies outlined in BHIN 22-005, BHIN 22-011, BHIN 22-013, BHIN 22-019, and BHIN 22-026.

In addition, the following policy guidance updates and replaces the Section 1115 Special Terms and Conditions (STCs) that were used to describe the DMC-ODS program for the years 2015-2021. In accordance with W&I Code section 14184.102(d), until county contract amendments are executed, DMC-ODS counties shall adhere to 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 into 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 3 to DHCS for approval. Upon DHCS approval, DHCS will enter into an intergovernmental agreement (IA) 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 Code of Federal Regulations (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 BHIN 22-003 regarding Medi-Cal SUD treatment services for beneficiaries under age 21 for further compliance with EPSDT requirements. Please note that the access criteria for beneficiaries under 21 is different and more flexible than the access criteria for adults accessing DMC-ODS services, to meet the EPSDT mandate and the intent for prevention and early intervention of SUD conditions.

DMC-ODS Program Criteria for Services

Medi-Cal adult beneficiaries whose county of responsibility is a DMC-ODS county and Medi-Cal beneficiaries under age 21 in all counties are able to receive DMC-ODS services consistent with the following access criteria, assessment, and level of care determination criteria.[1]

Initial Assessment and Services Provided During the Assessment Process

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), registered/certified counselor, or Peer Support Specialist 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 additional time to complete the assessment. If a beneficiary withdraws from treatment

[1] Counties should refer to BHIN 22-003 regarding Medi-Cal SUD treatment services for beneficiaries under age 21 for further compliance with EPSDT requirements.

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.[2] 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 health condition, including substance misuse and SUDs.

[2] Narcotic Treatment Programs (NTPs) shall conduct a history and physical exam by a 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

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.

Additional Coverage Requirements and Clarifications
Consistent with W&I Code section 14184.402(f), covered SUD prevention, screening, assessment, treatment, and recovery 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; or
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-CM) code.[3] In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10-CM code list, for example, codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services". For additional information regarding code selection during the assessment period for outpatient behavioral health services, please refer to BHIN 22-013.

Regarding (2), DHCS has released BHIN 22-019 to provide guidance on documentation requirements that took effect as of July 1, 2022.
While most DMC-ODS providers are expected to adopt problem lists as described in BHIN 22-019, treatment plans continue to be required for some services in accordance with federal requirements. For example:

[3] The ICD 10 Tabular (October 1st thru September 30th) at https://www.cms.gov/medicare/icd-10/2023-icd-10-cm

- NTPs: As noted in BHIN 22-019, NTPs are required by Federal law to create treatment plans for their beneficiaries. NTP requirements for documentation are not impacted by BHIN 22-019 and NTPs must continue to comply with federal and state regulations regarding treatment plans and documentation.
- Peer Support Services: CMS guidance requires that Peer Support Services be based on an approved plan of care. As noted in BHIN 22-019, the plan of care for Peer Support Services shall be documented within the progress notes in the beneficiary's clinical record. The Peer Support Services plan of care must be approved by a Behavioral Health Professional or a Peer Support Specialist Supervisor.[4] Additional guidance around documentation for Peer Support Services is forthcoming.

There are two scenarios where treatment plans are required, or referenced, by state licensing and certification requirements, and DHCS will accept a problem list to identify the needs of the beneficiary and the reasons for service encounters:

- Alcohol and Other Drug (AOD) Certification Standards: DHCS is in the process of updating the AOD Certification Standards that pertain to treatment plans to align with BHIN 22-019. Until the AOD Certification Standards have been updated, DMC-ODS providers may use a problem list, as defined in BHIN 22-019, in lieu of a treatment plan for beneficiaries.
- Adult Alcoholism or Drug Abuse Recovery or Treatment Facility Licensing Regulations: DMC-ODS providers may use a problem list, as defined in BHIN 22-019, in lieu of a treatment plan for beneficiaries to comport with adult alcoholism or drug abuse recovery or treatment facilities licensing regulations that pertain to treatment plans.

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 Access Criteria for Beneficiaries After Assessment*. For additional information regarding covered services for beneficiaries with co-occurring SUD and mental health conditions, please refer to BHIN 22-011.

[4] Behavioral Health Professionals must be licensed, waivered, 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, DMC-ODS or Specialty Mental Health Services. 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.

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.[5] A free ASAM Criteria Assessment Interview Guide, which may be but is not required to be used to complete the ASAM Criteria assessment, can be found here.

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.
g. These requirements for ASAM Level of Care assessments apply to NTP clients and settings.

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 Code 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

[5] W&I Code section 14184.402(e)(1)

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 Code 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 current DMC/DMC-ODS Billing Manual. The DMC/DMC-ODS billing manual will be updated to align with new policies. If the billing manual conflicts with guidance outlined in this BHIN, this BHIN is the governing authority. Please see Enclosure 2 for a 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 (FFS) 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, to include a CMS

approved ICD-10 diagnosis code.[6] In cases where services are provided due to a suspected SUD that has not yet been diagnosed, 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". For additional information regarding code selection during the assessment period for outpatient behavioral health services, please refer to BHIN 22-013. 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 (also known as Outpatient Drug Free or ODF) 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 include the following service components:

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

[6] The ICD 10 Tabular (October 1st thru September 30th).

- 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)*
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. However, 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, FAPHs, 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 FFS 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*
NTP, also described in the ASAM criteria as an 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)*
   MAT includes 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 (For additional guidance regarding Peer Support Specialist Certification, please refer to BHIN 21-041. For additional guidance regarding county implementation of Peer Support Services, please refer to BHIN 21-041, BHIN 22-006, BHIN 22-018, BHIN 22-026, BHIN 22-055, BHIN 22-061, and BHIN 22-062.)*
   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. In addition, Peer Support Services may be provided in conjunction with other services or levels of care described in this "Covered DMC-ODS Services" section, including inpatient and residential services, but shall be billed separately. There may be times when, based

on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

Peer Support Services are based on a plan of care that includes specific individualized goals as identified by CMS Medicaid Directors Letter #07-011. The Peer Support Services plan of care must be approved by a Behavioral Health Professional or a Peer Support Specialist Supervisor. For more information about the documentation requirements for Peer Support Services, please refer to BHIN 22-019.

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, waivered, 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, DMC-ODS or Specialty Mental Health Services.[7] 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. For additional** guidance regarding county implementation of Peer Support Services, **please refer to BHIN 22-026.

10. *Contingency Management*

Contingency Management (CM) is an evidence-based behavioral treatment that provides motivational incentives to reduce the use of stimulants. CM is the only treatment that has demonstrated robust outcomes for individuals with stimulant use disorder, including reduction or cessation of drug use and longer retention in treatment.

To expand access to evidence-based treatment for stimulant use disorder, DHCS will pilot Medi-Cal coverage of CM in select DMC-ODS counties starting Q1 2023. The Department will implement its CM pilot, the Recovery Incentives program, using an incentive manager vendor. Participation in the Recovery Incentives program is optional for DMC-ODS counties. As part of the pilot, eligible Medi-Cal members will participate in a structured 24-week outpatient CM program, followed by six or more months of additional recovery support services. Individuals will be able to earn motivational incentives in the form of low-denomination gift cards, with a total retail value determined per treatment episode.

For more information, please visit the DHCS Recovery Incentives program webpage and refer to BHIN 22-056.

11. *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

[7] 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.

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.[8]

Recovery Services include the following service components:

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

Effective January 1, 2022, counties can no longer submit DMC-ODS claims for services delivered by peers as a component of Recovery Services. For more information on DMC-ODS claims for services delivered by peers as a component of Recovery Services, please refer to BHIN 22-005.

12. *Care Coordination*

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

[8] For additional information, see BHIN 21-020.

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, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
- For guidance on claiming for care coordination within a level of care or as a standalone service, please refer to the most current DMC-ODS Billing Manual.

13. *Clinician 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[9]

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 FDA-approved to treat OUDs and AUDs. Additionally, DMC-ODS 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.

[9] See BHIN 21-024.

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.

Indian Health Care Providers
American Indian and Alaska Native individuals who are eligible for Medicaid and reside in counties that have opted into the DMC-ODS can also receive DMC-ODS services through Indian Health Care Providers (IHCPs). Please refer to BHIN 22-053 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 Federally Qualified Health Center (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.[10] Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the "List of Tribal FQHCs"
- *Urban Indian Organizations* – 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.

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.[11]

---

[10] 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.
See APL 21-008. [11] See BHIN No. 20-065 for additional information.

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.[12]

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 IA with DHCS and shall require the DMC-ODS Counties to comply with the following.

Selective Provider Contracting Requirements for DMC-ODS Counties
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 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.

[12] See BHIN No. 20-065 for additional information.

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 Code 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 IA. 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 another county (including a county that does not opt into 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
New counties opting to become a DMC-ODS county must submit a DMC-ODS implementation plan to DHCS 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 DHCS, a readiness review being completed DHCS, and their network being certified by DHCS. See Enclosures 6, 7 and 8

for the materials DHCS uses to conduct the readiness review. DMC-ODS Counties must also have an executed State/DMC-ODS County IA 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 execution of the IA, DMC-ODS Counties will be able to bill prospectively for all covered DMC-ODS services provided to their beneficiaries.

The IA 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 IA 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 services provided through county-operated providers (based on actual costs, consistent with a cost allocation methodology if warranted), contracted FFS 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 W&I 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 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 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, 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 for questions.

Sincerely,

Original signed by

Ivan Bhardwaj, Acting Chief
Medi-Cal Behavioral Health Division

Enclosures

1. Definitions
2. ASAM Criteria Continuum of Care and the DMC-ODS Program
3. County Implementation Plan Template
4. Provider Appeals Process
5. Provider Qualifications
6. Readiness Review – CMS Requirements
7. Readiness Review – Questions
8. Readiness Review – Document Checklist

ENCLOSURE 1

Definitions

"*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.[13] 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 SUD.
- Diagnosis of SUD 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.

"*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.

[13] 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

"*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 SUD 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 SUD services, or the assessment of the side effects or results of the medication. Medication Services does not include MAT for 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.

MAT for 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 OUD.

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 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

"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 consist of Educational Skill Building Groups, Engagement and Therapeutic Activity 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
SABIRT (commonly known as SBIRT)	State plan (individual services covered) SABIRT is delivered through FFS and MCPs delivery systems for individuals aged 11 and older Early intervention services in addition to SABIRT are available in DMC-ODS and Drug Medi-Cal for beneficiaries under age 21.	Required • Coordination with SABIRT delivered through FFS/MCPs • Additional early intervention services for beneficiaries under age 21
Outpatient services (also known as ODF)	State plan (individual services covered)	Required
Intensive outpatient services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required
Partial hospitalization services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Optional

Benefit	Medicaid authorities	Required or Optional for DMC-ODS Counties
Residential/inpatient services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required • At least one ASAM level of care upon implementation • ASAM Levels 3.5 available within two years • ASAM Levels 3.1 and 3.3 available within three years • Referral mechanisms and coordination with ASAM Levels 3.7 and 4.0 delivered through FFS/MCPs Optional • ASAM Levels 3.7 and 4.0
Withdrawal management services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Required • At least one level (ASAM Levels 1-WM, 2-WM, 3.2-WM, 4.7-WM, 4-WM) • Referral mechanisms and coordination with ASAM Levels 3.7-WM and 4.0 delivered through FFS/MCPs Optional • Additional levels (ASAM Levels 1-WM, 2-WM, 3.2-WM, 4.7-WM, 4-WM)

Benefit	Medicaid authorities	Required or Optional for DMC-ODS Counties
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 services	State plan (individual services covered) 1115 expenditure authority for services provided to individuals in IMDs	Optional
Contingency management	1115 expenditure authority (individual services covered)	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 the development of this implementation plan, did representatives from SUD, Mental Health (MH), and Physical Health all meet regularly on other topics, or has preparation for implementing DMC-ODS 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 DMC-ODS implementation discussions.
    - ☐ There were previously some meetings, but they have increased in frequency or intensity as a result of DMC-ODS.
    - ☐ There were no regular meetings previously. DMC-ODS 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
   - ☐ MAT (offer directly or have effective referral mechanisms in place)

   How will these required services be provided?

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

   OPTIONAL

   - ☐ Partial Hospitalization
   - ☐ Peer Support Services
   - ☐ ASAM Level 3.7
   - ☐ ASAM Level 4.0
   - ☐ Recovery Residences (not a Medi-Cal benefit)
   - ☐ Contingency Management
   - ☐ 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. Will the county participate in providing data and information to the University of California, Los Angeles Integrated Substance Abuse Programs for the DMC-ODS evaluation?

    - ☐ Yes (required)
    - ☐ No

8. Will the county's Quality Improvement (QI) Committee review the following data at a minimum, every quarter since external quality review (EQR) site reviews will begin after county implementation?

    - Number of days to first DMC-ODS service/follow-up appointments at the 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 and percentage of denied authorization requests, along with the amount of time required to approve or deny the authorization requests.

    - ☐ Yes (required)
    - ☐ No

    NOTE: These data elements will be incorporated into the EQRO protocol.

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 reviews the plan description, the county may need to make revisions. When making changes to the implementation plan, use the 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 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. 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/TRS).

   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, and clinician consultation, and direct delivery of MAT for addictive treatment, or effective referral mechanisms in place to deliver MAT at alternative sites. Optional: Peer Support Services, partial hospitalization, and ASAM levels 3.7 and 4.0, Contingency Management 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 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 DMC-ODS implementation date. This list will be used for billing purposes for the Short Doyle Medi-Cal II 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 DMC-ODS. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

7. **Coordination Assistance**. 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.
    - Collaborative treatment planning with 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.
    - Facilitation and tracking of referrals between systems

8. **Availability of Services**. Pursuant to 42 CFR 438.206, the 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.
    - 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., beneficiary under 21, 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 offer hours of operation to Medi-Cal beneficiaries that are no less than the hours of operation offered 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 DMC-ODS? 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 (QM) and Quality Improvement programs. This includes a description of the 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
    - 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 DMC-ODS 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 MOU between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery. If upon submission of an implementation plan, the managed care plan(s) has/have 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). Please note that updated MOU guidance will be released in early 2023.

16. 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.
    - Collaborative care planning with 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.
    - Facilitation and tracking of referrals

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

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

19. **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 (or SUD Program Administrator in counties with separate mental health and SUD departments must review and approve the Implementation Plan. The signature below verifies this approval.

_____ _____

County Behavioral Health Director 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.

ENCLOSURE 5

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												
	Assess-ment*	Care Coordinati-on**	Crisis Intervent-ion	Family Therapy	Counse-ling (Individu-al & Group)	Medical Psychot-herapy	Medic-ation Servic-es	Patient Education	Peer Suppo-rt Servic-es	Conting-ency Manage-ment	Observ-ation	Recovery Services
Practition-er Qualificati-ons	C, L*	C, L	C, L	L	C, L	M	C, L	C, L	P	C, L, P, O	C, L***	C, L

C = Counselors
An 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, 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 LPHA includes any of the following: Physician, Nurse Practitioner, Physician Assistant, Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, and Licensed Marriage and Family Therapist, and licensed-eligible practitioner registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician. To be considered "license-eligible," the individual must be registered with the appropriate state licensing authority for their respective field. Interns who have not yet received their advanced degree within their specific field and/or have not registered with the appropriate state board are not considered LPHAs.

M = Medical director of a Narcotic Treatment Program
The medical director of a NTP 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.

O = Other trained staff under supervision of an LPHA
This new staffing category is specific to the contingency management pilot, referred to as the Recovery Incentives Program. This would not change existing staffing requirements for other DMC-ODS services, which may only be provided by LPHAs, registered or certified counselors, or certified peers under the new, optional peer provider type and benefit noted above.

Notes

*The physical examination by an LPHA in accordance with 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.

ENCLOSURE 6

Readiness Review – CMS Requirements
Drug Medi-Cal Organized Delivery System (DMC-ODS)

The CMS requires the State to assess the readiness of counties opting into the DMC-ODS. To demonstrate readiness, a county opting into the DMC-ODS must meet the criteria in the table below. A non-exhaustive list of example materials or documents to demonstrate readiness in each category is listed in the "Example Action Steps' below. Specific readiness review requirements are listed in the following regulations:

- CMS' Managed Care Final Rule, published November 13, 2020
- 42 CFR §438.66(d) State Monitoring Requirements
- Department of Health Care Services BHIN No: 21-075
- DMC-ODS Contract (Intergovernmental Agreement)

Functional Area	Operation Activities for Assessment	Example Action Steps
1. Administration	○ Program Operations ○ Interagency Coordination ○ Compliance	Plan Functions: • Develop a written hiring plan including job descriptions. • Evaluate building readiness including workspace and accessibility and prepare a written report with findings. • Ensure system capacity to report member service calls and issues daily during the transition period. Prepare a written report detailing the system capacity. • Develop a written training schedule and prepare written training materials. • Develop member materials and submit to the state for technical assistance, if needed. • Develop call center scripts and train call center staff on available benefits. Submit call center scripts and training materials to DHCS for review. • Develop written call center contingency plans. • Hire a compliance officer and develop a process for reporting any potential fraud, waste, or abuse.

Functional Area	Operation Activities for Assessment	Example Action Steps
2. Beneficiary Services	○ Beneficiary Handbook Development ○ Enrollee Services and Supports	Plan Functions: • Develop beneficiary handbook and submit to DHCS for a compliance assessment. • Update the provider directory regularly for call center staff to reference. Directories are reviewed annually by DHCS.
3. Service Provisions	○ Utilization Management ○ Service Delivery ○ Service Planning	Plan Functions: • Develop practice guidelines for DHCS review
4. Access	○ Provider Network Adequacy ○ Access and Availability ○ Access for People with Disabilities or Other Special Needs ○ Contracts with Network Providers	Plan Functions: • Perform provider outreach to enroll providers and assist them throughout the DMC certification and plan credentialing processes. • Collect accurate information during the provider credentialing process to ensure Provider Directory is accurate and includes information such as cultural competency, disability accessibility, and open panels. • Develop Policies and procedures (P&Ps) regarding the provider credentialing process and ability for credentialing committee to meet more frequently if necessary • Develop P&Ps regarding Network Adequacy • Develop a single case agreement process to handle out of network providers. • Report provider network data. • Provide executed contracts for language line services and 24/7 access line.

Functional Area	Operation Activities for Assessment	Example Action Steps
5. Continuity and Coordination of Care	○ Develop and Monitor Care Coordination Plan to Facilitate Successful Transitions Between Levels of Care	Plan Functions: • Develop care coordination plans between various levels of care utilizing the ASAM criteria • Provide training to all providers in ASAM criteria and care coordination systems • Execute MOU with all Medi-Cal Managed Care Plans in the county of operation • Ensure systems are in place to follow continuity of care procedures outlined in the contract and by DHCS to ensure claims and services are not denied for the incorrect reasons
6. Grievance, Appeal, and Fair Hearing Process	○ General Requirements ○ Enrollee Reporting of Grievances and Appeals ○ Handling of Grievances and Appeals ○ Monitoring of Grievances and Appeals	Plan Functions: • Train call center and other enrollee facing staff to recognize when an issue is a grievance or appeal and when it should be referred to other staff at the Plan to handle. • Establish a written tracking system allowing all staff to track when a grievance or appeal is filed with internal notifications for processing. • Implement state specific reporting mechanisms.
7. Quality	○ Structural and Operational Standards ○ Quality Assessment and Performance Improvement ○ External Quality Reviews	Plan Functions: • Develop a QM plan and train staff on the management plan. • Create P&Ps related to the quality systems in place. • Develop Performance Improvement Projects and establish committees to measure any improvements as they relate to the new benefits.

Functional Area	Operation Activities for Assessment	Example Action Steps
8. Program Integrity	○ Payment Systems ○ Eligibility and Enrollment ○ Third Party Liability (TPL) ○ Information Systems, including Provider Payment Systems ○ Communication and Reporting ○ Finance, Data, and Systems Assurance ○ General Oversight ○ Provider Screening and Enrollment in DMC program	Plan Functions: • Provide finance and encounter data/reports. • Provide status of system readiness based on testing. • Prepare a written report detailing the system capacity. • Develop systems to identify program integrity issues. • Hire compliance officers and train staff on identification of fraud and abuse as it relates to the new benefits. • Develop reporting structure to the state when issues are identified. • Develop plan to track and report overpayments due to potential fraud to DHCS.
9. Finance	○ General Financial Oversight ○ Payments to Providers ○ TPL and Coordination of Benefits	Plan Functions: • Test claims payment functions and have working P&Ps on timely payment of claims to the provider network. • Train staff on TPL to ensure appropriate billing.

ENCLOSURE 7

Readiness Review – Questions
Drug Medi-Cal Organized Delivery System (DMC-ODS)

The DHCS is required to conduct both a desk review of documents and an onsite Readiness Review prior to a county's entry into the DMC-ODS [42 CFR 438.66(d)]. The questions below are examples of the types of abilities counties must possess prior to implementing DMC-ODS services. Please note that this is not an exhaustive list of questions or abilities the county must demonstrate during their Readiness Review. The county's responses to the questions must be evaluated in accordance with the IA, and federal and state requirements. Counties are considered Plans and are referred to as Plans throughout this document.

1. Administration

Hiring Plan

1. What new jobs have been added as a result of implementing DMC-ODS?
2. Please provide a copy of the job description for each of the new jobs created.
3. How does the County ensure that professional staff are enrolled and/or approved licensed, registered, certified, or recognized under California scope of practice?
4. What is the Plan's process for ensuring that professional staff (Physicians, LPHAs) receive a minimum of five (5) hours of continuing education related to addiction medicine each year?

Building Readiness

1. How is the Plan ensuring that buildings and workspaces are able to accommodate new staff?

Member Services System Capacity

1. Does the Plan have a call center and/or centralized phone line to take beneficiary calls?
2. Does the Plan have call center scripts developed?
3. How does the County provide assistance to non-English speaking clients?
4. Does the call center and/or phone line track the number of calls and topics discussed during the call?

5. What is the Plan's process for addressing issues that arise through the call center and/or centralized phone line?
6. What is the Plan's call center and/or centralized phone number?
7. Does the Plan have a call center contingency plan in place in the event that the call center is inundated with calls?

Training Schedule

1. How has the Plan prepared its staff and its providers for the new DMC-ODS Waiver?
2. What is the Plan's process for ensuring that all staff have the appropriate experience and necessary training upon hiring? Is there a new provider orientation?
3. What is the Plan's process for documenting trainings, certifications, and licenses within personnel files?
4. How does the Plan train providers and staff on the ASAM?
5. What type of ASAM trainings are utilized? How is it documented that provider staff have taken these training?
6. How does the Plan ensure providers are trained on at least two Evidence-Based Practices?
7. How will the Plan be monitoring its providers to ensure that at least two Evidence-Based Practices are being used?
8. Is there a process or procedure in place that requires provider staff to be trained prior to delivering services?
9. Please provide a copy of the procedure requiring provider staff to be trained.
10. Please provide a copy of the Plan's training schedule.

Compliance

1. Does the Plan have a Compliance Officer?
2. Who does the Compliance Officer report to?
3. Does the Plan have a system for training and education for the Compliance Officer?

2. Beneficiary Services

Beneficiary Handbook Development

1. Has the Plan finalized the beneficiary handbook with Plan-specific contact information and a logo?
2. Please provide a copy of the Plan's draft of the beneficiary handbook.
3. When will the handbook be posted on the Plan's website?
4. Please provide the link to the web page where the beneficiary handbook will be posted.
5. How does the Plan intend on distributing beneficiary handbooks to beneficiaries?
6. What is the Plan's process to ensure the beneficiary handbook is distributed to each beneficiary within a reasonable time after receiving notice of the beneficiary's enrollment?
7. How does the Plan ensure current beneficiaries receive the handbook?
8. How is the Plan notifying current beneficiaries of the change to their services?
9. Has the Plan finalized the Notice of Adverse Benefit Determination letter templates?

Provider Directory

1. What is the Plan's process for continuously updating the Provider Directory?
2. What is the Plan's process for ensuring the call center staff have the most updated version of the Provider Directory to reference?
3. How often is the Provider Directory updated?
4. Is the Provider Directory posted on the Plan's website?
5. Provide the link to the Plan's webpage with the current Provider Directory or planned DMC-ODS Provider Directory.
6. Does the Plan's Provider Directory indicate whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment?

3. Service Provisions

Practice Guidelines

1. Has the Plan developed Practice Guidelines that are approved for use by DHCS?
2. Describe the Plan's Practice Guidelines.
3. Provide a copy of the Plan's Practice Guidelines.
4. How are the Practice Guidelines disseminated to the Plan's provider network?

4. Access

Provider Outreach

1. What is the Plan's process for selecting network providers?
2. What outreach activities has the Plan done and is conducting to enroll providers as in-network providers?
3. Has the Plan offered any assistance in getting a provider interested in becoming a DMC certified network provider through the DHCS Provider Enrollment Division? If so, please explain the assistance the Plan is offering.
4. How does the Plan validate that accurate information is collected and included with the Plan's Provider Directory, particularly regarding cultural competency and disability accessibility?

Provider Policies and Procedures

1. Does the Plan have a policy and procedure in place that addresses selection and retention of network providers? Explain this process.
2. Provide a copy of the procedure addressing selection and retention of network providers.
3. Does the Plan have a policy and procedure for credentialing and re-credentialing its providers? Please explain this process.
4. Please provide a copy of the Plan's policy and procedure for credentialing and re-credentialing its providers.
5. Has the Plan established a QM Program that includes a mechanism to monitor provider credentialing? If so, please explain the monitoring process.

Network Adequacy

1. Does the Plan have policies and procedures in place that address network adequacy requirements, including Network Adequacy Monitoring, Out of Network Access, Timely Access, Service Availability, Physical Accessibility, Telehealth Services, 24/7 Access Line, and 24/7 Language Assistance?
2. Please provide a copy of the policies and procedures for network adequacy.
3. Please report data on the Plan’s network providers.
4. Please provide executed contracts for the Plan’s language line services and 24/7 access line.

Single Case Agreement Process

1. In the event that a NTP beneficiary goes out of town on vacation, does the Plan have a single case agreement process developed to ensure the beneficiary can continue receiving their medication while they are out-of-network? Please explain this process.
2. Please provide a copy of the single case agreement, in the event that a NTP beneficiary goes out of town on vacation and can continue receiving their medication from an out-of-network provider.

5. Continuity and Coordination of Care

Care Coordination Plans

1. Please explain the Plan's process for coordinating beneficiaries' care between levels of care utilizing the ASAM criteria.
2. Within what timeframe does the Plan require its providers to conduct an initial screening of a beneficiary's need?
3. Who does the coordination of care?
4. How can the beneficiary contact the designated person who coordinates care?

Staff Training

1. How has the Plan trained its care coordinator in ASAM criteria and care coordination systems?
2. How has the Plan trained its providers in ASAM criteria and care coordination systems?

Memorandum of Understandings (MOUs) with Medi-Cal Managed Care Plans

1. Has the Plan executed an MOU with the MCPs within the county of operation?
2. Please provide a copy of any executed MOU with the managed care plan(s) in the County.

Care Coordination Procedures

1. Does the Plan have care coordination procedures its providers must follow? If yes, provide a copy of these procedures.
2. Please provide a copy of the care coordination procedures.
3. How will the Plan monitor its providers to ensure they are following the county-developed care coordination procedures and ensure that claims and services are not denied for incorrect reasons?

6. Grievance, Appeal, and Fair Hearing Process

Call Center Training

1. What training is provided to call center and other enrollee facing staff to recognize when an issue is a grievance or appeal and when it should be referred to other staff at the Plan?
2. How do call center staff know who to refer calls to?
3. What training is provided regarding the grievances and appeals processes?

Internal Tracking System

1. What will be the Plan's process for tracking grievances and appeals?
2. Is there a formal written process or procedure for handling grievances and appeals? Explain this process.
3. Provide a copy of the Plan's written grievance and appeals procedure.

State Specific Reporting

1. How will the Plan implement the state specific reporting mechanism?

7. Quality

Quality Management Plan

1. Does the Plan have a QM Work Plan developed?
2. Describe the QM Work Plan.
3. Provide a copy of the Plan's QM Work Plan.
4. How are Quality Assurance staff trained on the QM Work Plan?

Policies and Procedures

1. Does the Plan have a written process for detecting both underutilization of services and overutilization of services? If so, provide a copy of this process.
2. Does the Plan have a written process to assess beneficiary/family satisfaction? If so, provide a copy of this process.
3. Does the Plan have a written process to monitor the safety and effectiveness of medication practices? If so, provide a copy of this process.
4. Does the Plan have a written process to monitor appropriate and timely intervention of occurrences that raise concerns about the quality of care? If so, provide a copy of this process.

Performance Improvement Projects

1. Has the Plan established an ongoing quality assessment and performance improvement program?
2. Who at the Plan is responsible for the QI program?
3. Does the Plan have a QI committee established to measure any improvements as they relate to the new benefits?
4. What activities is the QI committee responsible for?
5. Does the QI Program include a Licensed SUD staff person?
6. Has the Plan began planning or strategizing for the Plan's Quality Improvement projects? Please explain.

8. Program Integrity

Systems Development

1. Does the Plan have a system to track and collect Program Integrity issues? If so, describe this system.
2. Does the Plan have procedures for providers to determine beneficiary eligibility each month? If so, describe these procedures.

Compliance

1. Who is the Plan's Compliance Officer? Please provide their name and contact information.
2. Does the Plan and the Plan's subcontractors follow Plan implemented procedures for detecting and preventing fraud, waste, and abuse?

3. Has the Plan established a Regulatory Compliance Committee?
4. Who is on the Regulatory Compliance Committee and when do they meet?
5. What is the Plan's process for monitoring and auditing all providers for potential compliance problems?
6. How does the Plan train staff on identification of fraud and abuse as it relates to new benefits?
7. What is the Plan's process for reporting any potential fraud, waste, or abuse to DHCS?

Overpayments Processes

1. Does the Plan have a written procedure for the prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud to DHCS?
2. Please provide the procedure for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud to DHCS.
3. What is the Plan's process for a network provider to report to the Plan when it has received an overpayment?

9. Finance
Test Claims

1. How does the Plan ensure timely payment to provider networks?
2. Does the Plan have working P&Ps on timeline payment of claims to provider networks?
3. How does the Plan train its staff on other areas of TPL to ensure appropriate billing of third parties to ensure that DMC funds are used as a payment of last resort?

ENCLOSURE 8

Readiness Review – Document Checklist
Drug Medi-Cal Organized Delivery System (DMC-ODS)

	Requested Document	Provided (Y/N)
1	Provide a copy of the job description for each of the new jobs created.	
2	Provide a copy of the policy or procedure requiring provider staff training.	
3	Provide a copy of the Plan's training schedule.	
4	Provide a copy of the Plan's draft beneficiary handbook.	
5	Provide the link to the Plan's webpage with the current Provider Directory or planned DMC-ODS Provider Directory.	
6	Provide a copy of the Plan's Practice Guidelines.	
7	Provide a copy of the procedure addressing selection and retention of network providers.	
8	Provide a copy of the Plan's policy and procedure for credentialing and re-credentialing its providers.	
9	Provide a copy of the single case agreement, in the event that a NTP beneficiary goes out-of-town on vacation and can continue receiving their dosing from an out-of-network provider.	
10	Provide a copy of all executed Memorandums of Understanding with the managed care plan(s) in the County.	
11	Provide a copy of the care coordination procedures.	
12	Provide a copy of the Plan's written grievance and appeals procedure.	
13	Provide a copy of the Plan's QM Work Plan.	
14	Provide the Plan's process for detecting underutilization and overutilization of services.	
15	Provide the Plan's process for assessing beneficiary/family satisfaction.	
16	Provide the Plan's process for monitoring the safety and effectiveness of medication practices.	
17	Provide the Plan's process for monitoring appropriate and timely intervention of occurrences that raise quality of care concerns.	
18	Provide the Plan's Compliance Officer name and contact information.	
19	Provide the procedure for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud.	
20	Provide a completed Network Adequacy Certification Tool.	

21	Provide a copy of policies and procedures in place that address network adequacy requirements, including Network Adequacy Monitoring, Out of Network Access, Timely Access, Service Availability, Physical Accessibility, Telehealth Services, 24/7 Access Line, and 24/7 Language Assistance.	
22	Provide a copy of the Plan's nondiscrimination requirements, including language assistance and access to information for individuals with limited English proficiency and/or disabilities.	
23	Provide a completed Timely Access Data Tool.	
24	Provide a completed Transition of Care Requests Report.	
25	Provide a copy of Subcontractor Boilerplate.	
26	Provide a copy of Grievances and Appeals related to access to care.	
27	Provide a copy of subcontracts for interpreter, language line, and telehealth services.	
28	Provide a completed Alternative Access Standards Request Template (if applicable).	