

<b>BHS Policies and Procedures</b>	
 <p style="margin-left: 20px;">City and County of San Francisco Department of Public Health San Francisco Health Network BEHAVIORAL HEALTH SERVICES</p>	<p style="text-align: right;">1380 Howard Street, 5<sup>th</sup> Floor San Francisco, CA 94103 (415) 255-3400 FAX (415) 255-3567</p>
<b>Policy Title: SF Drug Medi-Cal Organized Delivery System Requirements for Years 2022-2026</b>	
<p>Issued By: <span style="border: 1px solid black; border-radius: 50%; padding: 2px;">DocuSigned by: <i>Maximilian Rocha</i> EB51A346C32641B...</span></p> <p>Maximilian Rocha Director of Systems of Care</p> <p>Date: September 28, 2022</p>	<p>Manual Number: 3.03-19</p> <p>References: BHIN 21-075; Welfare and Institutions Code (W&amp;I) section 14184.401; W&amp;I Code section 14184.402; Medicaid State Plan (Supplement 3 to Attachment 3.1-A, and Supplement 2 to Attachment 3.1-B</p>

**Equity Statement:** The San Francisco Department of Public Health, Behavioral Health Services (BHS) is committed to leading with race and prioritizing Intersectionality, including sex, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to move forward on the continuum of becoming an anti-racist institution through dismantling racism, building solidarity among racial groups, and working towards becoming a Trauma-Informed/Trauma Healing Organization in partnership with staff, clients, communities, and our contractors. We are committed to ensuring that every policy or procedure, developed and implemented, lead with an equity and anti-racist lens in order to provide the highest quality of care for our diverse clients while ensuring that our providers are equipped to provide services that are responsive to our client's needs and lived experiences.

**Purpose:** The purpose of this policy is to communicate the publication of updated program requirements and standards for the Drug Medi-Cal Organized Delivery System (DMC-ODS) Program for the period of January 2022 through December 2026. These updated program requirements are one part of California's new State Medicaid contract and the California Advancing and Innovating Medi-Cal (CalAIM) program. As a reminder, the prior DMC-ODS requirements and standards were from 2015 through 2021 and were represented as Section 1115 Standard Terms and Conditions.

CCR Title 22 and CCR Title 9 § 10021 are still in effect unless otherwise stated in the San Francisco Intergovernmental Agreement with DHCS. Opioid Treatment Programs (OTPs) shall comply with all federal and state narcotic treatment licensing requirements. OTP services are provided in DHCS-licensed OTP facilities under the California Code of Regulations, Title 9, Chapter 4, and Title 42 of the Code of Federal Regulations (CFR)

**Scope:** This policy applies to all Drug Medi-Cal network providers within the San Francisco Drug Medi-Cal/Organized Delivery System (SF DMC-ODS).

**Policy:** It is the policy of SFDPH that DMC-ODS providers, administrators, and staff implement program

requirements and standards as outlined in the current DMC-ODS Plan. The eligibility requirements for DMC-ODS are: (A) must be currently enrolled in Medi-Cal, (B) must reside in San Francisco County, and (C) meet the eligibility criteria for DMC-ODS services (described below as “DMC-ODS Program Criteria for Services”). Medi-Cal beneficiaries residing in San Francisco can receive DMC-ODS services consistent with assessment, access, and level of care determination criteria described in this policy.

**DMC-ODS Provider Qualifications**

DMC-ODS services are provided by DMC-certified providers. DMC certified providers providing DMC-ODS services must: 1) be licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations; 2) abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services; and 3) have a current, signed, provider agreement with San Francisco City and County for the delivery of DMC-ODS services.

**Opioid Treatment Program Assessment**

Opioid Treatment Programs (OTPs) shall conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam are done at admission to an OTP and qualifies for determining medical necessity under the DMC- ODS.

**DMC-ODS Program Criteria for Services Provided to Beneficiaries Age 21 Years and Over**

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) or registered/certified counselor, whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days 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 before 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. 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

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:

- ii. 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, before being incarcerated or during incarceration, determined by substance use history.

### Medical Necessity of Services

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

### 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.

1. 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.
2. For adult beneficiaries 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.
3. If a beneficiary withdraws from treatment before completing the ASAM Criteria assessment and later returns, the time period starts over.
4. A full ASAM assessment, or initial provisional referral tool for the preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services.
5. A full ASAM assessment does not need to be repeated unless the beneficiary’s condition changes.

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

### **DMC-ODS Program Criteria for Services Provided to Beneficiaries Under 21 Years of Age**

This policy makes clear that DMC services provided to beneficiaries under 21 years of age are to be delivered per the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under Section 1905I of the Social Security Act. BHS ensures beneficiaries under the age of 21 receive all applicable SUD services needed to correct or ameliorate health conditions covered under Section 1905(a) of the Social Security Act. Nothing in the SF DMC-ODS limits or modifies the scope of the EPSDT mandate and BHS maintains responsibility for the provision of SUD services according to the EPSDT mandate.

### Initial Assessment and Services Provided During the Assessment Process

Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medical reimbursable for up to 60 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established.

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. 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

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

### Medical Necessity of Services

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 a SUD are considered to ameliorate the condition and are thus covered as EPSDT services. (Section 1396dl(5) of Title 42 of the United States Code; W&I Section 14059.5(b)(1)).

### Level of Care Determination

1. 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.
2. For beneficiaries under 21, 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.
3. 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.
4. If a beneficiary withdraws from treatment before completing the ASAM Criteria assessment and later returns, the time period starts over.
5. A full ASAM assessment, or initial provisional referral tool for the preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services.
6. A full ASAM assessment does not need to be repeated unless the beneficiary's condition changes.

### EPSDT

Under the EPSDT mandate, any beneficiary under the age of 21 who is screened and determined to be at risk of developing a SUD may receive any service component covered under the outpatient level of care as early intervention services. A diagnosis from the Diagnostic and Statistical Manual or International Classification of Diseases, Tenth Edition (ICD-10) for Substance-Related and Addictive Disorders is not required for early intervention services. Early intervention services are provided under the outpatient treatment modality and must be made available by counties based on individual clinical needs, even if the beneficiary under age 21 is not participating in the full array of outpatient treatment services.

### **DMC-ODS Program Requirements Applicable to all DMC-ODS Providers**

#### Coverage Requirements and Clarifications

Effective January 1, 2022, in circumstances where services are appropriately delivered within the provider's

scope and when services are documented appropriately, BHS Compliance, consistent with W&I Code section 14184.402(f), will not disallow reimbursement for clinically appropriate and covered SUD prevention, screening, assessment, and treatment services, conducted during the assessment, solely due to lack of inclusion in an individual treatment plan, lack of client signature on the treatment plan, or if DMC-ODS services are provided to a beneficiary who has a co-occurring mental health condition if the beneficiary meets the DMC-ODS Criteria for Beneficiaries After Assessment.

Similarly, in circumstances where services are appropriately delivered within the provider's scope and when services are documented appropriately, then SUD prevention, screening, assessment, and treatment services can be reimbursable Medi-Cal services when:

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

As stated in the "Initial Assessment and Services Provided During the Assessment Process" subsections, clinically appropriate and covered DMC-ODS services are reimbursable during the assessment. BHS will not disallow reimbursement for clinically appropriate and covered DMC-ODS services provided during the assessment process if ultimately the assessment determines that the beneficiary does not meet the DMC-ODS Access Criteria for Beneficiaries After Assessment.

If services are provided due to a suspected SUD that has not yet been diagnosed, an episode or clinical record may be opened with a deferred diagnosis (Z03.89), other Z code, or any other valid ICD 10 diagnosis code. All claims must have a valid ICD-10 diagnosis code.

#### MAT Policy

Required MAT medications have been expanded to include all medications and biological products Food and Drug Administration (FDA)-approved to treat OUDs and AUDs. BHS ensures through monitoring that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have effective referral mechanisms/processes to MAT to beneficiaries with SUD diagnoses. Furthermore, under the "MAT Delivered at Alternative Sites" option, BHS can 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, SROs, street-based outreach).

#### CalAIM DMC-ODS MAT Policy

Under CalAIM, BHS ensures 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. BHS monitors the referral process or provision of MAT services.

BHS will 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 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).

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.

### **Required Evidenced-Based Treatment Practices**

BHS will monitor for and ensure that providers implement at least two of the following evidenced-based treatment practices (EBPs) within their treatment settings. The two EBPs are per provider, per service modality.

- o Motivational Interviewing
- o Cognitive-Behavioral Therapy
- o Relapse Prevention
- o Trauma-Informed Treatment
- o Psycho-Education

BHS ensures that providers have implemented EBPs and are delivering the practices to fidelity.

### **Indian Health Care Providers**

American Indian and Alaska Native individuals who are eligible for Medicaid and reside in San Francisco can receive DMC-ODS services through Indian Health Care Providers (IHCPs).

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.
  - o 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.

o 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”

- 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.

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.

San Francisco will reimburse DMC-certified IHCPs for the provision of these services to AI/AN Medi-Cal beneficiaries, even if San Francisco does not have a contract with the IHCP. In order to receive reimbursement from the City and County of San Francisco 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.

San Francisco will not pay for services provided to non-AI/AN beneficiaries by IHCPs that are not contracted with the City and County of San Francisco; and will continue to adhere to [42 CFR 438.14](#) requirements.

### **San Francisco DMC-ODS Responsibilities for DMC-ODS Benefits**

The county responsibilities for the DMC-ODS benefit are included in the San Francisco DMC-ODS intergovernmental Agreement with DHCS and requires that BHS comply with the following.

#### Selective Provider Contracting Requirements for DMC-ODS Counties (supersedes MHSUDS IN 19-018)

BHS selects the DMC-certified providers with whom we contract with to establish the DMC-ODS provider networks, with the exception of IHCPs.

#### Contract Denial and Appeal Process

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.

Providers that apply to be a contract provider but are not selected a written decision including the basis for the denial.

San Francisco DPH solicitation documents utilized for the selection of DMC providers include a protest

provision and have a protest procedure for providers that are not awarded a contract. The protest procedure includes 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 of [BHIN 21-075](#).

#### Residential and Inpatient Treatment Provider

BHS is 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

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

#### Authorization Policy for Residential/Inpatient Levels of Care

BHS 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. BHS 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

BHS does 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 will be used when beneficiaries call the County's beneficiary access number and visit BHS's Treatment Access Program (TAP) to determine the appropriate location for treatment.

#### Beneficiary Access Number

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

#### DMC-ODS County of Responsibility

BHS 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 BHS 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 BHS's provider network is unable to provide needed services to a particular beneficiary, then BHS will adequately and timely cover these services out-of-network for as long as the BHS'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 DMCODS 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, BHS ensures 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 BHS'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), BHS will adequately and timely cover these services out-of-network for the beneficiary, for as long as BHS's provider network is unable to provide them. In these cases, BHS shall coordinate and cover the out-of-network NTP services for the beneficiary. If a beneficiary working in or travelling to another county is not able to receive medically necessary DMC-ODS services, including NTP services, without paying "out of pocket", the DMC-ODS county of responsibility has failed to comply with the requirements contained in 42 CFR 438.206.

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

#### Intersection with the Criminal Justice System

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

#### **Contact Person:**

AOD Administrator

**Attachment:** Attachment 1 Covered DMC-ODS Services

#### **Distribution:**

BHS Policies and Procedure are distributed by BHS Quality Management, Office of Regulatory Affairs

Administrative Manual Holders

BHS Programs

SOC Program Manager

BOCC Program Managers

CDTA Program Managers

## **Attachment I**

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

DMC-ODS services include the following comprehensive continuum of outpatient, residential, and inpatient evidence-based SUD services.

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

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

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT) (commonly known as Screening, Brief Intervention, and Referral to Treatment, or SBIRT) is not a DMC-ODS benefit. It is a benefit in Medi-Cal Fee-for-Service and Medi-Cal managed care delivery system for beneficiaries aged 11 years and older. Early intervention services are covered DMC-ODS services for beneficiaries under the age of 21. Any beneficiary under the age of 21 who is screened and determined to be at risk of developing a SUD may receive any service component covered under the outpatient level of care as early intervention services. A SUD diagnosis is not required for early intervention services. As noted above, this does not eliminate the requirement that all Medi-Cal claims, including DMC-ODS claims, include a CMS approved ICD-10 diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS approved ICD-10 diagnosis code list. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services". Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the beneficiary under age 21 is not participating in the full array of outpatient treatment services.

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

Early intervention services may be delivered in a wide variety of settings and can be provided in person, by telehealth, or by telephone. Nothing in this policy limits or modifies the scope of the EPSDT mandate.

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

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

- 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 with 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 with 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 by 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 with 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.

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. BHS verifies 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.

Residential Treatment services can be provided in facilities of any size. The statewide goal for the average length of stay for residential treatment services 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. BHS network providers shall ensure that beneficiaries receiving residential treatment are transitioned to another level of care when clinically appropriate based on treatment progress. BHS monitors and adheres 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.

BHS maintains coverage and ensures access for ASAM Levels 3.1-3.5 residential SUD treatment services since 2016. Residential Treatment Services include the following:

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

#### Inpatient Services

DMC-ODS counties can 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.

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. Opioid Treatment Program

Opioid Treatment Program (OTP), 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. OTPs 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 OTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the OTP must prescribe the medication for dispensing at a pharmacy or refer the beneficiary to a provider capable of dispensing the medication. The OTP shall offer the beneficiary a minimum of fifty minutes of counseling services per calendar month. OTPs shall comply with all federal and state OTP licensing requirements. If the OTP cannot comply with all federal and state OTP requirements, then the OTP must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. OTP services are provided in DHCS-licensed OTP facilities according to the California Code of Regulations, Title 9, Chapter 4, Division 4, and title 42 of the CFR. Counseling services provided in the OTP modality can be provided in person, by telehealth, or by telephone. However, the medical evaluation for methadone treatment (which consists of medical history, laboratory tests, and a physical exam) must be conducted in person. OTP 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 an 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 a beneficiary is receiving Withdrawal Management in a residential setting, each beneficiary shall reside at the facility. All beneficiaries receiving Withdrawal Management services, regardless of 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 with 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 tools to support referral to additional services is appropriate. If it has not already been completed with the Withdrawal Management episode, the full ASAM Criteria assessment shall be completed within 30 days of the beneficiary's first visit with an LPHA or registered/certified counselor for non-Withdrawal Management services (or 60 days for beneficiaries under 21, or beneficiaries experiencing homelessness), as described above.

## **8. Medications for Addiction Treatment**

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

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

## 9. Peer Support Services

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 educate beneficiaries and their families about their conditions and the process of recovery. Peer support services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other people supporting the beneficiary (defined as collaterals) if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals. Peer Support Services are delivered and claimed as a standalone service. Beneficiaries may concurrently receive Peer Support Services and services from other levels of care described in this "Covered DMC-ODS Services" section. Peer support services are based on a plan of care approved by a Behavioral Health Professional (see definition of Behavioral Health Professional below; this term is specific to the administration of Peer Support Services). Peer Support Services consist of Educational Skill Building Groups, Engagement, and Therapeutic Activity services as defined below:

- Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills 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 per 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. 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.

## **10. Recovery Services**

Recovery Services are designed to support recovery and prevent relapse to restore 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 selfassessment 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 OTP 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.

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.

## **11. Care Coordination**

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

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

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

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

## **12. Clinician Consultation**

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

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

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