



SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

DATE: April 1, 2022

Effective Date: January 1, 2022

BHRS POLICY: 22-02

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

AUTHORITY: [Department of Healthcare Services Behavioral Health Information Notice 21-075](#); See footnotes

San Mateo County has adopted this policy and procedure developed by the California Mental Health Services Authority (CalMHSA) to meet the California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Quality Improvement Program (BHQIP) Milestone 2e requirements.

This policy is also posted on CalMHSA’s website [California Mental Health Services Authority | Policies and Procedures \(calmhsa.org\)](#)

PURPOSE

To provide DMC-ODS program requirements pursuant to the California Advancing & Innovating Medi-Cal (CalAIM), effective January 2022 through December 2026, which replaces the Section 1115 Standard Terms and Conditions used to describe the DMC-ODS program for the years 2015-2021. In accordance with W&I § 14184.102(d), until county contract amendments are executed, DMC-ODS counties shall adhere to the terms in the Behavioral Health Information Notice, [BHIN 21-075](#), where current contracts are silent or in conflict with the terms of BHIN 21-075. The information below reflects policy improvements under CalAIM. Any county, or consortium of counties in a regional model, or Tribal or Indian managed care entity that elects to opt-in to the DMC-ODS that does not already an approved implementation plan by the Department of Health Care Services (DHCS) shall refer to BHIN 21-075 for information on requirements for the implementation plan.

BACKGROUND

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



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DMC-ODS¹. Counties participating in the DMC-ODS program 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 (Drug Medi-Cal). 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. 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.

American Indian and Alaska Native individuals who are eligible for Medicaid and reside in counties that have opted-in to the DMC-ODS can also receive DMC-ODS services through Indian Health Care Providers (IHCPs)². Counties are required to reimburse IHCPs for medically necessary DMC-ODS services delivered by DMC certified providers regardless of whether the county has a contract with the IHCP.

The ASAM Criteria[®], formerly known as the ASAM patient placement criteria, is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcomes-oriented and results-based care in the treatment of substance use disorders (SUDs). The ASAM Criteria[®] relies on a comprehensive set of guidelines for level of care placement, continued stay, and transfer/discharge of patients with addiction, including those with co-occurring conditions. The ASAM Criteria[®] uses a multidimensional patient assessment to direct medical management and the structure, safety, security, and intensity of treatment services. Detailed information about The ASAM Criteria[®] is available on the [ASAM website](#).

POLICY

- A) County shall ensure that all required services covered under the DMC-ODS are available and accessible to beneficiaries of the DMC-ODS in accordance with the applicable state and federal time and distance for network providers³.
- B) Access to medically necessary services, including all Food and Drug Administration (FDA)-approved medications for Opioid Use Disorder, cannot be denied for beneficiaries meeting criteria for DMC-ODS services and beneficiaries shall not be placed on wait lists.
- C) DMC-ODS services shall be provided with reasonable promptness in accordance with federal Medicaid requirements and as specified in the State/DMC-ODS County Intergovernmental Agreement.

¹ 42 CFR 438.2 or 42 CFR 438.14 respectively

² [Behavioral Health Information Notice 20-065](#)

³ 42 CFR 438.68 and W&I Code Section 14197 and any behavioral health information notices

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- D) If the DMC-ODS network is unable to provide medically necessary covered services, the DMC-ODS county must adequately and in a timely manner cover these services out-of-network for as long as the DMC-ODS County's network is unable to provide them⁴.
- E) County shall provide prior authorization for residential and inpatient services--excluding Withdrawal Management (WM) Services--within 24 hours of the prior authorization request being submitted by the provider.
- F) County may not impose prior authorization or centralized DMC-ODS County-administered full ASAM assessment requirements prior to the provision of non-residential or non-inpatient assessment and treatment services, including WM Services.
- G) Medications for Addiction Treatment/Medication Assisted Treatment (MAT): County must demonstrate they either directly offer or have an effective referral process to MAT services for beneficiaries with SUD diagnoses treatable with MAT. Additionally, under the "alternative sites" option, County may cover drug products costs for MAT when the medications are purchased and administered or dispensed in a non-clinical setting.
 - 1. All medications and biological products utilized to treat SUDs, including long- acting injectables, continue to be available through the medical pharmacy benefit without prior authorization, and can be delivered to provider offices by pharmacies.
 - 2. 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 a program.
 - 3. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a beneficiary who declines counseling services.
 - 4. If the DMC-ODS provider is not capable of continuing to treat the beneficiary, the provider must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm handoff to support ongoing engagement.
- H) DMC-ODS for beneficiaries in the criminal justice system
 - 1. County should recognize and educate staff and collaborate with Parole and Probation partners.
 - 2. Parole and Probation is not a barrier to DMC-ODS treatment.
 - 3. Beneficiaries may receive recovery services immediately after incarceration regardless of whether they received SUD treatment during incarceration.
- I) Covered DMC-ODS Services
 - 1. DMC-ODS services are provided by Drug Medi-Cal (DMC)-certified providers and are based on medical necessity.
 - 2. DMC-ODS services must be recommended by Licensed Practitioners of the Healing Arts (LPHAs), within the scope of their practice.
 - 3. DMC-ODS services include the following comprehensive continuum of outpatient, residential, and inpatient evidence-based SUD services.

⁴ 42 CFR §438.206(b)(4)



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- a. Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5)⁵
- b. Outpatient Treatment Services (ASAM Level 1)
- c. Intensive Outpatient Treatment Services (ASAM Level 2.1)
- d. Partial Hospitalization Services (ASAM Level 2.5)
- e. Residential Treatment and Inpatient Services (ASAM Levels 3.1 – 4.0)
- f. Narcotic Treatment Program
- g. Withdrawal Management Services (ASAM Levels 1-WM, 2-WM, 3.2-WM, 3.7-WM, and 4-WM)
- h. Medication for Addition Treatment (also known as Medication Assisted Treatment – MAT)
- i. Peer Support Specialist Services (effective July 2022)
- j. Recovery Services
- k. Care Coordination
- l. Clinician Consultation (not a direct service to the beneficiary)

J) Indian Health Care Providers

1. American Indian and Alaska Native individuals who are eligible for Medicaid and reside in counties that have opted in to the DMC-ODS can also receive DMC-ODS services through Indian Health Care Providers (IHCPs). Please refer to BHIN 20-065 for additional guidance. IHCPs include:
 - 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.
 - i. 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.
 - ii. Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC provider, must do so consistent with the Tribal FQHC criteria established in the California State Plan, the Tribal FQHC section of the Medi-Cal provider manual, and APL 21-008.9 Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the “List of Tribal Federally Qualified Health Center Providers”

⁵ Alcohol and Drug Screening, Assessment, Brief Interventions and Referral (SABIRT, also known as SBIRT) is covered by Fee-For-Service and managed care delivery systems, not DMC-ODS, for beneficiaries aged 11 years and older.



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- c. Urban Indian Organizations (UIO) – A Nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of U.S. Code: Title 25, Chapter 18.
2. 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 county⁶.
3. In order to receive reimbursement from a county or the state for the provision of DMCODS 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 DMCODS services. DMC-ODS Counties must adhere to all 42 CFR 438.14 requirements⁷.

K) Practice Requirements

1. 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. The evidenced-based practices are:
 - a. 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.
 - 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

⁶ See BHIN 20-065 for additional information

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treatment program or as an aftercare 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 – 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.
 - f. DMC-ODS Counties shall ensure providers have implemented EBPs and are delivering the practices to fidelity.
- L) All facilities delivering Residential Treatment services under DMC-ODS must also be designated as capable of delivering care consistent with the ASAM Criteria®
- M) Department of Health Care Services Level of Care Designation or ASAM Level of Care Certification^{8,9}
1. All Residential Treatment facilities under DMC-ODS require a DHCS Level of Care (LOC) designation and/or at least one residential ASAM Certification.
 - a. DHCS Level 3.1 – Clinically Managed Low-Intensity Residential Services
 - b. DHCS Level 3.2 – Clinically Managed Residential WM
 - c. DHCS Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services
 - d. DHCS Level 3.5 – Clinically Managed High-Intensity Residential Services
- N) DMC-ODS Provider Qualifications
1. County shall ensure that all covered services are provided by Drug Medi-Cal (DMC) certified providers.
 2. County shall ensure that DMC-certified providers meet the following requirements:
 - a. Be licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations.
 - b. Abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services.
 - c. Provider shall sign an agreement with the DMC-ODS county or counties prior to rendering DMC-ODS services.
- O) Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

⁸ California Health and Safety Code Section 11834.015

⁹ [Behavioral Health Information Notice 21-001](#)

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1. In accordance with the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under Section 1905(r) of the Social Security Act¹⁰, County 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.

PROCEDURE

A) Initial Assessment¹¹

1. Medi-Cal beneficiaries whose county of responsibility is a DMC-ODS county are able to receive covered and clinically appropriate DMC-ODS services consistent with the following assessment, access, and level of care determination criteria.
2. Initial assessment for all levels of care, except for residential treatment services and narcotic treatment programs.
 - a. Initial assessment may be conducted
 - i. Face-to-face
 - ii. Telephone (synchronous audio-only)
 - iii. Telehealth (synchronous audio and video)
 - iv. In the community or home
3. Initial assessment completed by:
 - a. An LPHA
 - b. A registered/certified alcohol and other drug counselor
 - i. When an assessment is completed by a registered/certified counselor, an LPHA should evaluate the assessment in consultation with the registered/certified counselor who completed it.
 - ii. Consultation between LPHA and registered/certified counselor may be performed
 - a. In-person
 - b. Via telephone (synchronous audio-only)
 - c. Via telehealth (synchronous audio and video)
 - iii. Documentation of the initial assessment shall reflect consultation between LPHA and registered/certified counselor
 - iv. Initial diagnosis shall be determined and documented by an LPHA.
4. Residential treatment services

¹⁰ [Social Security Act §1905 \(ssa.gov\)](https://www.ssa.gov)

¹¹ Initial assessment and services provided during the assessment process is superseded [BHIN 16-044](#)
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- a. Prior authorization for residential and inpatient services (excluding WM services) is required within 24 hours of the prior authorization request being submitted by the provider.
 - b. County shall review the DSM and ASAM Criteria© to ensure that the beneficiary meets the requirements for the service.
5. Initial assessment for Narcotic Treatment Programs (NTPs)
- a. History and physical exams conducted by an LPHA at admission, pursuant to state and federal regulations, qualifies for the determination of medical necessity.
6. Timeliness and covered services during the initial assessment
- a. Beneficiaries aged 21 years and older
 - i. The initial assessment shall be completed within 30 calendar days following the first visit with an LPHA or registered/certified counselor.
 - ii. Covered and clinically appropriate services may be provided during the 30-day initial assessment period.
 - b. Beneficiaries under 21 years of age
 - i. The initial assessment shall be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor.
 - ii. Covered and clinically appropriate services may be provided during the 60-day initial assessment period.
 - c. Adult beneficiaries experiencing homelessness:
 - i. The initial assessment shall be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor.
 - ii. The practitioner shall document that the beneficiary is experiencing homelessness and requires additional time to complete the initial assessment.
 - d. Timeliness when beneficiary withdrawal from treatment prior to completion of assessment
 - i. When beneficiary withdraws from treatment prior to completion of the assessment or establishing a diagnosis, and later returns to care, the 30-day or 60-day assessment period starts over.
7. Diagnosis During Initial Assessment (except for residential treatment services)
- a. Diagnostic determination shall be made by an LPHA
 - b. Covered and clinically appropriate services may be delivered following the first visit with an LPHA or registered/certified counselor.
 - c. Covered and clinically appropriate services may be delivered before a Diagnostic and Statistical Manual (DSM) diagnosis for Substance-Related and Addictive Disorders is established. A provisional diagnosis may be used prior to establishing diagnosis.



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- i. Medically necessary services may be provided for:
 - a. up to 30 days for beneficiaries 21 years of age and older
 - b. up to 60 days for beneficiaries under the age of 21 or for beneficiaries experiencing homelessness.
- d. Provisional diagnosis
 - i. Provisional diagnoses are used prior to the determination of a diagnosis or in cases where suspected SUD has not yet been diagnosed.
 - a. An LPHA may document and categorize a suspected SUD under “Other Specified” and “Unspecified” disorder or “factors influencing health status and contact with health services” (Z-codes).
 - b. Diagnoses shall be updated by an LPHA when a beneficiary’s condition changes to accurately reflect the beneficiary’s needs

B) Access Criteria AFTER Initial Assessment¹²

1. Beneficiaries 21 years and older

- a. A service is considered “medically necessary” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
 - b. At least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
- OR
- c. At least one diagnosis from the Diagnostic and Statistical Manual of 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.

2. Beneficiaries under the age of 21

- a. Receive covered and “medically necessary” services. Services are considered “medically necessary” if the service is necessary to correct or ameliorate screened health conditions ((pursuant to Early and Periodic

¹² [W&I Section 14059.5\(a\)](#)

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Screening, Diagnostic, and Treatment (EPSDT) under the federal statutes and regulations¹³).

- b. Services need not be curative or completely restorative to ameliorate a substance use condition, including substance misuse and substance use disorders (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.

C) Diagnosis AFTER Initial Assessment

1. All diagnostic determinations shall be made by an LPHA.
2. Covered and clinically appropriate services may be delivered following the first visit with an LPHA or registered/certified counselor.
3. Covered and clinically appropriate services may be delivered whether or not a Diagnostic and Statistical Manual (DSM) diagnosis for Substance-Related and Addictive Disorders is established.
4. A provisional diagnosis may be used prior to establishing diagnosis. Medically necessary services may be provided for:
 - a. up to 30 days for beneficiaries 21 years of age or older
 - b. up to 60 days for beneficiaries under the age of 21, or for beneficiaries experiencing homelessness.
5. Provisional diagnosis
 - a. An LPHA may document and categorize a suspected SUD under “Other Specified” and “Unspecified” disorder or “factors influencing health status and contact with health services” (Z-codes).
 - b. Provisional diagnosis shall be updated by an LPHA to accurately reflect beneficiary needs.

D) Additional Clarification

1. Services for covered services are reimbursable¹⁴ even when:
 - a. Services are provided prior to determination of a diagnosis or prior to determination of whether access criteria are met, as described above¹⁵.
 - b. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan¹⁶; or

¹³ Section 1396d(r) of Title 42 of the United States Code.

¹⁴ W&C Code 14184.402(f)

¹⁵ All Medi-Cal claims for reimbursement continue to require the inclusion of a CMS-approved ICD-10 diagnosis code.

¹⁶ Per BHIN 21-075, DHCS anticipates providing additional guidance for this item.

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- c. The beneficiary has a co-occurring mental health disorder.
 - i. Clinically appropriate and covered DMC services delivered by DMC providers are covered and reimbursable whether or not the beneficiary has a co-occurring mental health disorder.
 - ii. The county 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.
 - iii. The county shall not disallow reimbursement for clinically appropriate and covered SUD prevention, screening, assessment, and treatment services due to lack of inclusion in an individual treatment plan, or lack of client signature on the treatment plan.

E) Level of Care Determination

1. Practitioner shall use the American Society of Addiction Medicine (ASAM) to determine the appropriate level of SUD treatment service¹⁷
 - a. For beneficiaries aged 21 year and over
 - i. A full assessment using the ASAM Criteria© shall be completed within 30 calendar days of the beneficiary's first visit with an LPHA or registered/certified counselor.
 - b. For beneficiaries under the age of 21 or for adult beneficiaries experiencing homelessness
 - i. A full assessment using the ASMA Criteria© shall be completed within 60 calendar days of the beneficiary's first visit with an LPHA or a registered/certified counselor.
2. Placement and level of care determination shall be in the least restrictive level of care that is clinically appropriate to treat the beneficiary's condition.
3. A full ASAM assessment shall be repeated when a beneficiary's condition changes.

F) Additional Clarification

1. Timeliness - If a beneficiary withdraws from treatment prior to completing the ASAM assessment and later returns, the time period starts over as noted above.
2. Clinically necessary services are permissible prior to completion of a full ASAM assessment.
3. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. *Please note that no preliminary level of care*

¹⁷ W&I Code 14184.402(e)



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recommendation or screening tool is a substitute for a comprehensive ASAM Criteria® assessment.

G) Covered Services

Covered services are based on recommendations by an LPHA, within their scope of practice. Services shall be provided by DMC-certified practitioners. Services shall be “medically necessary”.

1. ASAM Level 0.5 - Screening, Brief Intervention, Referral to Treatment and Early Intervention Services

- a. Early intervention services are covered for beneficiaries under the age of 21. Any beneficiary under age 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. 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.
- b. An SUD diagnosis is not required for early intervention services.
- c. A full assessment utilizing the ASAM Criteria® is not required for a beneficiary under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used.
 - i. 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.
- d. 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.
- e. Additional clarification:
 - i. SBIRT is not a DMC-ODS benefit. Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT), commonly known as Brief Intervention, and Referral and Treatment (SBIRT) is not a DMC-ODS benefit. This is a benefit in the managed care delivery system for beneficiaries aged 11 years and older.
 - ii. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. Please note that no preliminary level of care recommendation or screening tool is a substitute for a comprehensive ASAM Criteria® assessment.



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2. ASAM Level 1 - Outpatient Treatment Services (often referred to as Outpatient Drug Free)

- a. Outpatient treatment services include the following:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - iv. Family Therapy
 - v. Medication Services
 - vi. MAT for Opioid Use Disorder (OUD)
 - vii. MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
 - viii. Patient Education
 - ix. Recovery Services
 - x. SUD Crisis Intervention Services
- b. Service hours:
 - i. Beneficiaries aged 21 years and older
 - a. 9 hours a week
 - ii. Beneficiary under the age of 21
 - b. 6 hours a week
 - iii. Services may exceed the maximum based on individual medical necessity.
- c. Services may be provided in person, by telehealth, or by telephone.
- d. Medication Assisted Treatment (MAT)
 - i. County is required to either offer medications for addiction 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).
 - ii. County shall monitor the referral process or provision of MAT services.

3. ASAM Level 2.1 – Intensive Outpatient Treatment Services

- a. Intensive Outpatient Services are provided in a structured programming environment.
- b. Intensive outpatient treatment services include the following:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - iv. Family Therapy
 - v. Medication Services
 - vi. MAT for Opioid Use Disorder (OUD)
 - vii. MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs



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- viii. Patient Education
- ix. Recovery Services
- x. SUD Crisis Intervention Services
- c. Service hours:
 - i. Beneficiaries aged 21 years and older
 - 1. Minimum of 9 hours with maximum of 19 hours a week
 - ii. Beneficiary under the age of 21
 - 1. Minimum of 6 hours with maximum of 19 hours a week
- d. Services may exceed the maximum based on individual medical necessity.
- e. Services may be provided in person, by telehealth, or by telephone.
- f. Medication Assisted Treatment (MAT)
 - i. Provider is required to either offer medications for addiction 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. Effective referral mechanism is defined as facilitating access to MAT off-site for beneficiaries if not provide on-site). Providing a beneficiary, the contact information for a treatment program, is considered insufficient.
 - ii. County shall monitor the referral process or provision of MAT services.

4. ASAM Level 2.5 - Partial Hospitalization Services (Optional DMC-ODS level)

- a. Partial Hospitalization Services are provided in a clinically intensive programming environment 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. Partial Hospitalization Services 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.
- b. Service components include the following:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - iv. Family Therapy
 - v. Medication Services
 - vi. MAT for opioid use disorder (OUD)
 - vii. MAT for alcohol use disorder (AUD) and other non-opioid SUDs
 - viii. Patient Education
 - ix. Recovery Services



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- x. SUD Crisis Intervention Services
- c. Requires 20 or more hours of weekly intensive programming.
- d. Services may be provided in person, by synchronous telehealth, or by telephone.
- e. Medication Assisted Treatment (MAT)
 - i. 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).
 - ii. County shall monitor the referral process or provision of MAT services.

H) ASAM Levels 3.1, 3.3, & 3.5 - Residential Treatment (This section supersedes MHSUDS IN 16-042)

- a. Residential Treatment Services are provided in a short-term residential program through one of the following levels:
 - i. Level 3.1 - Clinically Managed Low-Intensity Residential Services
 - ii. Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
 - iii. Level 3.5 - Clinically Managed High Intensity Residential Services
- b. Service components:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - iv. Family Therapy
 - v. Medication Services
 - vi. MAT for OUD
 - vii. MAT for AUD and other non-opioid SUDs
 - viii. Patient Education
 - ix. Recovery Services
 - x. SUD Crisis Intervention Services
- c. Services shall address functional deficits documented in the ASAM Criteria[©]
 - i. Services aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems.
- d. A beneficiary shall live on the premises and be considered a “short-term resident” of the residential facility where the beneficiary receives services under this DMC-ODS level of care.



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- e. Services may be provided in facilities of any size.
- f. Services are driven by the beneficiary's care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting.
- g. Residential treatment services for adults under these levels 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 or freestanding Acute Psychiatric Hospitals (FAPHs) licensed by Department of Public Health (DPH).
- h. Residential providers licensed by a state agency other than DHCS must be DMC-Certified.
- i. DHCS Level of Care designation and/or ASAM Level of Care Certification:
 - i. All facilities delivering Residential Treatment services under DMC-ODS must also be designated as capable of delivering care consistent with the ASAM Criteria.
 - ii. Designation is required for facilities offering ASAM levels 3.1, 3.3, 3.5.
 - iii. All counties with residential facilities offering levels 3.1., 3.3, and 3.5, licensed by a state agency other than DHCS, shall have an ASAM Level of Care Certification for each of the levels of care provided at the facility under the DMCS-ODS program by January 1, 2024
- j. Services may be provided in person, by telehealth, or by telephone
 - i. Most services shall be in person.
 - ii. Telehealth and telephone services shall be used to supplement, not replace, the in-person services and in-person treatment milieu.
- k. Medication Assisted Treatment (MAT)
 - i. 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).
- l. County shall monitor the referral process or provision of MAT services.
- m. Length of Stay
 - i. The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by



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individualized clinical need. Beneficiaries shall be transitioned to appropriate levels of care as medically necessary.

- ii. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

I) ASAM Levels 3.7 Medically Monitored Inpatient Services & 4.0 - Medically Managed Intensive Inpatient Services (This section supersedes MHSUDS IN 16-042)

- a. County may voluntarily cover and receive reimbursement through 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 County covers these levels of care, the County must have a clearly defined referral mechanism and care coordination for these levels of care. Additional information can be found on the DHCS All-Plan Letter 18-001¹⁸ which clarifies coverages of voluntary inpatient detoxification through the Medi-Cal Fee-for-Service program.
- b. Service components:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - iv. Family Therapy
 - v. Medication Services
 - vi. MAT for OUD
 - vii. MAT for AUD and other non-opioid SUDs
 - viii. Patient Education
 - ix. Recovery Services
 - x. SUD Crisis Intervention Services
- c. Services shall address functional deficits documented in the ASAM Criteria©
 - i. Services aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems.
- d. A beneficiary shall live on the premises and considered a “short-term resident” of the inpatient facility where the beneficiary receives services under this DMC-ODS level of care.
 - i. Treatment services under these levels 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

¹⁸ [DHCS All-Plan Letter 1801](#)

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residential facilities licensed by DHCS, residential facilities licensed by the DHCS, residential facilities licensed by the Department of Social Services, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health or freestanding Acute Psychiatric Hospitals (FAPHs) licensed by Department of Public Health (DPH).

- e. Services may be provided in person, by telehealth, or by telephone
 - i. Most services shall be in person.
 - ii. Telehealth and telephone services shall be used to supplement, not replace, the in-person services and in-person treatment milieu.
- f. Medication Assisted Treatment (MAT)
 - i. 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).
 - ii. County shall monitor the referral process or provision of MAT services.
- g. Services are driven by the beneficiary's care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting
- h. Length of Stay
 - i. The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Beneficiaries shall be transitioned to appropriate levels of care as medically necessary.
 - ii. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

J) Narcotic Treatment Program (This section supersedes MHSUDS IN 16-048)

1. Narcotic Treatment Program (NTP), also described in the ASAM Criteria© as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary. 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



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in DHCS-licensed NTP facilities pursuant to the California Code of Regulations, title 9, Chapter 4, and Title 42 of the Code of Federal Regulations (CFR).

2. NTPs are required to administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary including:
 - a. Methadone
 - b. Buprenorphine (transmucosal and long-acting injectable)
 - c. Naltrexone (oral and long-acting injectable)
 - d. Disulfiram
 - e. Naloxone
 - f. 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.
 - g. Service components:
 - i. Assessment
 - ii. Care Coordination
 - iii. Counseling (individual and group)
 - a. The NTP shall offer the beneficiary a minimum of fifty (50) minutes of counseling services per calendar month
 - b. Counseling services may be provided in-person, by telehealth, or by telephone
 - iv. Family Therapy
 - v. Medical Psychotherapy
 - vi. Medication Services
 - vii. MAT for OUD
 - viii. MAT for AUD and other non-opioid SUDs
 - ix. Patient Education
 - x. Recovery Services
 - xi. SUD Crisis Intervention Services
 - xii. Medical evaluation for methadone treatment
 - a. Medical history
 - b. Laboratory tests
 - c. Physical exam



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- d. Medical evaluation must be conducted in-person

K) Withdrawal Management (WM) Services

1. WM services are provided as a part of a continuum of care to beneficiaries experiencing withdrawal in the following outpatient, residential, and inpatient settings. Beneficiary shall be monitored during the detoxification process. Services are urgent and provided on a short-term basis.
2. A full ASAM Criteria© assessment shall not be required as a condition of admission to a facility providing WM. Service activities 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 beneficiary can receive comprehensive treatment services.
 - a. Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision).
 - b. 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).
 - c. Level 3.2-WM: Clinically managed residential withdrawal management (24- hour support for moderate withdrawal symptoms that are not manageable in outpatient setting).
 - i. This is considered a residential level of care and therefore requires the facility to be designated as capable of delivering care consistent with ASAM Criteria©.
 - ii. A DHCS level of care designation and/or an ASAM Level of Care Certification is required.
 - d. Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24- hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits).
 - e. Level 4.0-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).
3. Service components for outpatient, residential, and inpatient settings:
 - a. Assessment
 - b. Care Coordination



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- c. Medication Services
 - d. MAT for OUD
 - e. MAT for AUD and other non-opioid SUDs
 - f. Observation
 - g. Recovery Services
4. Care transitions to facilitate additional services or transition to a comprehensive treatment program.
- a. WM services are urgent and provided on a short-term basis.
 - b. Practitioner shall conduct a full ASAM Criteria© assessment, brief screening, or other tools to support referral to additional services as appropriate.
 - c. If a full ASAM Criteria© assessment was not completed as part of the withdrawal management service episode.
 - i. Receiving program shall adhere to initial assessment timeliness requirements.
5. WM services may be provided in an outpatient, residential, or inpatient setting.
- a. For residential settings, each beneficiary shall reside at the facility.
6. Medication Assisted Treatment (MAT) 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).

L) Medications for Addiction Treatment (also known as Medication-Assisted Treatment or MAT)

- 1. Medications for addiction treatment include all medications and biological products Food and Drug Administration (FDA) approved to treat Alcohol Use Disorder (AUD), Opioid Use Disorder (OUD), and any SUD.
 - a. Methadone
 - b. Buprenorphine (transmucosal and long-acting injectable)
 - c. Naltrexone (oral and long-acting injectable)
 - d. Disulfiram
 - e. Naloxone
- 2. Service components:
 - a. Assessment
 - b. Care Coordination
 - c. Counseling (individual and group)
 - d. Family Therapy



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- e. Medication Services
 - f. Patient Education
 - g. Recovery Services
 - h. SUD Crisis Intervention Services
 - i. Withdrawal Management Services
3. MAT may be provided in clinical or non-clinical settings.
 4. MAT may be delivered as a standalone service.
 5. Additional clarification on MAT
 - a. DMC -ODS counties shall ensure 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 service for the beneficiary with SUD diagnoses that are treatable with medication or biological products.
 - i. Effective referral mechanism is defined as facilitating access to MAT off-site for beneficiaries if not provide on-site
 - ii. Providing a beneficiary, the contact information for a treatment program is not considered sufficient.
 - iii. An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary shall be made whether or not the provider seeks reimbursement through DMC-ODS.
 - iv. Counties shall monitor the referral process or provision of MAT services.
 - b. The required MAT medications were expanded to include all medications and biological products Food and Drug Administration (FDA)-approved to treat opioid use disorders (OUD) and Alcohol Use Disorders (AUD)¹⁹.
 - c. DMC-ODS counties 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
 - i. This means county pays for cost for MAT medications purchased by providers and administered or dispensed on site or in the community and billed to the county DMC-ODS plan.
 - ii. If the DMC-ODS county elect the above option could reimburse providers for the medications, such as naloxone, trans-mucosal buprenorphine, and/or long-acting injectable medications (such as buprenorphine or naltrexone),

¹⁹ On December 29, 2020, DHCS obtained a one-year extension for DMC-ODS 115 waiver.



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administered in DMC facilities and non-clinical or community settings.

- d. DMC-ODS counties who *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 cover the drug product costs for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a stand-alone service.
- e. 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.
- f. Beneficiaries needing or using 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.
- g. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a beneficiary who declines counseling services.
- h. For beneficiaries with a 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).
- i. 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, support continuity of care and facilitate a warm hand-off to ensure engagement.

M) Peer Support Services (This section of the information notice supersedes MHSUDS IN 17-008) Implemented as a County Option Effective July 1, 2022

1. Services are provided by Certified Peer Support Specialists²⁰
 - a. A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification.
 - b. A Peer Support Specialist must meet all other applicable California state requirements, including ongoing education requirements.

²⁰ Behavioral Health Information Notice 21-041

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- c. Peer Support Specialists must provide services under the direction of a Behavioral Health Professional. “Under the direction of” means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery, or review, approval and signing of client plans. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the service provided. Services are provided under the direction of a physician; a licensed or waived psychologist; a licensed, waived or registered social worker; a licensed, waived or registered marriage and family therapist; a licensed, waived or registered professional clinical counselor, or a registered nurse (including a certified nurse specialist, or a nurse practitioner).
 - i. Behavioral Health Professionals must be licensed, waived, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of DMC-ODS or Specialty Mental Health Services.²¹
 - ii. Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements.
 - d. 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.
2. 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. Beneficiaries may concurrently receive Peer Support Services and services from other levels of care.
 3. Peer Support Services are based on a plan of care approved by a Behavioral Health Professional (see definition of Behavioral Health Professional above; this term is specific to the administration of Peer Support Services).

²¹ [Supplement 3 to Attachment 3.1-A](#) of the California State Plan. DMC-ODS services are described in the “Expanded SUD Treatment Services” section

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Services may be provided with the beneficiary or in collaboration with significant support person(s).

- a. Services may 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.
4. Service components
- a. Educational Skill Building Groups - providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiary 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.
 - b. Engagement services - 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.
 - c. Therapeutic Activity - 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.
5. Peer Support Services are delivered and claimed as a standalone service.
 6. Services may be provided in a clinical or non-clinical setting.

N) Recovery Services

1. Recovery services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level with emphasis on the beneficiary as the central role in



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managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management.

2. Service components:
 - a. Assessment
 - b. Care Coordination
 - c. Counseling (individual and group)
 - d. Family Therapy
 - e. Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the beneficiary's SUD.
 - f. 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.
3. Services may be provided based on the beneficiary's self-assessment or provider assessment of relapse risk.
4. Diagnosis of "remission" is not required to receive Recovery Services
5. Services may be provided concurrently with MAT services, including NTP services.
6. Services may be provided immediately after incarceration with a prior diagnosis of SUD.
7. Services may be provided in person, by telehealth, or by telephone
8. Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care described.

O) Care Coordination (This section supersedes in part MHSUDS IN 17-045 regarding the Healthcare Common Procedure Coding System (HCPCS) codes for claiming Case Management).

1. Care coordination was previously referred to as "case management" for the years 2015-2021.
2. Care coordination shall be provided in conjunction with *all* levels of treatment.
3. 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.
4. Service components include one or more of the following:
 - a. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.



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- b. 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.
 - c. 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.
5. Care Coordination may also be delivered and claimed as a standalone service in a DMC-ODS County.
 6. Services can be provided in clinical or non-clinical settings, including the community.
 7. Services may be provided in-person, by telehealth, or by telephone
 8. Care coordination services shall be provided with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness.²²

P) Clinician Consultation (This section supersedes, in part, MHSUDS IN 17-045 regarding the Healthcare Common Procedure Coding System (HCPCS) codes for claiming Physician Consultation).

1. Clinician consultation is *not* a direct service provided to a beneficiary.
2. Clinician Consultation replaces and expands the previous “Physician Consultation” service referred to during the years 2015-2021.
3. 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. Clinician consultation:
 - a. Includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific beneficiaries.
 - b. Consists of DMC-ODS LPHAs consulting with other LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care.
4. County may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services.

²² DMC-ODS counties shall have an executed memoranda of understanding to support care coordination



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5. Clinical consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems.

Q) DMC-ODS Financing

1. January 1, 2022, through June 30, 2023
 - a. For claiming federal financial participation (FFP), County will certify the total allowable expenditure incurred in providing the DMC-ODS waiver services provided through county-operated providers (based on actual cost, consistent with cost allocation methodology if warranted), contractor fee-for-service providers, or contracted managed care plans (based on actual expenditures).
2. July 1, 2023, and ongoing
 - a. DHCS will use intergovernmental transfers from all participating counties to finance the non-federal share of all DMC-ODS payments. County will 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. County shall first meet the needs of Medi-Cal beneficiaries before spending these restricted funds on non-Medi-Cal services. County shall make monthly transfers to DHCS from these and any other funds eligible under federal law or federal Medicaid reimbursement to finance the non-federal share of all DMC-ODS payments.

R) External Quality Review

1. County shall include in their implementation plan a strategy and timeline for meeting external quality review requirements (438.310-370).

S) Responsibilities of DMC-ODS Counties for DMC-ODS Benefits

1. The responsibilities of DMC-ODS Counties for the DMC-ODS benefit shall be included in each DMC-ODS County's intergovernmental agreement with DHCS and shall require the DMC-ODS Counties to comply with the following.
2. Selective Provider Contracting Requirements for DMC-ODS Counties (This section of the information notice supersedes MHSUDS IN 19-018)
 - a. DMC-ODS Counties select the DMC-certified providers with whom they contract to establish their DMC-ODS provider networks, with the exception of Indian Health Care Providers (IHCPs) as described above in the "Indian Health Care Providers" section.
 - b. 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.
3. Contract Denial and Appeal Process



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- a. Counties shall serve providers that apply to be a contract provider but are not selected a written decision including the basis for the denial.
 - b. 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.
4. Residential and Inpatient Treatment Provider
- a. 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.
5. Access
- a. Each DMC-ODS County must ensure that all required services covered under the DMC-ODS are available and accessible to enrollees of the DMC-ODS in accordance with the applicable state and federal time and distance standards for network providers developed by the DHCS, including those set forth in 42 CFR 438.68, and W&I Section 14197 and any Information Notices issued pursuant to those requirements.
 - b. Access to medically necessary services, including all FDA-approved medications for OUD, cannot be denied for beneficiaries meeting criteria for DMC-ODS services nor shall beneficiaries be put on wait lists. DMC-ODS beneficiaries shall receive services from DMC-certified providers. All DMC-ODS services shall be furnished with reasonable promptness in accordance with federal Medicaid requirements and as specified in the State/DMC-ODS County Intergovernmental Agreement.
 - c. 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.
6. Authorization Policy for Residential/Inpatient Levels of Care
- a. 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.



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DMC-ODS Counties will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service.

7. Authorization Policy for Non-Residential/Inpatient Levels of Care
 - a. 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.
8. Beneficiary Access Number
 - a. 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.
9. DMC-ODS County of Responsibility
 - a. 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.
 - b. 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.
 - c. Accordingly, the DMC-ODS County shall ensure that beneficiaries receiving Narcotic Treatment Program (NTP) services and working in or travelling to another county (including a county that does not opt in to the DMC-ODS program) do not experience a disruption of NTP services. In accordance with 42 CFR 438.206, if the DMC-ODS county's provider network is unable



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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.

- T) 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

DEFINITIONS

Adolescent: Refers to beneficiaries under age 21.

Assessment: Consists of activities to evaluate or monitor the status of a beneficiary's behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards.²³ Assessment may be initial and periodic and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary. Assessment services may include one or more of the following components:

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
- Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under the "Other laboratory and X-ray services" benefit of the California Medicaid State Plan).

²³ 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

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- 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: 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 focuses on the needs of the participants. Group counseling shall be provided to a group that includes 2-12 individuals.

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

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

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

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

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

- "Patient Education", which is education for the beneficiary on addiction, treatment, recovery and associated health risks.

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- Prescribing and monitoring for MAT for OUD, which is prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT for OUD.

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: Provided to beneficiaries when medically necessary for maximum reduction of the SUD symptoms and restoration of the beneficiary to their best possible functional level.

- 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.

FORMS ATTACHMENTS

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,



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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

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.

REVISION HISTORY

N/A

Approved: Signature on File

Scott Gilman, MSA
BHRS Director