

Effective Date: (TBD by County)	Policy Title: Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022-2026
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<input type="checkbox"/> MHP <input checked="" type="checkbox"/> DMC-ODS <input type="checkbox"/> DMC State Plan	Reference to BHIN No.: 23-001 (Supersedes BHINs 20-074E and 21-075)

PURPOSE

The purpose of this policy and procedure is to provide DMC-ODS program requirements pursuant to CalAIM, effective January 2022 through December 2026, including program updates, which replace the Section 1115 Special Terms and Conditions used to describe the DMC-ODS program for the years 2015-2021.

BACKGROUND

CalAIM is a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reform across the Medi-Cal program. DHCS conducted broad stakeholder engagement to elicit county, provider, and beneficiary feedback on how to improve Medi-Cal programs, including the DMC-ODS. As a result of that input, DHCS proposed to the Centers for Medicare and Medicaid Services (CMS) a set of updates to DMC-ODS, some of which CMS approved for the January – December 2021 extension period (see Behavioral Health Information Notices (BHINs) [21-019](#), [21-020](#), [21-021](#), and [21-024](#)), and others which were effective January 2022 and [BHIN 21-075](#) implemented those updates. This policy and procedure aligns the DMC-ODS program requirements with the CalAIM behavioral health initiatives that are effective July 2022, including the policies outlined in [BHIN 22-005](#), [BHIN 22-011](#), [BHIN 22-013](#), [BHIN 22-019](#), and [BHIN 22-026](#).

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

POLICY

Drug Medi-Cal Organized Delivery System

DMC-ODS is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS. Since the DMC-ODS pilot program began in 2015, all California counties have had the option to participate in the program to provide their resident Medi-Cal beneficiaries with a range of evidence-based SUD treatment services in addition to those available under the Medi-Cal State Plan. Critical elements of DMC-ODS include providing a continuum of care modeled

after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care.

The county, or consortium of counties in a regional model, or Tribal or Indian managed care entity that elects to opt into the DMC-ODS (hereinafter referred to as “DMC-ODS County”), that does not already have a DHCS-approved implementation plan, must submit an implementation plan using the template provided in Enclosure 3 to DHCS for approval. Upon DHCS approval, DHCS will enter into an intergovernmental agreement (IA) with the DMC-ODS County (or consortium of counties in a regional model, or Tribal or Indian managed care entity), to administer DMC-ODS through a Prepaid Inpatient Health Plan as defined in 42 Code of Federal Regulations (CFR) 438.2 or 42 CFR 438.14 respectively. To receive services through the DMC-ODS, a beneficiary must be enrolled in Medi-Cal, reside in a participating county, and meet the criteria for DMC-ODS services established below in the “DMC-ODS Program Criteria for Services” subsection.

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

EPSDT

In accordance with the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under [Section 1905\(r\) of the Social Security Act](#), the county, irrespective of their participation in the DMC-ODS program, shall ensure that all beneficiaries under age 21 receive all applicable SUD services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act. Nothing in the DMC- ODS limits or modifies the scope of the EPSDT mandate. The DMC-ODS county is responsible for the provision of SUD services pursuant to the EPSDT mandate. The county should refer to [BHIN 22-003](#) regarding Medi-Cal SUD treatment services for beneficiaries under age 21 for further compliance with EPSDT requirements. Please note that the access criteria for beneficiaries under 21 is different and more flexible than the access criteria for adults accessing DMC-ODS services, to meet the EPSDT mandate and the intent for prevention and early intervention of SUD conditions.

DMC-ODS Program Criteria for Services

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

PROCEDURE

Initial Assessment and Services Provided During the Assessment Process

Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA), registered/certified counselor, or Peer Support Specialist whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if the beneficiary is under age 21, or if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day time period starts over.

The initial assessment shall be performed face-to-face, by telehealth (“telehealth” throughout this document is defined as synchronous audio and video) or by telephone (synchronous audio-only) by an LPHA or registered or certified counselor and may be done in the community or the home.² If the assessment of the beneficiary is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

DMC-ODS Access Criteria for Beneficiaries After Assessment

- a. *Beneficiaries 21 years and older:* To qualify for DMC-ODS services after the initial assessment process, beneficiaries 21 years of age and older must meet one of the following criteria:
 - i. Have at least one diagnosis from DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, OR
 - ii. Have had at least one diagnosis from the DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco- Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

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

² Narcotic Treatment Programs (NTPs) shall conduct a history and physical exam by a LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies for the purpose of determining medical necessity under the DMC-ODS

- b. Beneficiaries under the age of 21:* Beneficiaries under age 21 qualify to receive all medically necessary DMC-ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state’s Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

Additional Coverage Requirements and Clarifications

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

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

Regarding (1), clinically appropriate and covered DMC-ODS services provided to beneficiaries over 21 are reimbursable during the assessment process as described above in the *“Initial Assessment and Services Provided During the Assessment Process”* subsection. In addition, 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*.

This does not eliminate the requirement that all Medi-Cal claims, including DMC-ODS claims, include a CMS approved International Classification of Diseases, Tenth Revision (ICD-10-CM) code.³ In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10-CM code list, for example, codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services”. For additional information regarding code selection during the assessment period for outpatient behavioral health services, please refer to [BHIN 22-013](#).

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

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

California Mental Health Services Authority (CalMHSA)

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

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

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

Regarding (3), medically necessary covered DMC-ODS services delivered by DMC-ODS providers are covered and reimbursable Medi-Cal services whether or not the beneficiary has a co-occurring mental health condition. County shall not disallow reimbursement for covered DMC-ODS services provided to a beneficiary who has a co-occurring mental health condition if the beneficiary meets the *DMC-ODS Access Criteria for Beneficiaries After Assessment*. For additional information regarding covered services for beneficiaries with co-occurring SUD and mental health conditions, please refer to [BHIN 22-011](#).

Level of Care Determination

The ASAM Criteria shall be used to determine placement into the appropriate level of care for all beneficiaries, and is separate and distinct from determining medical necessity.⁵ A free ASAM Criteria Assessment Interview Guide, which may be but is not required to be used to complete the ASAM Criteria assessment, can be found [here](#).

⁴ 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, DMC-ODS or Specialty Mental Health Services. See [Supplement 3 to Attachment 3.1-A](#) of the California State Plan. DMC-ODS services are described in the "Expanded SUD Treatment Services" section.

⁵ W&I Code section 14184.402(e)(1)

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

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

Medical Necessity of Services

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

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. Consistent with federal guidance, services need not be curative or 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)).

County shall update policies and procedures, provider contracts, beneficiary handbooks, and related material to ensure the medical necessity standard is accurately reflected in all materials consistent with [W&I Code section 14059.5](#) and the terms of BHIN 23-001.

Covered DMC-ODS Services

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

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

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

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

Early intervention services are covered DMC-ODS services for beneficiaries under the age of 21. Any beneficiary under the age of 21 who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. An SUD diagnosis is not required for early intervention services. As noted above, this does not eliminate the requirement that all Medi-Cal claims, including DMC-ODS claims, to include a CMS approved ICD-10 diagnosis code.⁶ In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10 diagnosis code list. For example, these include codes for “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services”. For additional information regarding code selection during the assessment period for outpatient behavioral health services, please refer to [BHIN 22-013](#). Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the beneficiary under age 21 is not participating in the full array of outpatient treatment services.

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

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

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

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

2. Outpatient Treatment Services (ASAM Level 1)

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

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

3. Intensive Outpatient Treatment Services (ASAM Level 2.1)

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

- Assessment
- Care Coordination

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

4. Partial Hospitalization Services (ASAM Level 2.5)

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

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

5. Residential Treatment and Inpatient Services (ASAM Levels 3.1 – 4.0) Residential Treatment Services are delivered to beneficiaries when medically necessary in a short-term residential program corresponding to at least one of the following levels:

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

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

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

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

Residential Treatment Services

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

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

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

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

providers delivering ASAM Levels of care 3.1, 3.3 or 3.5 obtain an ASAM LOC Certification for each level of care provided effective January 1, 2024.

Residential Treatment services can be provided in facilities of any size. The statewide goal for the average length of stay for residential treatment services provided by participating counties is 30 days. The goal for a statewide average length of stay for residential services of 30 days is not a quantitative treatment limitation or hard “cap” on individual stays; lengths of stay in residential treatment settings shall be determined by individualized clinical need. However, county shall ensure that beneficiaries receiving residential treatment are transitioned to another level of care when clinically appropriate based on treatment progress. The county 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.

County shall implement coverage and ensure access for residential SUD treatment services as follows:

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

Residential Treatment Services include the following services:

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

Inpatient Services

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

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

Inpatient Treatment Services include the following services:

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

6. *Narcotic Treatment Program*

NTP, also described in the ASAM criteria as an OTP, is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), disulfiram, and naloxone. If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the beneficiary to a provider capable of dispensing the medication. The NTP shall offer the beneficiary a minimum of fifty minutes of counseling services per calendar month. NTPs shall comply with all federal and state NTP licensing requirements. If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. NTP services are provided in DHCS-licensed NTP facilities pursuant to the California Code of Regulations, Title 9, Chapter 4, Division 4, and title 42 of the CFR. Counseling services provided in the NTP modality can be provided in person, by telehealth, or by telephone. However, the medical evaluation for methadone treatment (which consists of a medical history, laboratory tests, and a physical exam) must be conducted in-person. NTP Services include the following service components:

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

- SUD Crisis Intervention Services

7. Withdrawal Management Services

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

- Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision)
- Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting)
- Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting)
- Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits)
- Level 4-WM: Medically managed intensive inpatient withdrawal management (Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability).

Withdrawal Management Services include the following service components:

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

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

Withdrawal management services are urgent and provided on a short-term basis. When provided as part of withdrawal management services, service activities, such as the assessment, focus on the stabilization and management of psychological and physiological

symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where comprehensive treatment services are provided. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate. If it has not already been completed in relation to the Withdrawal Management episode, the full ASAM Criteria assessment shall be completed within 30 days of the beneficiary's first visit with an LPHA or registered/certified counselor for non-Withdrawal Management services (or 60 days for beneficiaries under 21, or beneficiaries experiencing homelessness), as described above.

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

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

9. Peer Support Services (For additional guidance regarding Peer Support Specialist Certification, please refer to [BHIN 21-041](#). For additional guidance regarding county implementation of Peer Support Services, please refer to [BHIN 21-041](#), [BHIN 22-006](#), [BHIN 22-018](#), [BHIN 22-026](#), [BHIN 22-055](#), [BHIN 22-061](#), and [BHIN 22-062](#).)

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

conjunction with other services or levels of care described in this “Covered DMC-ODS Services” section, including inpatient and residential services, but shall be billed separately. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

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

Peer Support Services consist of Educational Skill Building Groups, Engagement and Therapeutic Activity services as defined below:

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

A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification. The individual must meet all other applicable California state requirements, including ongoing education requirements. Peer Support Specialists must provide services under the direction of a Behavioral Health Professional. Behavioral Health Professionals must be licensed, 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, DMC-ODS or Specialty Mental

Health Services.⁷ Although Peer Support Services must be provided under the direction of a Behavioral Health Professional, Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements. For additional guidance regarding Peer Support Specialist Certification information and Peer Support Specialist Supervisor standards, please refer to [BHIN 21-041](#).

10. Contingency Management

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

11. Recovery Services

Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to beneficiaries. Beneficiaries may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services. Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD. Services may be provided in person, by telehealth, or by telephone. Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care described in this "Covered DMC-ODS Services" section, or as a service delivered as part of these levels of care.⁸

Recovery Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the beneficiary's SUD.
- Relapse Prevention, which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary's SUD.

⁷ See [Supplement 3 to Attachment 3.1-A](#) of the California State Plan. DMC-ODS services are described in the "Expanded SUD Treatment Services" section.

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

12. Care Coordination

Care coordination was previously referred to as “case management” in the Section 1115 STCs that were used to describe the DMC-ODS program for the years 2015-2021. Per CMS feedback, DHCS has retitled and re-described this benefit as “care coordination.”

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

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

- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
- Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
- For guidance on claiming for care coordination within a level of care or as a standalone service, please refer to the most current [DMC-ODS Billing Manual](#).

13. Clinician Consultation

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

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

Clinician Consultation is not a direct service provided to DMC-ODS beneficiaries. Rather, Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. It includes consultations between

clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS beneficiaries. County may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services. These consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems.

MAT Policy Clarifications⁹

Previous DMC-ODS MAT Policy

Originally in the DMC-ODS 1115 Waiver, methadone, buprenorphine, naloxone, and disulfiram were only available in the NTP setting. However, under the “MAT Delivered at Alternative Sites” option, county has 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). County can make this election reimbursable to providers for the medications, such as naloxone, trans-mucosal buprenorphine, and/or long-acting injectable medications (such as buprenorphine or naltrexone), administered in DMC facilities, justice settings, and non-clinical or community settings.

On December 29, 2020, DHCS obtained a one-year extension for the DMC-ODS 1115 Waiver. In the DMC-ODS one-year extension, the required MAT medications were expanded to include all medications and biological products FDA-approved to treat OUDs and AUDs. Additionally, county was required to ensure that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanisms/process to MAT to beneficiaries with SUD diagnoses.

Furthermore, under the “MAT Delivered at Alternative Sites” option, county has the option to cover drug product costs for MAT when the medications are purchased and administered or dispensed in a non-clinical setting (e.g., criminal justice settings or street-based outreach).

CalAIM DMC-ODS MAT Policy

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

⁹ See [BHIN 21-024](#).

California Mental Health Services Authority (CalMHSA)

reimbursable to 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 county does not choose to cover the drug product costs for MAT outside of the pharmacy or NTP benefit, county is still required to reimburse for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a standalone service.

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

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

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

Indian Health Care Providers

American Indian and Alaska Native individuals who are eligible for Medicaid and reside in a county that has opted into the DMC-ODS can also receive DMC-ODS services through Indian Health Care Providers (IHCPs). Please refer to [BHIN 22-053](#) for additional guidance.

IHCPs include:

- *Indian Health Service (IHS) facilities* – Facilities and/or health care programs administered and staffed by the federal Indian Health Service.
- *Tribal 638 Providers* – Federally recognized Tribes or Tribal organizations that contract or compact with IHS to plan, conduct and administer one or more individual programs, functions, services or activities under Public Law 93-638.
 - Tribal 638 providers enrolled in Medi-Cal as an Indian Health Services-Memorandum of Agreement (IHS-MOA) provider must appear on the [“List of American Indian Health Program Providers”](#) set forth in [APL 17-020](#), Attachment 1 in order to qualify for reimbursement as a Tribal 638 Provider under this BHIN.

- Tribal 638 providers enrolled in Medi-Cal as a Tribal Federally Qualified Health Center (FQHC) provider, must do so consistent with the Tribal FQHC criteria established in the California State Plan, the Tribal FQHC section of the Medi-Cal provider manual, and [APL 21-008](#).¹⁰ Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the "[List of Tribal FQHCs](#)"
- *Urban Indian Organizations* – A Nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of U.S. Code: Title 25, Chapter 18.

All American Indian and Alaska Native (AI/AN) Medi-Cal beneficiaries whose county of responsibility is the 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. County must reimburse DMC-certified IHCPs for the provision of these services to AI/AN Medi-Cal beneficiaries, even if the county does not have a contract with the IHCP. County is not obligated to pay for services provided to non-AI/AN beneficiaries by IHCPs that are not contracted with the DMC-ODS county.¹¹

In order to receive reimbursement from the 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, county must demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to DMC-ODS services. County must adhere to all 42 CFR 438.14 requirements.¹²

Responsibilities of DMC-ODS Counties for DMC-ODS Benefits

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

Selective Provider Contracting Requirements for DMC-ODS Counties

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

¹⁰ See Supplement 6 to Attachment 4.19-B of the California Medicaid State Plan. The Tribal FQHC section of the Medi-Cal provider manual is available at: <https://www.dhcs.ca.gov/Documents/Supplement6toAttachment4.19-B-2-26-21.pdf>. See [APL 21-008](#).

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

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

Contract Denial and Appeal Process

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

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

Residential and Inpatient Treatment Provider

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

Access

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

Authorization Policy for Residential/Inpatient Levels of Care

County 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. County will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service.

Authorization Policy for Non-Residential/Inpatient Levels of Care

County 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 county's beneficiary access number to determine the appropriate location for treatment.

Beneficiary Access Number

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

DMC-ODS County of Responsibility

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 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 county's provider network is unable to provide needed services to a particular beneficiary, the county shall adequately and timely cover these services out-of-network for as long as the county's network is unable to provide them.

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

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

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

Implementation Planning and Federal Approval Process

A new county opting to become a DMC-ODS county must submit a DMC-ODS implementation plan to DHCS using the DMC-ODS implementation plan template included in Enclosure 3 to this policy and procedure. County cannot commence services without an implementation plan being approved by DHCS, a readiness review being completed DHCS, and their network being certified by DHCS. See Enclosures 6, 7 and 8 for the materials DHCS uses to conduct the readiness review. County must also have an executed State/DMC-ODS County IA with the DMC-ODS County Board of Supervisors and approved by CMS, as well as executed memoranda of understanding with all Medi-Cal MCPs operating within the county.

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

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

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

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

Upon CMS approval of an execution of the IA, county will be able to bill prospectively for all covered DMC-ODS services provided to their beneficiaries.

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

Practice Requirements

County 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. County shall ensure the providers have implemented EBPs and are delivering the practices to fidelity. The State will monitor the implementation of EBPs during reviews. The EBPs are:

- Motivational Interviewing – A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person’s ambivalence toward

- treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on beneficiaries' past successes.
- Cognitive-Behavioral Therapy – Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
 - Relapse Prevention – A behavioral self-control program that teaches individuals with SUD how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial SUD treatment.
 - Trauma-Informed Treatment – Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.
 - Psycho-Education – Psycho-educational groups are designed to educate beneficiaries about substance abuse and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

Intersection with the Criminal Justice System

Beneficiaries involved in the criminal justice system are often harder to treat for SUD. While research has shown that the criminal justice population can respond effectively to treatment services, the beneficiary may require more intensive services. County should recognize and educate staff and collaborative partners that Parole and Probation status is not a barrier to DMC-ODS. In addition, county shall ensure that beneficiaries may receive recovery services immediately after incarceration regardless of whether or not they received SUD treatment during incarceration.

DMC-ODS County Oversight, Monitoring, and Reporting

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

DMC-ODS Financing

January 1, 2022 through June 30, 2023

California Mental Health Services Authority (CalMHSA)

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

County shall propose county-specific interim rates for all covered DMC-ODS services that are provided by contracted providers, except for the NTP modality, and the State will approve or disapprove those rates. NTP reimbursement shall be set pursuant to the process set forth in W&I Code section 14021.51. If during the State review process, the State denies the proposed rates, the county will be provided the opportunity to adjust the rates and resubmit to the State. The State shall retain all approval of the rates to assess that the rates are sufficient to ensure access to available DMC-ODS waiver services. Regional model counties shall contract with Medi-Cal MCPs to administer the DMC-ODS benefit, and will reimburse the managed care organizations the contracted Per User Per Month (PUPM) rate. The PUPM is reconciled to the lower of actual costs to the managed care plan or prevailing charges for the services rendered.

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

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

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

July 1, 2023 and ongoing

DHCS will use intergovernmental transfers from participating county to finance the nonfederal 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 must first meet the needs of Medi-Cal beneficiaries before spending these restricted funds on non-Medi-Cal services. County will make monthly transfers to DHCS from these and any other funds eligible under federal law for federal Medicaid reimbursement to finance the nonfederal share of all DMC-ODS payments.

Participating nonregional counties will be reimbursed pursuant to a fee schedule for all covered DMC-ODS services.

External Quality Review

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

Network Adequacy Requirements

County is required to comply with network adequacy requirements. County will be required to submit executed memoranda of understanding with county MCPs and complete the State's readiness review.

DEFINITIONS

Adolescent: Refers to beneficiaries under age 21.

Drug Medi-Cal Organized Delivery System (DMC-ODS): The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. DHCS initially received approval in August 2015 from the Centers for Medicare & Medicaid Services (CMS) to implement the DMC-ODS through the State's prior Section 1115 demonstration. DHCS received approval from CMS on December 29, 2021 to reauthorize the DMC-ODS in the CalAIM Section 1915(b) waiver through December 31, 2026, alongside the State's other Medi-Cal delivery systems: Medi-Cal managed care, dental managed care, and Specialty Mental Health Services (SMHS).

Fee-For-Service (FFS) Medi-Cal Delivery System: Under FFS, the state pays enrolled Medi-Cal providers directly for covered services provided to Medi-Cal beneficiaries. FFS providers render services and then submit claims for payment that are adjudicated, processed, and paid (or denied) by the Medi-Cal program's fiscal intermediary.

Managed Care Plan (MCP): MCPs are responsible for the Medi-Cal physical healthcare benefit. They are also responsible for a portion of the mental health benefit and must provide specified services to adults diagnosed with a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM), that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. MCPs must also provide medically necessary non-specialty mental health services (NSMHS) to children under the age of 21. MCPs refer to and coordinate with county Mental Health Plans (MHPs) for the delivery of specialty mental health services (SMHS).

FORMS/ATTACHMENTS

[Enclosures \(beginning on page 32 of BHIN 23-001\)](#)

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

REVISION HISTORY

Date	Revision	Page Number(s)
N/A	N/A	N/A