DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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Supersedes: BHIN 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 California Advancing and Innovating Medi-Cal (CalAIM), effective January 2022 through December 2026, including program updates.

SUPERSEDES: BHIN 20-074E; BHIN 21-024; and BHIN 23-001.

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); APL 17-020; APL 18-001; APL 21-008; SB 184; MHSUDS 18-010E; MHSUDS 18-051; BHIN 20-065; BHIN 21-001; BHIN 21-041; BHIN 22-003; BHIN 22-005; BHIN 22-006; BHIN 22-011; BHIN 22-013; BHIN 22-018; BHIN 22-026; BHIN 22-045; BHIN 22-053; BHIN 22-061;

BHIN 22-062; BHIN 22-067; BHIN 23-003; BHIN 23-006; BHIN 23-010; BHIN 23-012; BHIN 23-017; BHIN 23-018; BHIN 23-025; BHIN 23-026; BHIN 23-040; BHIN 23-041; BHIN 23-048; BHIN 23-049; BHIN 23-054; BHIN 23-057; BHIN 23-059; BHIN 23-064; and BHIN 23-068.

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BACKGROUND:

CalAIM is a multi-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reforms across the Medi-Cal program. DHCS conducted extensive stakeholder engagement to elicit county, provider, and member 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 and others which were effective January 2022. BHIN 21-075 implemented those initial updates. The Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026 BHINs are superseded by updated BHINs when additional CalAIM initiatives are implemented that impact DMC-ODS.

This BHIN updates DMC-ODS program requirements to align with CalAIM behavioral health initiatives, including the policies outlined in 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 23-003; BHIN 23-006; BHIN 23-010; BHIN 23-012; BHIN 23-017; BHIN 23-018; BHIN 23-025; BHIN 23-026; BHIN 23-040; BHIN 23-041; BHIN 23-048; BHIN 23-049; BHIN 23-054; BHIN 23-057; BHIN 23-059; BHIN 23-064; BHIN 23-068; and SPA 23-0026.

Anytime a BHIN is referenced in this document, that reference shall also be deemed to include any subsequently issued superseding BHINs.

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 SUDs. Medi-Cal-eligible individuals include adult members whose county of residence participates in DMC-ODS and Medi-Cal members under the age of 21 in all counties.[1] Medi-Cal adult members whose county of residence participates in DMC-ODS, and Medi-Cal members under age 21 in all counties, are able to receive DMC-ODS services consistent with this BHIN's medical necessity of

[1] The County of Residence is the field in the Medi-Cal Eligibility Data System (MEDS) and MEDSLITE that indicates the county in which the member resides or the county in which a justice-involved individual plans to reside upon their release. See the County of Residence and Responsibility BHIN on the DHCS BHIN Table of Contents webpage for more information.

services criteria, access criteria, assessment criteria, and level of care determination criteria.[2]

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 members with an expanded range of evidence-based SUD treatment services. Critical elements of the 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 SUD treatment, and increased coordination with other systems of care.

The DMC-ODS plan (inclusive of the DMC-ODS county, 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 plans may also contract with a Managed Care Plan (MCP) to provide services. DMC-ODS plans 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 members 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 plans 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 members under age 21 for further guidance on compliance with EPSDT requirements. Please note that the access criteria for members under 21 are 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

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”

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

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

All DMC-ODS plans shall maintain policies and procedures, provider contracts, beneficiary handbooks, and related materials that accurately reflect these medical necessity standards, consistent with W&I Code section 14059.5 and the terms of this BHIN.[3]

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:

(a) Services are provided prior to determination of a diagnosis or prior to determination of whether DMC-ODS access criteria (see description below) are met; or
(b) The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or
(c) The member has a co-occurring mental health condition.

Regarding (a), clinically appropriate and covered DMC-ODS services provided to members over 21 are reimbursable during the assessment process as described in the "*Initial Assessment and Services Provided During the Assessment Process"* subsection. In addition, DMC-ODS plan(s) shall not disallow reimbursement for clinically appropriate and covered DMC-ODS services provided during the assessment process if the assessment subsequently determines that the member does **not** meet the criteria listed under the "*DMC-ODS Access Criteria for Members After Assessment"* subsection.

This does not eliminate the requirement that all Medi-Cal claims, including DMC-ODS claims, include a CMS approved International Classification of Diseases, Tenth

[3] DMC-ODS Beneficiary Handbooks are available in BHIN 23-048.

Revision (ICD-10-CM) code.[4] 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 (b), the DHCS guidance on documentation requirements that took effect as of January 1, 2024 can be found in BHIN 23-068. NTPs must comply with the NTP treatment plan components set forth in 42 CFR 8.12.

Regarding (c), medically necessary covered DMC-ODS services delivered by DMC-ODS providers are covered and reimbursable Medi-Cal services whether or not the member has a co-occurring mental health condition. DMC-ODS plans shall not disallow reimbursement for covered DMC-ODS services provided to a member who has a co-occurring mental health condition if the member meets the criteria listed under the "*DMC-ODS Access Criteria for Members After Assessment"* subsection.

For additional information regarding covered services for members with co-occurring SUD and mental health conditions, please refer to BHIN 22-011.

DMC-ODS Access Criteria for Members After Assessment

(a) *Members 21 years and older:* To qualify for DMC-ODS services after the initial assessment process, members 21 years of age and older must meet one of the following criteria:

(1) Have at least one diagnosis from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, or
(2) 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.

[4] The 2024 ICD-10-CM Tabular (October 1, 2023, through September 30, 2024) is available at https://www.cms.gov/medicare/icd-10/2024-icd-10-cm.

(b) *Members under the age of 21*: Members 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. 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. DMC-ODS plans are obligated to provide early intervention services under the outpatient modality to members under the age of 21 at risk of developing an SUD, regardless of whether they meet diagnostic criteria for SUD, and even if the member is not participating in the full array of outpatient treatment services. For additional information regarding EPSDT requirements, please refer to BHIN 22-003.

DMC-ODS Assessments and Services

Initial Assessment and Services Provided During the Assessment Process

Pursuant to Welfare and Institutions Code section 14184.402(f)(1)(A), an SUD diagnosis is not a prerequisite for access to covered DMC-ODS services. Covered and clinically appropriate DMC-ODS services are Medi-Cal reimbursable during the assessment process, whether or not a Diagnostic and Statistical Manual of Mental Disorder (DSM) diagnosis for Substance-Related and Addictive Disorders is immediately established. Specific level-of-care assessment and authorization policies remain in effect for Residential Treatment Services and Withdrawal Management Services, as described below.

The standardized assessment requirements for DMC-ODS services can be found in BHIN 23-068.

Level of Care Determination

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

necessity.[5,6] Additional guidance on ASAM Level of Care determinations is as follows:

(a) A full ASAM Criteria assessment is not required to deliver prevention and early intervention services for members under 21; a brief screening ASAM Criteria tool is sufficient for these services.
(b) 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.
(c) A full ASAM assessment does not need to be repeated unless the member's condition changes.
(d) These requirements for ASAM level of care assessments apply to NTP clients and settings.

Residential and inpatient DMC-ODS services are subject to prior authorization. See this BHIN's section Authorization Policy for Residential/Inpatient Levels of Care for specific authorization requirements for residential and inpatient services.

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

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. Required and optional services and levels of care within the DMC-ODS benefits are depicted in Enclosure 2. DMC-ODS services must be recommended by a Licensed Professional of the Healing Arts (LPHA), as defined in California's Medicaid State Plan, acting within the scope of their practice. DMC-ODS services must be provided by DMC-certified providers and based on medical necessity.[7,8]

DMC-ODS covered services may be provided in person, by telehealth (synchronous audio-only and synchronous video interactions), or by telephone. Member choice

[5] Narcotic Treatment Programs (NTPs) shall conduct a medical history and physical exam pursuant to state and federal regulations (CCR, tit. 9, Section 10270(a)). This medical history and physical exam done at admission to a NTP qualifies for the purpose of determining medical necessity under the DMC-ODS.
[6] W&I Code section 14184.402(e)(1).
[7] See Enclosure 5 of this BHIN and California State Plan, Sec. 3, Att. 3.1-A, Supp. 3 for guidance on DMC-ODS providers.
[8] Visit the DHCS DMC providers webpage for resources for Drug Medi-Cal providers.

must be preserved; therefore, members have the right to request and receive covered services in person.[9] This requirement applies to the following DMC-ODS services and service components:[10]

(a) Early Intervention Services
(b) Outpatient Treatment Services
(c) Intensive Outpatient Treatment Services
(d) Partial Hospitalization Services
(e) Residential Treatment Services
(f) Inpatient Services
(g) Recovery Services
(h) Care Coordination
(i) Clinician Consultation

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.

(a) *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 members less than 21 years of age.

Early intervention services are covered DMC-ODS services for members under the age of 21. Any member 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.[11] A full assessment utilizing the ASAM criteria is not required for a DMC member under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may

[9] See BHIN 23-018 for telehealth requirements for DMC-ODS covered services.
[10] Any exceptions to this requirement are described in the service descriptions.
[11] As noted above, this does not eliminate the requirement that all Medi-Cal claims, including DMC-ODS claims, must include a CMS approved ICD-10-CM diagnosis code. 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 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.

be used in lieu of a full ASAM for purposes of assessing for SBIRT or Early Intervention Services. A full ASAM assessment shall be performed, and the member under the age of 21 shall receive a referral to the appropriate level of care indicated by the assessment if the member's conditions or symptoms constitute diagnostic criteria for SUD.

Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the member under age 21 is not participating in the full array of outpatient treatment services.

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

(b) *Outpatient Treatment Services (ASAM Level 1)*

Outpatient treatment services (also known as Outpatient Drug Free or ODF) are provided to members when medically necessary. These services may be offered for up to nine hours a week for adults, and six hours a week for members under the age of 21. Services may exceed the maximum based on individual medical necessity.

Outpatient treatment services include the following service components:

(1) Assessment
(2) Care Coordination
(3) Counseling (individual and group)
(4) Family Therapy
(5) Medication Services
(6) MAT for Opioid Use Disorder (OUD)
(7) MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
(8) Patient Education
(9) Recovery Services
(10) SUD Crisis Intervention Services

(c) *Intensive Outpatient Treatment Services (ASAM Level 2.1)*

Intensive Outpatient Treatment Services are provided to members when medically necessary in a structured programming environment. These services may be offered for 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 members under the age of 21. Services may exceed the maximum based on individual medical necessity.

Intensive Outpatient Treatment Services include the following service components:

(1) Assessment
(2) Care Coordination
(3) Counseling (individual and group)
(4) Family Therapy
(5) Medication Services
(6) MAT for OUD
(7) MAT for AUD and other non-opioid SUDs
(8) Patient Education
(9) Recovery Services
(10) SUD Crisis Intervention Services

(d) *Partial Hospitalization Services (ASAM Level 2.5)*

Partial Hospitalization Services are optional for DMC-ODS plans.

Partial Hospitalization Services are clinically intensive programming designed to address the treatment needs of members with severe SUD requiring more intensive treatment services than can be provided at lower levels of care. Partial Hospitalization Services are delivered to members when medically necessary in a clinically intensive programming environment and consist of a minimum of 20 hours of clinically intensive programming per week. 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.

Partial Hospitalization Services include the following service components:

(1) Assessment
(2) Care Coordination
(3) Counseling (individual and group)
(4) Family Therapy
(5) Medication Services
(6) MAT for OUD
(7) MAT for AUD and other non-opioid SUDs
(8) Patient Education
(9) Recovery Services
(10) SUD Crisis Intervention Services

(e) *Residential Treatment and Inpatient Services (ASAM Levels 3.1 – 4.0)*

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

(1) Level 3.1 - Clinically Managed Low-Intensity Residential Services
(2) Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
(3) Level 3.5 - Clinically Managed High Intensity Residential Services

Inpatient Treatment Services are delivered to members when medically necessary in a short-term inpatient program corresponding to at least one of the following levels:[12]

(1) Level 3.7 - Medically Monitored Intensive Inpatient Services
(2) Level 4.0 - Medically Managed Intensive Inpatient Services

Residential and Inpatient Treatment Services require a clearly established site for services and in-person contact with a beneficiary in order to be claimed.[13] 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 member 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.

Residential Treatment Services (ASAM Levels 3.1, 3.3, 3.5)
DMC-ODS plans shall implement coverage and ensure access for residential SUD treatment services as follows:

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

[12] DMC-ODS plans may 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, Freestanding Acute Psychiatric Hospitals (FAPHs), or Chemical Dependency Recovery Hospitals (CDRHs). Regardless of whether the DMC-ODS plan 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.

[13] See BHIN 23-018 for additional information.

Residential Treatment Services include the following services:

(1) Assessment
(2) Care Coordination
(3) Counseling (individual and group)
(4) Family Therapy
(5) Medication Services
(6) MAT for OUD
(7) MAT for AUD and other non-opioid SUDs
(8) Patient Education
(9) Recovery Services
(10) SUD Crisis Intervention Services

Residential Treatment Services 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 and residential facilities licensed by the Department of Social Services. In order to participate in the DMC-ODS program and offer ASAM Levels 3.1, 3.3, or 3.5, residential providers licensed by a state agency other than DHCS must be DMC-certified.

Residential Treatment Services can be provided in facilities of any size. 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, and 3.5 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. 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. DMC-ODS plans will be responsible for ensuring and verifying that DMC-ODS providers delivering ASAM Levels 3.1, 3.3 or 3.5 obtain an ASAM LOC Certification and/or DHCS LOC Designation for each level of care provided effective January 1, 2024.[14]

The statewide goal for the average length of stay for Residential Treatment Services provided by DMC-ODS plans 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, DMC-ODS plans shall ensure that members receiving residential treatment are transitioned to another level of care

[14] DHCS LOC designations are only available to residential facilities licensed by DHCS.

when clinically appropriate based on treatment progress. DMC-ODS plans 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.

Inpatient Services (ASAM Level 3.7 and 4.0)

DMC-ODS plans may 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, Freestanding Acute Psychiatric Hospitals (FAPHs), or Chemical Dependency Recovery Hospitals (CDRHs). Regardless of whether the DMC-ODS plan 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 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:

(1) Assessment
(2) Care Coordination
(3) Counseling (individual and group)
(4) Family Therapy
(5) Medication Services
(6) MAT for OUD
(7) MAT for AUD and other non-opioid SUDs
(8) Patient Education
(9) Recovery Services
(10) SUD Crisis Intervention Services

(f) *Narcotic Treatment Program (NTP)*

An NTP, also described in the ASAM criteria as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary.

NTPs are required to administer, dispense, or prescribe medications for members 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 member to a provider capable of dispensing the medication.

Pursuant to California Code of Regulations (CCR), Title 9, Chapter 4 10345(a), The NTP shall offer the member 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 member in choosing another medication for opioid use disorder (MOUD) and/or 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 Code of Federal Regulations (42 CFR).

Counseling services provided in the NTP modality may be provided in person, by telehealth (synchronous audio-only and synchronous video interactions), or by telephone. Member choice must be preserved; therefore, members have the right to request and receive in-person services.[15] To provide synchronous audio-only counseling services without video capability, an NTP must submit a letter of need to DHCS by emailing dhcsntp@dhcs.ca.gov and requesting an exception to CCR, Title 9, Chapter 4 10345(b)(3)(A) upon the request of the member. 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:

(1) Assessment
(2) Care Coordination
(3) Counseling (individual and group)
(4) Family Therapy
(5) Medical Psychotherapy
(6) Medication Services
(7) MAT for OUD
(8) MAT for AUD and other non-opioid SUDs

[15] See BHIN 23-018 for telehealth requirements for DMC-ODS covered services.

(9) Patient Education
(10) Recovery Services
(11) SUD Crisis Intervention Services

(g) *Withdrawal Management Services*

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

(1) Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision)
(2) 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)
(3) Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting)
(4) Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits)
(5) 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 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.

Withdrawal Management Services may be provided in an outpatient, residential or inpatient setting.[16] If a member is receiving Withdrawal Management in a residential setting, each member shall reside at the facility. All members receiving Withdrawal

[16] Please refer to BHIN 21-001 and attachments for Level of Care Certification/Designation requirements applicable to Withdrawal Management delivered in residential settings.

Management services, regardless in which type of setting, shall be monitored during the withdrawal management process.

Withdrawal Management Services include the following service components:

(1) Assessment
(2) Care Coordination
(3) Medication Services
(4) MAT for OUD
(5) MAT for AUD and other non-opioid SUDs
(6) Observation
(7) Recovery Services

(h) *Medications for Addiction Treatment (MAT)*[17]

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:

(1) Assessment
(2) Care Coordination
(3) Counseling (individual and group)
(4) Family Therapy
(5) Medication Services
(6) Patient Education
(7) Recovery Services
(8) SUD Crisis Intervention Services
(9) Withdrawal Management Services

For additional guidance regarding MAT requirements, please refer to *DMC-ODS MAT Policy* section of this BHIN and to BHIN 23-054.

(i) *Medi-Cal Peer Support Services*

Medi-Cal Peer Support Services are defined as "culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of

[17] Also known as medication-assisted treatment.

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 Medi-Cal members through strength-based coaching, support linkages to community resources, and educate members and their families about their conditions and the process of recovery." Medi-Cal Peer Support Services may be provided with the member or significant support person(s) and may be provided in a clinical or non-clinical setting.

Medi-Cal Peer Support Services can be delivered and claimed as a standalone service or provided in conjunction with other DMC-ODS services or levels of care described in this "Covered DMC-ODS Services" section, including inpatient and residential services. For guidance on claiming Medi-Cal Peer Support Services, please refer to the most current DMC-ODS Billing Manual.

Medi-Cal Peer Support Services became available as a county option as of July 1, 2022. For counties that did not choose to opt-in for the July 1, 2022, implementation, they may choose to do on an annual basis. For additional guidance regarding Medi-Cal Peer Support Services, please refer to BHIN 21-041; BHIN 22-006; BHIN 22-018; BHIN 22-026; BHIN 22-061; BHIN 22-062; BHIN 22-067; BHIN 23-003; BHIN 23-010; BHIN 23-012; and the Medi-Cal Peer Support Services webpage.

(j) *Contingency Management*

Contingency Management (CM) is an evidence-based, cost-effective behavioral treatment for SUD that provides motivational incentives to treat individuals and reinforces positive behavior change for an individual 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. California is the first state in the country to receive Medicaid expenditure authority to include CM as a benefit. CM is a core component of DHCS' efforts to address the ongoing overdose crisis and further advance the state's goals to reduce racial disparities and advance health equity.

To expand access to evidence-based treatment for stimulant use disorder, DHCS began piloting Medi-Cal coverage of CM through the Recovery Incentives Program, for select DMC-ODS plans in Q1 2023. Participation in the Recovery Incentives Program is optional for DMC-ODS plans, and it is available as an opt-in benefit for all DMC-ODS plans through December 31, 2026.

The Recovery Incentives Program is intended to complement SUD treatment services and other evidence-based practices already offered by DMC-ODS providers. 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, including information on how to opt into the program, please visit the DHCS Recovery Incentives Program webpage and refer to BHIN 23-040. DMC-ODS plans that are interested in opting into Recovery Services may email RecoveryIncentives@dhcs.ca.gov.

(k) *Recovery Services*

Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the member to their best possible functional level. Recovery Services emphasize the member's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to members.

Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care described in this BHIN's "Covered DMC-ODS Services" section, or as a service delivered as part of these levels of care. Recovery Services may be provided in clinical or non-clinical settings (including the community).

Members may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Members do not need to be diagnosed as being in remission to access Recovery Services. Members may receive Recovery Services while receiving other DMC-ODS services, including MAT services and including NTP services. Members may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD.

Recovery Services include the following service components:

(1) Assessment
(2) Care Coordination
(3) Counseling (individual and group)
(4) Family Therapy
(5) Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the member's SUD.

(6) Relapse Prevention, which includes interventions designed to teach members with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the member's SUD.

For additional guidance regarding Recovery Services, please refer to BHIN 22-005.

(l) *Care Coordination*[18]

Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the member with linkages to services and supports designed to restore the member to their best possible functional level.

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

Care coordination includes one or more of the following components:

(1) Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
(2) 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.
(3) 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.
(4) 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.

[18] Care Coordination was previously referred to as "case management" in the Section 1115 Special Terms and Conditions (STCs) that were used to describe the DMC-ODS program for the years 2015 – 2021. Per CMS feedback, DHCS has retitled this benefit to "care coordination."

(m) *Clinician Consultation*[19]

Clinician Consultation consists of DMC-ODS providers who are qualified to perform assessments, as described in California's Medicaid State Plan, consulting with providers, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care.[20]

Clinician Consultation is not a direct service provided to DMC-ODS members. 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 members. DMC-ODS plans may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services.

(n) *Mobile Crisis Services*

Mobile Crisis services provide rapid response, individual assessment, and community-based stabilization to Medi-Cal members who are experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to members experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

Consistent with existing guidance and given the unique nature of behavioral health crises, mobile crisis services are covered and reimbursable prior to determination of a mental health or SUD diagnosis, or a determination that the member meets access criteria for SMHS, DMC and/or DMC-ODS services.[21]

For additional guidance regarding Mobile Crisis Services, please refer to BHIN 23-025.

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[19] 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.

[20] See Enclosure 5 of this BHIN and California State Plan, Sec. 3, Att. 3.1-A, Supp. 3 for guidance on DMC-ODS providers.

[21] See also Welf. & Inst. Code, 14184.402, subd. (f).

DMC-ODS MAT Policy

For the following DMC-ODS services or service components, DMC-ODS plans shall ensure that all DMC-ODS providers either offer MAT services directly, or have an effective referral process in place to the most clinically appropriate MAT services, pursuant to the requirements set forth in BHIN 23-054:

(a) Outpatient Treatment Services
(b) Intensive Outpatient Treatment Services
(c) Partial Hospitalization Services
(d) Residential Treatment Services
(e) Inpatient Services
(f) Withdrawal Management Services

An effective referral process shall include an established relationship with a MAT provider and transportation to appointments for MAT. Providing contact information for a MAT provider does not meet the requirement of an effective referral. An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the member is compliant whether or not that provider seeks reimbursement through DMC-ODS.

DMC-ODS plans shall monitor the referral process or provision of MAT services. Providers are required to comply with DHCS' MAT access policy, which applies to all licensed and/or certified SUD programs and is described in BHIN 23-054.

DMC-ODS plans 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 plans 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 plans do not choose to cover the drug product costs for MAT outside of the pharmacy or NTP benefit, DMC-ODS plans 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.

Members 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 member who declines counseling services. For members who lack 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 member, 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.

While naloxone is not medication used to treat SUD, naloxone is a critical tool in responding to the opioid crisis. Naloxone is a life-saving medication used to reverse an opioid overdose, including heroin, fentanyl, and prescription opioid medication overdoses. DMC-ODS providers have the flexibility to provide or arrange for naloxone to be prescribed and provided to each DMC-ODS beneficiary by leveraging Medi-Cal Rx.

For example, DMC-ODS providers, authorized to prescribe medication, can prescribe naloxone to each member who is under their care and arrange for staff to routinely fill these naloxone prescriptions at a pharmacy on behalf of the members. Additionally, DMC-ODS providers can coordinate delivery of the naloxone from a pharmacy to the member’s location.

Medical Directors and prescribing clinicians of DMC-ODS providers are also able to establish a Standardized Protocol that authorizes designated staff working in a DMC-ODS provider agency (using a standardized procedure and standing order specific to prescribing naloxone) to issue prescriptions on behalf of the Medical Directors or prescribing clinicians to a local pharmacy for naloxone.

The pharmacy bills these naloxone prescriptions through Medi-Cal Rx. The staff may bring the dispensed naloxone back to the DMC-ODS provider site, or the pharmacy may arrange delivery to furnish naloxone directly to patients. This method enables DMC-ODS providers to better facilitate onsite access to naloxone reimbursed through Medi-cal Rx. DMC-ODS providers may also refer patients to pharmacies that will dispense naloxone directly to the patient.

For additional guidance regarding naloxone, please refer to BHIN 23-064.

Justice-Involved Populations and CalAIM Justice-Involved Initiatives

Individuals involved in the criminal justice system experience disproportionately higher rates of behavioral health diagnoses, trauma and overdose in comparison to people who have never been incarcerated. Overdose is a leading cause of death of people currently incarcerated and the leading cause of death for those recently released; during the first two weeks of release, a justice-involved individual is 129 times more likely to die from overdose than the general population.[22,23]

These risks disparately impact people of color, who are disproportionately represented in the Justice-Involved population due to systemic inequities in the criminal justice system and a higher likelihood of incarceration due to mental health issues, discriminatory policing and the criminalization of substance use disorders.[24] As of 2017, 28.5% of incarcerated men in California were African American, despite making up only 5.6% of the state's male residents. Furthermore, African American men are imprisoned at a rate 10 times higher than that of white men, and Latino men at a rate three times that of men of other races.[25]

California's justice-involved individuals also experience additional barriers to access SUD treatment, despite this population's increasing need. Over the past decade, the proportion of incarcerated individuals in California jails with an active mental health case rose by 63%.[5] As of 2019, 66% of incarcerated Californians have moderate or high need for SUD treatment.[26] Research has shown that justice-involved individuals can respond effectively to treatment services and may require tailored engagement approaches and more intensive services. Carceral, parole, or probation status shall not be a barrier to receipt of SUD services.

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[22] Binswanger, Ingris, M.D., et al. (January 2007). *Release from Prison – A High Risk of Death for Former Inmates*. The New England Journal of Medicine. https://www.nejm.org/doi/full/10.1056/nejmsa064115.

[23] Allen, Denise M., M.A., M.S., Ph.D., et al (April 2023). *Impacts of the Integrated Substance Use Disorder Treatment (ISUDT) Program on Morbidity and Mortality*. California Correctional Health Care Services. https://cchcs.ca.gov/wp-content/uploads/sites/60/2023-ISUDT-Report_v36.pdf.

[24] *Transformation of Medi-Cal: Justice-Involved*. California Department of Health Care Services. https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-JI-a11y.pdf

[25] Hayes, Joseph, et al. (July 2019). *California's Prison Population*. Public Policy Institute of California. https://www.ppic.org/publication/californias-prison-population/#:~:text=Since%202017%2C%20California's%20institutional%20prison,individually%20operate%20beyond%20that%20capacity.

[26] (February 2020). *The Prevalence of Mental Illness in California Jails is Rising*. California Health Policy Strategies, LLC. https://calhps.com/wp-content/uploads/2023/03/Jail_MentalHealth_JPSReport_02-03-2020.pdf

The CalAIM Justice-Involved Initiative is a core component of DHCS' efforts to address the ongoing overdose crisis and further advance the state's goals to reduce racial disparities and advance health equity. On January 26, 2023, California became the first state in the nation to receive federal approval to offer a targeted set of Medicaid services to Medi-Cal-eligible youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release. Through a federal Medicaid 1115 demonstration waiver approved by CMS, DHCS will partner with state agencies, counties, providers, and community-based organizations to establish a coordinated community reentry process that will assist people leaving incarceration with connecting to the physical and behavioral health services they need prior to release and re-entering their communities.

The CalAIM Justice-Involved Reentry Initiative intends to build a bridge to community-based care for justice-involved Medi-Cal members who meet program criteria, including members with SUDs, by offering them select, covered Medi-Cal services for up to 90 days prior to their release (collectively referred to as "pre-release services") to stabilize their health conditions and establish a plan for their community-based care Pre-release services are the responsibility of the correctional facilities, and not part of DMC-ODS plans' contractual coverage obligations. Correctional facilities may choose to deliver pre-release services and/or enter into contracts for pre-release services with DMC-ODS plans or community-based SUD treatment providers.

To ensure seamless continuity of care following re-entry into the community, justice-involved members shall be promptly connected to appropriate community-based services, including mental health and substance use treatment through coordinated behavioral health links (BH Links). As part of BH Links, DMC-ODS plans will be required, within 14 days prior to release (if known), and in coordination with the pre-release care manager, to ensure processes are in place for a BH Link between the correctional behavioral health provider, a DMC-ODS provider, and the member. DMC-ODS plans are required to implement all components of BH Links, including ability to receive referrals from correctional facilities in all counties, by October 1, 2024.

BHIN 23-059 and the Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Reentry Initiative describe new requirements for DMC-ODS plans to implement BH Links in collaboration with correctional facilities, and guidance for providers and counties on the health care needs criteria and covered pre-release services. Questions on BHIN 23-059 or other parts of the CalAIM Justice-Involved Initiative may be directed to CalAIMJusticeAdvisoryGroup@dhcs.ca.gov.

Indian Health Care Providers

American Indian and Alaska Native (AI/AN) 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:

(a) *Indian Health Service (IHS) facilities* – Facilities and/or health care programs administered and staffed by the federal Indian Health Service.
(b) *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.

    (1) 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.
    (2) Tribal 638 providers enrolled in Medi-Cal as a Tribal Federally Qualified Health Center (FQHC) provider, must do so consistently 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.[27] Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the "List of Tribal FQHCs"

(c) *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 AI/AN Medi-Cal members whose county of responsibility participates in DMC-ODS may choose to receive DMC-ODS services at any DMC-certified IHCP, whether or not the IHCP has a current contract with the member's county of responsibility and whether or not the IHCP is located in the member's county of responsibility. DMC-ODS plans must reimburse DMC-certified IHCPs for the provision of these services to AI/AN Medi-Cal

[27] 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.

members, even if the DMC-ODS plan does not have a contract with the IHCP. DMC-ODS plans are not obligated to pay for services provided to non-AI/AN members by IHCPs that are not contracted with the DMC-ODS plan.[28]

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 plans must demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to DMC-ODS services. DMC-ODS plans must adhere to all 42 CFR 438.14 requirements.[29]

Responsibilities of DMC-ODS Plans for DMC-ODS Benefits

The responsibilities of DMC-ODS plans for the DMC-ODS benefit shall be included in each DMC-ODS plan's Intergovernmental Agreement (IA) with DHCS. DMC-ODS plans shall comply with the following:

Selective Provider Contracting Requirements for DMC-ODS Plans

DMC-ODS plans 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 plan contract cannot receive a direct contract with the State to provide services to residents of DMC-ODS counties.

Contract Denial and Appeal Process

If a provider that applies to be a contract provider is not selected, DMC-ODS plans shall serve that provider with a written decision including the basis for the denial.

Any solicitation document utilized by plans for the selection of DMC providers must include a protest provision. Plans shall have a protest procedure for providers that are not awarded a contract. The protest procedure shall include requirements outlined in the State/DMC-ODS Plan IA. Providers that submit a bid to be a contract provider, but are not selected, must exhaust the DMC-ODS plan's protest procedure if a provider wishes to challenge the denial to DHCS. If the plan does not render a decision within 30 calendar days after the protest was filed with the plan, the protest shall be deemed denied and the provider may appeal the failure to DHCS. A provider may submit an appeal to DHCS following the process established in Enclosure 4.

[28] See BHIN 20-065 for additional information.
[29] See BHIN 20-065 for additional information.

Access

Each DMC-ODS plan 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 network adequacy standards developed by DHCS, including those set forth in 42 CFR 438.68, and W&I Code section 14197 and any BHINs issued pursuant to those requirements. Access to medically necessary services, including all FDA-approved medications for OUD, cannot be denied for members meeting criteria for DMC-ODS services nor shall members be put on wait lists. DMC-ODS members 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 Plan IA. If the DMC-ODS network is unable to provide medically necessary covered services, the DMC-ODS plan must adequately and timely cover these services out-of-network for as long as the DMC-ODS plan's network is unable to provide them. Additional information regarding network adequacy requirements can be found in BHIN 23-041.

Residential and Inpatient Treatment Provider Level of Care Certifications/Designations

By January 1, 2024, all providers delivering Residential Treatment Services Levels 3.1, 3.3, or 3.5 within the DMC-ODS must have either a DHCS LOC Designation and/or an ASAM LOC Certification as referenced in BHIN 21-001. BHIN 21-001 also describes applicable requirements for providers of residential Withdrawal Management Services.

Authorization Policy for Residential/Inpatient Levels of Care

DMC-ODS plans shall provide independent review of authorization requests for residential and inpatient services (excluding withdrawal management services) and notify the provider of the plan's decision within 24 hours of the submission of the request by the provider.

DHCS does not require DMC-ODS plans to obtain a complete assessment or diagnosis to authorize residential treatment. DMC-ODS plans must review sufficient information, including DSM and ASAM Criteria, to ensure that the member meets the requirements for the service, and must communicate authorization policies to network providers consistent with the guidance below. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by an individual who has appropriate expertise in addressing the member's medical and behavioral health.[30]

[30] 42 CFR, § 438.210(b)(3).

Counties shall maintain and implement written policies and procedures to address the authorization of residential treatment in accordance with this BHIN, the DMC-ODS intergovernmental agreement, and federal law.[31] Authorization procedures and utilization management criteria shall:

(a) Be based on DMC-ODS access criteria, including access criteria for member under age 21 pursuant to the EPSDT mandate;
(b) Be consistent with current evidence-based clinical practice guidelines, principles, and processes;[32]
(c) Include mechanisms to ensure consistent application of review criteria for authorization decisions;
(d) Provide for consultation with the requesting provider when appropriate;
(e) Be developed with involvement from network providers;
(f) Be evaluated at least annually, and updated as necessary; and,
(g) Be disclosed to the county's members and network providers.

Authorization Policy for Non-Residential/Inpatient Levels of Care

DMC-ODS plans may not impose prior authorization or centralized DMC-ODS plan-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 members call the DMC-ODS plan's member access number or by providers in the DMC-ODS network to determine the appropriate location for treatment.

Member Access Number

All DMC-ODS plans shall have a 24/7 toll free number for both prospective and current members 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 members, as needed.

DMC-ODS County of Responsibility, County of Residence, Care Transitions, and Continuity of Care Policy

The County of Responsibility field in MEDS and MEDSLITE is the official source for determining which county and/or corresponding DMC-ODS plan is responsible to pay

[31] 42 CFR, § 438.210(b).
[32] The ASAM Criteria shall be used to determine a member's placement into the appropriate level of care.

claims and provide any necessary authorizations for medically necessary SUD services provided to an eligible member, unless or until an inter-county transfer (ICT) has been initiated to change the address of a member's residence to another county. If a member moves to a new county or is being released from prison, jail, or a youth correctional facility and initiates an ICT, the new county is responsible for DMC-ODS services as of the date that the county of residence field in MEDS and MEDSLITE is updated. Please see the County of Responsibility and Reimbursement for SMHS, DMC and DMC-ODS BHIN on the DHCS BHIN Table of Contents webpage for more information.

The DMC-ODS plan is responsible for ensuring that its residents with SUD receive appropriate covered treatment services. If a member is able to access all needed covered services, then the DMC-ODS plan is not obligated to subcontract with additional providers to provide more choices for that individual member. However, in accordance with 42 CFR 438.206(b)(4), if the DMC-ODS plan's provider network is unable to provide needed services to a particular member, the DMC-ODS plan shall adequately and timely cover these services out-of-network for as long as the DMC-ODS plan'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 plan to another DMC-ODS plan when a member, 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 plan must allow the member 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 member would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

Accordingly, the DMC-ODS plan shall also ensure that members 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 plan's provider network is unable to provide necessary services to a particular member (e.g., when a member travels out of county and requires daily NTP dosing), the DMC-ODS plan shall adequately and timely cover these services out-of-network for the member, for as long as the DMC-ODS plan's provider network is unable to provide them. In these cases, the DMC-ODS plan shall coordinate and cover the out-of-network NTP services for the member. If a member 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.

Evidence-Based Practice Requirements

DMC-ODS plans 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 Template. The two EBPs are per provider, per service modality. DMC-ODS plans 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:

(a) Motivational Interviewing – A member-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 members' past successes.
(b) 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.
(c) 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 a recovery services program to sustain gains achieved during initial SUD treatment.
(d) Trauma-Informed Treatment – Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.
(e) Psycho-Education – Psychoeducation is designed to educate members about substance abuse and related behaviors and consequences. Psychoeducation provides information designed to have a direct application to members' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist members in recovery, develop an understanding of the process of recovery, and prompt people using substances to act on their own behalf. Psychoeducation can be provided to individuals and to groups.

DMC-ODS Quality Improvement

In accordance with the IA between the state and the DMC-ODS plan, the DMC-ODS plan shall have a Quality Improvement (QI) Plan that describes the DMC-ODS plan's approach 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 plans that have an integrated mental health and SUD department, this QI Plan may be combined with the Mental Health Plan (MHP) QI Plan.

DMC-ODS Plan Oversight, Monitoring, and Reporting

DMC-ODS plans must oversee subcontractors' compliance through on-site monitoring reviews and monitoring report submissions to DHCS. DMC-ODS plans are required to comply with compliance monitoring reviews conducted by DHCS and to develop and implement Corrective Action Plans (CAPs) as needed. DMC-ODS plans are required to submit a CAP to DHCS within 60 days from the issuance of the Findings Report from DHCS. DHCS may require enhanced monitoring and oversight activities due to compliance deficiencies as described in BHIN 23-006. In addition, DHCS may impose administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see BHIN 22-045, and any subsequent guidance on this topic.

DMC-ODS Financing

As of July 1, 2023, DHCS transitioned Medi-Cal specialty behavioral health delivery systems from a cost-based reimbursement methodology to a fee for service reimbursement payment structure. Under this model, DHCS will reimburse DMC-ODS counties that are not part of a regional model for services rendered to Medi-Cal members pursuant to a DHCS-developed county fee schedule for all covered DMC-ODS services.

DMC-ODS counties will negotiate rates with individual network providers in accordance with their internal processes. DHCS will annually publish all DMC-ODS fee schedules on its website. The DMC-ODS counties are not required to reimburse network providers at the rates posted on the DHCS website. The posted rates do not include costs incurred by counties to administer DMC-ODS. Counties that administer DMC-ODS will start or continue to claim quarterly and be paid separately for administrative and utilization review and quality assurance costs. Participating DMC-ODS regional counties are not included in the DMC-ODS county fee schedules and will continue to utilize the payment model outlined in their IA. Please see BHIN 23-017: Specialty Mental Health Services and Drug Medi-Cal Services Rates for more information.

Starting in SFY 2023-24, DHCS and counties will use intergovernmental transfers (IGT) to finance DMC-ODS services. An IGT is a transfer of funds from a county (the public agency) to DHCS (the Medicaid Single State Agency) to be used as the county portion of the nonfederal share in claiming FFP for Medi-Cal covered Behavioral Health Services. Through one of two processes chosen by the DMC-ODS county, the county shall make monthly transfers to DHCS, or authorize DHCS to withhold from these and any other funds eligible under federal law for federal Medicaid reimbursement, to finance the nonfederal share of all DMC-ODS payments. Each county must execute an IGT

Agreement with DHCS to implement the IGT-based reimbursement methodology. Please see BHIN 23-026: County Behavioral Health IGT for more information.

DMC-ODS plans will continue to claim reimbursement for administrative costs on a quarterly basis using form MC 5312 and will continue to claim reimbursement for UR/QA costs on a quarterly basis using form DHCS 5311. Please see BHIN 23-049: Administration and Utilization Review/Quality Assurance (UR/QA) Reimbursement Under Payment Reform for more information.

Implementation Planning for New DMC-ODS Plans

Prior to a county opting in to participate in DMC-ODS, the county must submit a county implementation plan to DHCS using the DMC-ODS County Implementation Plan Template included in Enclosure 3 of this BHIN by July 5th annually for an effective date of July 1st of the subsequent calendar year. Counties cannot commence DMC-ODS services without a DHCS preliminary approved county implementation plan, a completed DHCS readiness review, and their provider network being certified by DHCS. See Enclosures 6, 7 and 8 for the readiness review requirements. DMC-ODS plans must also have an executed DHCS/DMC-ODS County IA approved by the DMC-ODS County Board of Supervisors and post contractual execution approval by DHCS, as well as an executed memoranda of understanding with all Medi-Cal Managed Care Plans operating within the DMC-ODS plan.

In order to receive readiness review approval, counties shall agree to implement coverage and ensure access for residential SUD treatment services as follows:

(a) At least one ASAM level of care upon implementation;
(b) ASAM Level 3.5 available within two years of DMC-ODS implementation; and
(c) ASAM Levels 3.1-3.5 available within three years of DMC-ODS implementation.

The DMC-ODS county implementation plan and readiness review materials must describe referral mechanisms and care coordination for ASAM Levels 3.7 and 4.0 so members can access those services, if not offered by the county. The county implementation plan and readiness review materials must also describe coverage and ensure access for at least one level of Withdrawal Management services upon implementation.

Upon DHCS approval of the readiness review materials and execution of the IA, the county will be able to bill for all covered DMC-ODS services provided to their members. The IA will provide further detailed requirements, including but not limited to service delivery, access, monitoring, appeals, and other state and federal requirements.

Please contact BHCalAIM@dhcs.ca.gov for questions.

Sincerely,

Original signed by

Ivan Bhardwaj, Division Chief
Medi-Cal Behavioral Health – Policy Division

Michele Wong, Division Chief
Medi-Cal Behavioral Health – Oversight & Monitoring Division

Enclosures